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Qual Health Res 2007; 17; 1149
DOI: 10.1177/1049732307308305

Qualitative Health Research
Volume 17 Number 8
October 2007 1149-1159
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10.1177/1049732307308305
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Ethical Components of Researcher–Researched Relationships in Qualitative Interviewing

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Qualitative interviews are widely and often uncritically adopted for health care research, with little justification of therapeutic value. Although they might provide valuable insights into the perspectives of participants, they represent only a version of reality, rather than "truth" per se. Qualitative research is vulnerable to bias through the attitudes and qualities of the researcher, social desirability factors, and conditions of worth. Exploitation, through role confusion, therapeutic misconception, and misrepresentation are particular risks for health care–related research. Ethical codes, biomedical principles and care philosophies provide little contextual guidance on the moral dilemmas encountered in the practice of research. If nurse researchers are to navigate the moral complexities of research relationships, then sensitivity to risk to participants must be of continual concern, from conception of the study to the reporting of outcomes. Examination of the self through critical reflection and supervision are therefore necessary components of ethical research.

Keywords: *biomedical ethics; ethics of care; reflection; exploitation; relationships*

Qualitative studies have been increasingly favored as a means of understanding the patient's perspective in health care research, with the widely held view that interviews provide authentic access to the lived experience of the other (Fossey, Harvey, McDermott, & Davidson, 2002; Frank, 2000; Moyle, 2002).

The interview method of data collection has been advocated as being particularly well suited to the collection of data on sensitive topics (Richards & Schwartz, 2002), as well as an effective means of gaining insight into patients' experience of suffering (Clarke, Febbraro, Hatzipantelis, Laurier, & Nelson, 2005; Kinmouth, 1995), and their perception of the efficacy of medical or nursing intervention (Ziebland, Chapple, Dumelow, Evans, Prinjha, & Rozmovits, 2004). Others have argued, however, that the interview is overused in qualitative research, and its uncritical adoption has given researchers a false sense of authenticity (Atkinson, 1997; Silverman, 2000).

Acknowledgement of the interpersonal and contextual components of research as being unavoidable has led to a closer examination of the personal qualities that researchers bring to interviews, and the ethical uncertainties of researcher–researched relationships (Kylmä, Vehvillainen-Julkunen, & Lahdevirta, 1999). The illusion that researchers do not influence the research process has not, however, been altogether abandoned, and technical aspects of the interview are still more likely to be reported on than the interactions between interviewer and participant (Richards & Emslie, 2000).

Continued attempts to discount the personal presence, values, and beliefs of the researcher are congruent with quantitative or positivistic methods of scientific research, which purport the existence of an objective reality that might be measured empirically (Cutcliffe, 2000). In positivism, the identity of the researcher is not pertinent, as objective reality might be captured by anyone using the correct scientific method (Campbell & Wasco, 2000).

Qualitative research is, however, concerned with answering questions about the experience and meaning people give to dimensions of their lives and social worlds, and attempting to explain those experiences, behaviors, interactions, and social contexts without the use of statistical procedures or quantification (Fossey et al, 2002). To understand how reality is constructed and interpreted, the researcher's inherent subjectivities, including values, beliefs, and emotions should be accepted as centrally involved in the research process, and the notion of objectivity rejected as neither necessary, nor even desirable (Campbell & Wasco, 2000).

In this article, I examine the relationship between the researcher and the researched, and the ethical dilemmas that arise from the intrusive nature of the qualitative interview. Although it is recognized that many issues evolve from discussion of research relationships—such as insider versus outsider perspectives and/or the study of cultural relationships and peers—the particular focus here is on health care research in which researchers are also health care professionals and participants are also recipients of care. Modulating variables, which affect the process and outcome of research, are discussed within the qualitative paradigm, and recommendations for ethical interviewing are proposed.

The Interview Method

The aims of qualitative research interviews are purportedly to gain access to the experiences, feelings, and social worlds of participants (Fossey et al., 2002). Interviews are designed to produce data, which are useful or relevant in terms of the research question, and the type of interview and the processes involved are determined by the philosophical perspective, which underpins the research design (Robinson & Thorne, 1988).

