

Title: Transferring from clinical pharmacy practice to qualitative research: questioning identity, epistemology and ethical frameworks

Keywords (up to 10) identity, sociological, ethics, clinical researcher, pharmacist, healthcare professional, role

Abstract:

Researcher identity can present methodological and practical, as well as epistemological and ethical tensions in sociological research. Identity management, such as the presentation of the self during a research interview, can have significant effects on the research encounter and data collected. An example of this is 'white coat syndrome', the disjointed interaction between clinicians and patients arising from unequal power and expertise, which can also occur in research encounters. For clinicians engaged in qualitative social research, identity management can be particularly challenging given the potential for 'white coat syndrome'.

Drawing on the experiences of a registered pharmacist undertaking qualitative research, we discuss the epistemological transition many clinicians go through when embarking on sociological research. We suggest that identity management is not just a matter of optimising data collection but also has ethical tensions.

Drawing on Goffman's social role theory, we discuss the epistemic tensions between researchers' dual identities through positivist and constructivist frames, discussing the professional and legal implications, as well as the methodological practicalities of identity negotiation.

We discuss conflicting professional and regulatory ethical frameworks, and ethics committees' negotiation of intervention and elicitation during research encounters and the conflict in managing professional, legal and clinical responsibilities whilst adhering to expected social research conventions.

Introduction

This paper is a reflection on the process of researchers crossing, and straddling, disciplinary boundaries and the challenges that this presents in terms of identity management and competing ethical obligations. It argues that the process of developing a sociological imagination presents challenges for those moving from a generally positivist discipline to conducting qualitative, social science research. This mobility requires a high degree of

reflexivity, careful identity management and the negotiation of diverse, often competing, research design perspectives. This paper is structured to reflect the personal experiences of a pharmacist (APR) embarking on sociological research and frames the experience using Goffman's social role theory, that people present different identities in different social contexts. It describes the difficulty faced by pharmacists, and other clinical professionals, that embark on sociological research when deciding to present their clinical identities. The paper then considers the ethical tensions presented by dual identities and closes considering how different paradigmatic approaches attempt to deal with disciplinarily mobile practitioners.

We argue that clinicians, with traditionally positivist backgrounds, must negotiate conflicting epistemological, professional and ethical frameworks when conducting sociological research. We present here personal experiences and reflections of moving from the positivist disciplines and practices of medicinal chemistry and pharmacy into medical sociology. We suggest that such disciplinary mobility involves new epistemological engagement with the social world, which presents both opportunities and challenges for those carrying out empirical research. On the one hand, this disciplinary mobility and epistemological fluidity offers the opportunity to engage with, and draw upon, a wider range of theoretical frameworks and methodological tools in addressing research questions. On the other hand, such mobility presents challenges; such as the effective bracketing of existing perspectives and developing a high level of trans-literacy. Moreover, we argue that such mobility can lead to what we might understand as 'an identity crisis' for disciplinarily mobile researchers. This identity crisis raises both practical and ethical questions. This paper, then, argues for a need for greater reflexivity in research design and ethical review to enable researchers to navigate identity management and conflicting ethico-legal obligations. To begin with, we offer some background context on the particular case we present here.

Context

This paper is a reflection on the challenges and tensions experienced by a pharmacist (APR – one of the authors) who trained and previously practiced in a predominantly positivist paradigm, and is now engaged in sociological qualitative research. Undertaking this sociological project necessitated a high degree of disciplinary mobility and led to the reflections offered here; firstly, we describe the project briefly.