Unstructured interviews are well suited to nondirective research paradigms, whereas semistructured interviews use an interview guide to facilitate a more focused exploration of a specific topic, or to follow up on specific issues that emerge during data collection (Fossey et al., 2002). Follow-up interviews have also been advocated as a mechanism for checking the authenticity of emerging insights identified by researchers, to ensure that these have meaning for participants (Cutcliffe, 2000).

The qualitative interview has been extensively used in nursing research (Melia, 1987, 1996; Morse, 1994; Moyle, 2002; Schreiber, 1996), with the widely held view that interviews provide authentic access to the lived experience of the other (Fossey et al., 2002), which might be faithfully interpreted by the person of the researcher. Silverman (1998) has argued that the interview is overused in qualitative research and that its uncritical adoption provides little more than anecdotal insights, giving researchers a false sense of authenticity (Atkinson, 1997; Silverman, 2000). This sense of authenticity, Silverman (1998) asserts, is spurious because of atheoretical or nonanalytical accounts of studies in literature, which are often retrospective, fail to give the reader sufficient or detailed data extracts, and provide a suspiciously cohesive summary of responses that do not take account of deviant cases.

If the assertion that interviews are of questionable merit is accepted, then it follows that the ethics of conducting such interviews, which often elicit painful and distressing experiences for participants (Kylmä et al., 1999), are also questionable. However, Silverman (1998) does not dismiss the worth of qualitative interview per se, but rather argues for a more rigorous approach to validity through more robust analytical thought and a clear indication of how the research question and outcome have value. A moral obligation then exists for the researcher to ensure that there is sound justification for the investigation and research method, which extends beyond intrusive curiosity and achieves more then the "telling of sad stories" (Thorne & Darbyshire, 2005).

Factors of Influence

Critical theorists dispute the existence of a single, objective reality, but consider knowledge to be a construction of gender, race, class, culture, economics, and values, which determine perceptions of the participant's social world (Campbell & Wasco, 2000). In social constructivism, multiplicities of realities are seen as being socially constructed. Discourses construct different versions of reality, with many potential worlds of meaning (Marks, Murray, Evans, Willig, Woodall, & Sykes, 2005).

The implication for critical research methodologies informed by these perspectives are that they emphasise the need for self-reflection and empowerment for participants, rather than uncritical acceptance of discoveries and researcher-driven agendas (Fossey et al., 2002). In both theories, the identity of the researcher is of key importance because the researcher is actively involved in the social construction of the research reality. Values, beliefs, and life experiences influence the construction of research questions, data collection, and interpretation of findings (Campbell & Wasco, 2000), and need to be brought into conscious awareness if they are to facilitate rather than impede critical analysis (Berger & Kellner, 1981; Hutchinson, 1993).

The factors that have been recognized as influencing the relationship between researchers and participants include age, appearance, social class, culture, inequalities of knowledge and power, environment, and gender (Baxter & Eyles, 1997; Richards & Emslie, 2000). The quality of the relationship might depend on the level of formality or informality generated by perceptions of professional boundaries, the capacity for intimacy and the personal qualities projected by the researcher (Baxter & Eyles, 1997).

Richards and Emslie (2000) investigated the influence of professional background on interviewing by comparing their experiences as two researchers from different professional backgrounds (general practice and sociology), working on similar qualitative studies in the same university department. Both studies involved in-depth interviews with 60 middle-aged men and women of varied occupational social class. Emslie is a sociologist (Scottish, in her late 20s) and Richards (English, in her mid-30s) is a general practitioner (GP). Both are White, female, and middle class, and have similar experiences of qualitative research.

Both researchers noted certain interactions that seemed to be associated with differing professional backgrounds. The GP was explicit about her professional background and many working-class participants were consequentially deferential to her status as a doctor. One participant apologized for expressing negative views of doctors. Middle-class participants were not deferential and assumed a commonality of opinions and experiences, which was stronger in male than female participants. All participants asked clinical questions.

The sociologist introduced herself as a researcher only and stressed that she was not medically qualified. A number of participants assumed her to be a student (due in part to her casual attire) and one participant referred to her as “the girl from the university.” Participants readily expressed negative views about doctors and their experience of treatment. Richards and Emslie (2000) concluded that their professional backgrounds extensively influenced the perceptions of participants and the process and outcomes of interviews.

Very few studies give such detailed descriptions of the researchers’ personal qualities (age, class, appearance, and status), which allow the reader to evaluate the validity of claims regarding conceptual bias. In common with many researchers, however, Richards and Emslie (2000) provide few detailed examples of transcriptions, which, given the number of participants, detracts from claims of representativeness. Their conclusion that interviews were affected by professional backgrounds is only partially justified. Although issues of appearance and age are mentioned, these are not given equal consideration, despite Emslie’s characterization as a student. There is perhaps nothing startling in the revelation that participants are less likely to criticize professional groups that are represented by the researcher, but it does serve to strengthen arguments for explicitly addressing role boundaries with participants.

Determinants of the Ethical Research Relationship

Ethically sound research should guarantee the protection of human rights. These include disclosure concerning the study, privacy, anonymity, confidentiality, fair treatment, protection from discomfort and harm, and self-determination (Kylmä et al., 1999). It is difficult, however, to define ethical conduct in the context of qualitative interviewing in advance, as moral questions can arise at any time during the research process, being determined by changing levels of competence, types of disclosure, and the unintended consequences of growing emotional intimacy. From study design to data collection and publication, ethical conduct is not fixed, but needs to be continually responsive to personal, social, and contextual constructions (Aita & Richer, 2005; Goodwin, Pope, Mort, & Smith, 2003).

Ethical guidance for research is currently provided by a number of associations, including the British Sociological Association (1991), the Royal College of Nursing (1998), the British Medical Association (1999), the Medical Research Council (2000), and the Department of Health (DoH; 2002). The Declaration of Helsinki (World Medical Association, 1964), with amendments in 1996, asserted that participants should be informed about the nature and outcomes of research, and be free to decide whether or not to participate without fear of negative repercussions (Ramcharan & Cutcliffe, 2001). The British Sociological Association’s Statement of Ethical Practice (1991) offers guidance for researchers involved in qualitative studies, addressing the nature of power relationships between researchers and participants, consent and anonymity, and privacy and confidentiality (Richards & Schwartz, 2002).

Despite a preponderance of official guidelines for quantitative research, there is evidence to suggest that local medical research ethics committees have difficulty assessing ethical issues arising in relation to qualitative studies, which has hindered the research of sensitive topics (Gauld, 1999; Moyle, 2002). So-called vulnerable groups—such as those with mental health problems— have therefore often been denied a voice in qualitative research because of beliefs of ipso facto incompetence and nonautonomy.

The principle-based approach to conducting ethical research is commonly cited as the most appropriate foundation for judging the moral actions of the researcher and the virtues of research aims and outcomes (Kylmä et al., 1999; Lacey, 1998; Tee & Lathlean, 2004). Respect for autonomy, beneficence, and nonmaleficence has become a key component of any discussion of the researcher–researched relationship, which, it is argued, will ensure that the end objective in qualitative research does not override the rights, health, well-being and care of research participants (DoH, 2001; Merrell & Williams, 1995). The principle-based approach to biomedical ethics does not, however, provide contextual guidance for researchers, nor does it address the circular arguments surrounding conducting qualitative research with nonautonomous persons whose supposed powerlessness is an inevitable obstacle to ethical research, which in turn perpetuates powerlessness through a denial of dialogue.

Autonomy

Autonomy has been defined as the capacity to think, decide, and act on the basis of such thought and decision freely (Gillon, 1986). Beauchamp and Childress (2001) identify two conditions that they see as being essential for autonomy: The first is liberty (independence from controlling influences) and the second is agency (capacity for intentional action). Respect for autonomy is conceptualized in health care as informed consent (Beauchamp & Childress, 2001).

In the context of research, informed consent is an explicit agreement by participants to participate in the research process after receiving and comprehending information regarding the nature of the research. Such consent is given without threat or inducement and requires that participants have the mental competence to give consent and voluntariness (Tee & Lathlean, 2004). Threats to voluntariness can arise from any quality that has the capacity to control or dominate a potential subject's decision to participate in research. This includes the vulnerabilities of potential participants, the characteristics of the researcher, the researcher's acts, and the research setting (Nelson & Mertz, 2002).

Vulnerable groups are those that have been characterized as partially or entirely unable to make autonomous decisions, people with mental illness, patients detained under the Mental Health Act (1983), the elderly, children, and those suffering organic and functional cognitive impairment (Tee & Lathlean, 2004). Such groups are referred to by Beauchamp and Childress (2001) as nonautonomous persons. The Declaration of Helsinki recognizes the term *vulnerability* and states that:

> Some research populations are vulnerable and need special protection . . . those who cannot give or refuse consent . . . those who may be subject to giving consent under duress, those who will not benefit personally from the research and those for whom the research is combined with care. (World Medical Association, 1964, p.1, section 8)

Groups might be vulnerable because of their inability to comprehend information and/or make voluntary choices, or because of a historical lack of autonomy such as women and ethnic minority groups (Aita & Richer, 2005). Vulnerability might also be ascribed to participants because of the sensitivity of the topic or its social context (Lee & Renzetti, 1990).

Moyle (2002) conducted a phenomenological study using unstructured interviews with seven participants (six females and one male) who had a major depressive illness in an acute psychiatric setting. All participants except one had been undergoing electroconvulsive therapy (ECT). Informed consent had been obtained from all participants, who were recruited through senior nursing staff. The aim of the study was to understand about caregiving and nurturing from the participant's perspective, and what it revealed was that participants identified that little time was given by nursing staff to nurturing through the therapeutic relationship.

Depressive illness impacted the participants' recall and articulation of the experience, and raised ethical concerns about informed consent, vulnerability, and exploitation through the research relationship. One participant who had given consent prior to ECT had no recollection of this afterward, and was withdrawn from the study. Participants were interviewed weekly while hospitalized; one participant was interviewed weekly for 6 months.

Interviews took place after ECT. How soon these interviews took place is not identified, but was immediate enough with one participant for speech to still be affected. As the study was focused on nurturing and not on the effects of ECT, this is a questionable practice that might have added stress for vulnerable participants. The dangers of confusing the interview with a therapeutic encounter were mentioned, but given that participants felt that their need to be nurtured had not been met by nursing staff, and the prolonged nature of engagement with some participants, the increased risks of exploitation merit further discussion. Participants frequently sought reassurance that their confidences would not be shared with nursing staff, but Moyle (2002) does not identify how these concerns were answered, or whether ethical dilemmas arose with regard to professional versus clinical obligations.

No examples from transcripts were given, and a number of the moral uncertainties that appear to arise might have been answered for the reader by a more transparent presentation of responses and processes. The study does, however, illustrate the fluctuating nature of informed consent and the formidable task of assessing where competence ends and incompetence might be brought about through periodic medical intervention, which has resonance for many patient groups undergoing treatment during research.

Vulnerability Through Misrepresentation

Qualitative research is concerned with descriptions and interpretations of research participants' narratives, actions, and social contexts (Fossey et al., 2002). By constructing identities for their participants, qualitative researchers risk seriously breaching respect for participants' autonomy through distorted interpretation and generalization (Cushing, 1994; Richards & Schwartz, 2002). When participants lose control over how their narratives are interpreted, they also risk losing control over self-identity (Richards & Schwartz, 2002).

Transcriptions are not a literal representation of participants' personal narratives. Changes to grammar and punctuation, and simplification or loss of tone, pace, or volume can create an emotionally sanitized version of the account (Alldred & Gillies, 2002). Interpretation is based on the interviewer's perceptions, which are affected by what the researcher is able to hear within the text. Participants' accounts might be mitigated by social desirability response bias because of the need for approval and the demands of a particular situation (Collins, Shattell, & Thomas, 2005).

The need for positive self-regard might lead to a selective perception of experience in terms of conditions of worth. Those beliefs and behaviors, which are congruent with the person's image of self, are permitted into awareness, whereas those that are not are distorted or denied (Rogers, 1959). Intrusive threats arise when the researcher investigates the private spheres of participants, and interpretation might leave participants feeling uncomfortable about what is suggested in the description and analysis given by the researcher (Lee, 1993; Williams, 1998). Research outcomes, at best, represent only a version of the truth, but cannot be said to describe the lived experience of another.

Beneficence and Nonmaleficence

The principle of beneficence includes an obligation to provide benefits for the patient and to balance such benefits against risks (Beauchamp & Childress, 2001). Nonmaleficence requires that the nurse should do the patient no harm and should prevent and remove already existing harm (Tuxhill, 1994).

It has been asserted that there is a similarity between research interviews and therapeutic encounters (Bourne, 1998; Richards & Emslie, 2000). Tee and Lathlean (2004) suggest that the person-centred skills required to develop research relationships and maintain engagement are similar to those which are requisite for the creation of therapeutic nurse–patient alliance. Listening and attending to, and reflecting and summarizing back key elements of participants' responses might be perceived as powerful cathartic facilitators (Richards & Emslie, 2000). The interview process might therefore give rise to unexpected benefits (Merrell & Williams, 1995), or might equally cause harm through the revelation of emotionally sensitive and painful details which participants did not intend to reveal (Stacey, 1988). Rapport is necessary to elicit engagement, but where rapport is at its best, exploitation of relationships is of most concern (Goodwin et al., 2003).

When the interview is conceptualized as having a therapeutic as well as a research remit, this might lead to difficulties for both the participants and the researcher (Kylmä et al., 1999), as the qualitative interview is often designed to be probing in nature as it aims to gain access to deeper levels of understanding of the reasons and context for participants' beliefs and actions (Richards & Schwartz, 2002). Anxiety, distress, guilt, and damage to participants' self-esteem might occur as a result of exploitation through the overly intrusive interview (Hammersley & Atkinson, 1993). Empathetic engagement in the participants' narrative might lead to internalization of suffering and development of compassion stress by the interviewer (Rager, 2005). When researchers are directly involved in the care of the participant, the interview process is more likely to be confused with a therapeutic encounter and participants might divulge more information than they had anticipated when consenting to the study (Richards & Schwartz, 2002).

Justice

Concepts of justice are explained in terms of what is deserved by each individual, and to what each individual is entitled, without partiality and with the aim of delivering equitable treatment (Botes, 2000).

Inconvenience and costs involved in participating in qualitative research are often underestimated, when qualitative studies in health services involve in-depth interviews with participants (Richards & Schwartz, 2002). Interviews are frequently long and repeated, necessitating intrusion into the participant's home or attendance at a research center (Murphy & Dingwall, 2001; Richards & Schwartz, 2002).

Promoting justice requires that there be a fair and equitable distribution of benefits and burden, as well as fairness in the selection of research participants (Kahn, Mastrioanni, & Sugarman, 1998). Justice might conflict with confidentiality, and ideas about the greater good and the autonomy of those being studied (Merrell & Williams, 1995). The remit of confidentiality and ground rules should be established when there is risk that participants' disclosures might reveal potentially significant harm to self or others, which would require that confidentiality be overridden (Nursing and Midwifery Council, 2004). Political control over the dissemination of findings might not be within the researcher's control (Merrell & Williams, 1995), and therefore, participants might be at particular risk of negative repercussion in cases of individual or group identification.

Participants are particularly vulnerable to identification in qualitative studies (Hammersley & Atkinson, 1993; Kylmä et al., 1999). The danger of identification carries with it the associated risk of sanctions, stigma, prejudice, and reprisal to the participant or their wider social group (Kylmä et al., 1999). Interview transcripts contain multiple clues to the person's identity, and even after being anonymized, quotations and context might provide enough information for participants to be identified by themselves or others (Richards & Schwartz, 2002).

Kylmä et al. (1999) investigated the potential ethical challenges in a prospective grounded theory study on the dynamics of hope in HIV-positive adults and their significant others. The main emphasis of the article was on the prospective ethical aspects of the study and the relationship between the researcher and the participants in individual interviews. Risks to participants through the painful reliving of experiences, potential manipulation by the researcher (who was also a nurse), and risks of identification were the main themes identified. Kylmä et al. (1999) considered the conflicting role expectations that might occur when the researcher is also a nurse. They identify the possibility that the participants might not always understand the researcher's investigatory role, and they might see him or her primarily as a caregiver.

There is an inevitable power imbalance in the research relationship, even when the researcher is committed to an ethical and egalitarian position (Hammersley & Atkinson, 1993). When the researcher is also a health professional, this might lead to role confusion and blurring of role boundaries for participants, giving rise to mistaken ideas of obligation (Bland, 2002). When the nurse or clinician researcher is also directly involved in care or treatment, participants might feel pressured to participate in research because they depend on the good will of their carers (Richards & Schwartz, 2002). Nurses, therefore, need to give extra care to issues of coercion, deception through misrepresentation, and attention to moral problems uncovered in the research process (Olsen & Mahrenholz, 2000).

Ethics of Care

The disparity of position and power between the researcher and researched has been highlighted by feminist research (deVault, 1990; Edwards & Mauthner, 2002; Oakley, 1988; Olesen, 1994; Reinharz, 1992). Campbell and Wasco (2000) have argued that essentially masculine views of research have glossed over issues of gender and race in the face-to-face interview encounter, as in the analytic strategies deployed after data collection.

Gilligan (1982) distinguished the ethics-of-care approach from the principle-based approach, suggesting that the former approach is most often (though not exclusively) characteristic of females, and the latter approach is most often (though not exclusively) found in males. The ethics-of-care approach advocates that ethical decision making has emotional as well as cognitive components. Each moral problem is unique, and moral agents are seen as being rooted in social contexts, interpersonal relationships, and personal narratives. Emotions are not only relevant, but are a proper source of moral judgement, and bias is seen to be acceptable and inevitable (Manning, 1998). The ethics-of-care approach maintains that affective responsiveness is necessary to moral decision making, with the aim of developing sympathetic understanding and some degree of empathetic awareness (Manning, 1998; Noddings, 1984). This is facilitated through egalitarian relationships grounded in reciprocity and a sense of mutuality.

Figure 1 summarizes the components of ethical research relationships. The research process changes the researcher, and this changed self becomes part of the data itself (Coffey, 1999; Davies, 1999). Feminist standpoints therefore assert that the processes of research should explore all aspects of the researcher's identity, values, beliefs, and emotions, and that this articulation of self must be communicated publicly within the research context (Campbell & Wasco, 2000). The aim is to strengthen nonhierarchical connections between researchers and participants rather than

Figure 1
Components of the Ethical Research Relationship

Acknowledgement of bias	1. Closer examination of the personal qualities that researchers bring to interviews, including personal presence, values, and beliefs. 2. Explicit acknowledgement that research findings do not represent objective reality, but a coconstruction of knowledge influenced by context and the belief systems of the researcher and participant.
Rigor	1. Factors influencing the research relationship should be addressed in the construction and reporting of research (e.g., age, appearance, social class, culture, inequalities of knowledge and power, environment, and gender). 2. Reflexivity is necessary for researchers to critically examine their own priori assumptions and actions through being self-conscious and self-aware. 3. Examples from transcripts should be sufficient to give a representative presentation of responses and processes. Misinterpretation of participants' experiences might be reduced through respondent validation. 4. Changes to grammar and punctuation, and simplification or loss of tone, pace, or volume during the transcription of interviews should be minimized.
Rapport	1. Factors of influence include the level of formality or informality, perceptions of professional boundaries, the capacity for intimacy, and the personal qualities projected by the researcher. 2. Ideal research relationships are characterised by genuine rapport, honesty, and emotional closeness, while recognizing the potential abuses of power, which might be increased by facilitation of deeper levels of rapport.
Respect for autonomy	1. Informed consent is given by participants without threat or inducement, after receiving and comprehending information regarding the nature of the research. Participants must have the mental competence to give consent, which might alter during the course of the research and requires that the researcher is continually sensitive to changes in the voluntariness of participants. 2. The power imbalance between researchers and participants should be reduced through the promotion of egalitarian relationships, grounded in reciprocity and a sense of mutuality. 3. Participants should be involved and consulted by ethics approval committees. Vulnerable groups, such as those with mental illness, should not automatically be prevented from participating in research.
Avoidance of exploitation	1. Anxiety, distress, guilt, and damage to participants' self-esteem might occur as a result of exploitation through the overly intrusive interview. The remit of the research interview should be clearly defined to avoid confusion with therapeutic aims, particularly when the researcher has clinical responsibilities. When sensitive issues are explored, consideration should be given to the availability of further support mechanisms, and debriefing for participants and researchers. 2. Research should be worth doing, in the sense that the results are likely to lead to tangible benefit for patients. Inconvenience and costs should be minimized.
Confidentiality	Ground rules should be established, particularly when there is risk that participants' disclosures might reveal potentially significant harm to self or others, which would require that confidentiality be overridden, or when political control over the dissemination of findings might not be within the researcher's control. Interview transcripts should not provide information that could lead to the identification of participants.

formulating moral principles that stand above power and context (Campbell & Wasco, 2000; Edwards & Mauthner, 2002). Ideal research relationships are characterized by genuine rapport, honesty, and emotional closeness, while recognizing the potential abuses of power, which might be increased by facilitation of deeper levels of rapport (Campbell & Wasco, 2000; Duncombe & Jessop, 2002; Merrell & Williams, 1994).

Silverman (2000) and Atkinson (1997) have argued that a research agenda should not be muddled with emotionalism and therapeutic and emancipatory outcomes for participants, and should focus on robust indicators of validity (Silverman, 1998). However, from an ethics-of-care perspective, which prizes the relationship and personhood of the participant, rigor should be balanced with moral concerns. Issues of confidentiality, anonymity, and sensitivity to the perceived wishes of participants will therefore override concerns about the completeness of research (Goodwin et al., 2003).

Whichever ethical frameworks and methods of data gathering are used, extensive engagement with participants is an essential feature of all qualitative research, and immersion in the participants' personal narratives is necessary if the subjective meaning of content and context are to be understood (Fossey et al., 2002). Rules, rights, or responsibilities cannot shape ethical conduct if motivation, behavior, values, attitudes, beliefs, and interpersonal processes are not consciously analyzed. Moral dilemmas require both prospective consideration and retrospective study if harm to participants is to be prevented and research outcomes are to have validity.

Reflexivity

Researchers might not be aware of the direction the research will take, nor of its outcomes (Merrell & Williams, 1995). Decision making about ethics is problematic when the research design is emergent, and reflexivity is necessary if the researcher is to navigate the expected and unexpected moral dilemmas that arise at each stage of the research process (Ramcharan & Cutcliffe, 2001).

In contrast to much medical research, nursing research protocols have been found to be more vulnerable to ethical problems arising from the relationship between the researcher and participant than from physical harm (Olsen & Mahrenholz, 2000). This implies that the nurse researcher must invest in considerable self-awareness and analysis of values, attitudes, agendas and interpersonal abilities if research relationships are to be facilitative and nonmaleficent. The researcher must be morally sensitive, able to identify ethical problems, and respond with moral reasoning to decide on proper actions when moral dilemmas occur (Aita & Richer, 2005).

Researchers are reflexive when they refer back and critically examine their own priori assumptions and actions through being self-conscious and self-aware about the research process and their own role within it (Finlay, 2002; Holloway, 1997; Koch & Harrington, 1998). Reflection focuses on the location and influence of the researcher, participant, text, and environment, penetrating the representational exercise and shaping the data analysis (Koch & Harrington, 1998; Murphy & Dingwall, 2001).

Learning to reflect on action facilitates reflection in action and before action (Greenwood, 1993; Schon, 1983). The purpose of reflection is not only to conduct a cognitive postmortem, but also to look to the future through the practice of anticipation. Researchers are part of, rather than separate from, the data (Lipson, 1991). Qualitative research is affected by the social location of researchers, and their personal qualities, values, gender, ethnicity, and class identities (Richards & Emslie, 2000; Turner, 1981). Anticipatory reflection gives consideration to the potential effects of these variables and others on the data, while also attempting to understand the effect that preconceptions and assumptions will have (Holloway, 1997).

The outcome of reflection depends on who does it and its effectiveness relies on the ability of the researcher to be critically self-conscious and aware (Finlay, 2002). There is little advantage to reflexivity when excessive self-analysis is at the expense of focusing research on participants, and is neither provocative nor revealing (Northway, 2000). The process and outcome of reflection should therefore be conveyed to the reader to enable public scrutiny of the integrity of the research (Finlay, 2002; Williams, 1993).

As emergent theories developed through qualitative research always include something of the researcher (Altheide & Johnson, 1994), reflexive reporting should inform readers about the researcher's interests, experiences, and actions in research reports (Finlay, 2002). This serves to help the researcher and reader to evaluate the research process, methods, and outcomes. It allows the reader to appraise understandings gained from engaging with the study participants, data, and setting, and weigh the ethical dimensions of the researcher's conduct (Finlay, 2002; Fossey et al., 2002).

Recommendations for Ethical Practice

In the reporting of qualitative research, the aims of the study, or research questions, should be clearly and explicitly articulated to enable the reader to evaluate the fit between intentions and subsequent choices (Fossey et al., 2002). Research should be worth doing, in the sense that the results are likely to lead to tangible benefit for patients (Richards & Schwartz, 2002).

Participants should be involved and consulted by ethics approval committees (Tee & Lathlean, 2004). Transparent consent procedures should be linked to ongoing assessment of informed consent and sensitivity to changes in participant decision-making capacity (Kylmä et al., 1999; Tee & Lathlean, 2004). Respondents who feel they are being judged are likely to be cautious in the conversation they have with any interviewer, and the interpersonal skills of the interviewer are an important factor in the development of the relationship (Chew-Graham, May, & Perry, 2002).

Participants might experience loss when the study concludes and the researcher withdraws (Murphy & Dingwall, 2001). When sensitive issues are explored, consideration should be given to the availability of further support mechanisms and debriefing for participants and researchers (Tee & Lathlean, 2004). Although rapport is essential between researchers and participants (Goodwin et al., 2003; Punch, 1994), exploitation of the participants' needs to meet the aims of research is not acceptable, and researchers should be aware of the risk of manipulation through professional identity and skills (Tee & Lathlean, 2004).

Codes of ethical practice might be unrealistic in the real-life setting, at best, and are often too lax, ambiguous, and indeterminate (Dingwall, 1980; Hornsby-Smith, 1993). They are not situated in social contexts and cannot be a substitute for moral reasoning and reflexivity. Guidelines that routinely deny the rights of vulnerable groups to participate in research might be challenged by the inclusion of service users on the boards of local ethics committees. Clinical supervision and reflexive exploration are necessary to examine the values, attitudes, and preconceptions held by researchers (Tee & Lathlean, 2004). Preconceptions do not inevitably lead to bias, providing researchers clarify them to themselves through self-awareness and reflection, and demonstrate this process to their readers (Chew-Graham et al., 2002).

Misinterpretation of participants' experiences might be reduced through respondent validation, whereby researchers feed back the analysis to the participants before the findings are published (Richards & Schwartz, 2002). This recognizes that participants are the experts in the field of their own experience and views (Williams, 1998). The practice of respondent validation might, however, be limited when continued contact with sensitive disclosure would be distressing (Kylmä et al., 1999) and when power inequalities might make it difficult for participants to negatively evaluate the researcher's account (Lincoln & Guba, 1985).

Attending to rights of self-determination or autonomy might be addressed by exploring with participants how risks should be assessed and responded to. So-called vulnerable groups, such as those with mental illness, should not be prevented from participating in research, as overly paternalistic attitudes might continue to deny historically disempowered groups a voice (Raudonis, 1992).

Conclusion

The growing popularity of qualitative interviews in health care research necessitates an acknowledgement of the particular ethical dilemmas that arise from the relationship between the researcher and the researched. Official guidelines and ethical codes of practice are insufficient to allow the researcher to navigate through the continually evolving course and context of research in a way that is morally responsive to the participant, while ensuring the integrity of the research.

An ethic of care that emphasizes relationship awareness and the promotion of collaboration provides a moral foundation for the examination of self through critical reflection and supervision. Becoming aware of those values, attitudes, and attributes that impact interpersonal relationships within the research context is necessary in attempting to understand the effect that such preconceptions and behavior will have. If nurse researchers are to fully address the moral complexities of research relationships, then sensitivity to risk to participants must be of continual concern, from conception of the study to the reporting of outcomes.

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