The Project

Medicines adherence pertains to how a patient takes their medicine and if this is in accordance with the prescription – though many conflicting definitions exist. Healthcare disciplines (i.e. positivist disciplines) have provided answers to questions of patients' medicines adherence but these have tended to be quantitative and so lacking the rich detail of qualitative data and have focused on demographic issues (e.g. age, ethnicity, gender) rather than taking into account the complex intersections of social life which might make people from certain groups less likely to adhere (e.g. women and caring roles)(Geertz 1973). Moreover, despite attempts to provide a generalizable model and a definitive way to improve adherence, as is the aim of much of the research, the data to emerge from such studies has failed to reach a consensus (Haynes, Ackloo et al. 2008, Nieuwlaat, Wilczynski et al. 2014). Some qualitative research has demonstrated that a more holistic approach that (a) samples a smaller number of patients, (b) looks to obtain rich, deep data and (c) locates the adherence question within the everyday lived experiences of patients as their lives pertain to factors, such as family life and diagnosis, rather than just their age, ethnicity, or gender might be more useful. Whyte et al. (2002) present a good alternative to a positivist consideration of medicines in their work on the social lives of medicines. Here medicines are described 'beyond their material (chemical) properties' as objects which negotiate social meaning through different actors. Describing mothers' medication of children with coughs and colds, the authors state that medicines are used to send social messages; to the child that they care for them, to their husbands and neighbours that they are not negligent mothers and to themselves that they are good mothers. Insights such as this present something of a dichotomy within the ontology of medicines adherence; on the one positivist hand, therapeutic chemical entities used to prevent disease and on the other constructivist hand, a social tool used to negotiate relationships. Webster et al. (2002) expand on this in their discussion of lay pharmacology. Here medicines are understood and used through a lay paradigm of understanding in relation to efficacy, side effects and safety. This literature supports a qualitative approach to medicines adherence. As a result, we are undertaking a phenomenological project using interview and focus group methods to elicit data and draw on constructivist frameworks in theorizing patients' medicines use. The wider aim of the project is to inform interventions to facilitate 'better' medicines adherence – although, again, many definitions of 'better' adherence exist. Although the subject of the project (i.e. why patients are not adhering to their medicines regimen) is one highly familiar to positivist healthcare

practitioners, a constructivist epistemological approach is not. As such, as a healthcare practitioner, negotiating an epistemological framing for the research - developing a 'sociological imagination' - was challenging and it is this process that we reflect on here.

Developing a sociological imagination

In the UK healthcare practitioners are largely educated within the positivist paradigm. Whilst medical sociology has been taught to medical and nursing students for a number of years, the majority of the curriculum tends to remain rooted in positivist, quantitative 'ways of doing' and natural science (Muller, and et al. 2014). Moreover, medical sociology has been adopted into the pharmacy curriculum to a much lesser extent. This paradigm, which underpins subsequent healthcare practice, encourages research that is repeatable, objective and positivist. As Timmermans and Berg (2003) show, the hierarchy of research and evidence in science and healthcare places a higher value on data which satisfies these criteria. Elsewhere, Vickers et al. (1997) have also noted that qualitative case-study research based on a small number of participants, which is limited in its generalizability, is considered inferior in healthcare. Phenomenological inquiry, and indeed qualitative research informed by constructivist approaches more generally, largely lacks the objectivity and repeatability that is valued highly within a positivist framework. As a pharmacist, a science-based health profession, moving to a more constructivist discipline and, thus, 'changing gear' to align with the epistemological views of phenomenology was difficult, presenting challenges relating to identity management and ethics.

Educating health professionals within positivist frameworks might limit the extent to which they can be 'disciplinarily mobile' and limit inter- and cross- disciplinary work. If pharmacy, for example, were to work within a positivist tradition and social sciences to continue to be welded to highly critical constructivism, we risk reproducing the disciplinary silos that the interdisciplinary agenda works hard to move away from. This is not to say that we should work inter-disciplinarily (or engage with diverse epistemologies) just for the sake of it, but rather that there needs to be a real effort made to be disciplinarily flexible and mobile to address research questions in the most appropriate way.

Aligning the research subject with an appropriate epistemological paradigm provided an excellent way to shift long-held beliefs about qualitative and quantitative research and to

begin developing a sociological imagination to address the research question. Such epistemological flexibility also provides the scope for practitioners to move away from healthcare research consistently undertaking large quantitative studies, and to think more critically about a wider variety of methodological approaches to particular research problems. Whilst healthcare education is teaching health professionals about research paradigms, professional practice often cultivates positivist perspectives with many judging the quality of research on the number of subjects in the study; the bigger, the better. APR's clinical experience as a pharmacist has been that less concern is put on what research is trying to find out but rather research findings and their applicability to patient care. A more holistic understanding of a wider variety of research methods and design was needed to address the research question of medicines adherence and would be useful for any healthcare professional entering research. Reading about the history and development of social research was essential, although at times the concepts seemed abstract, philosophical and difficult to relate to everyday practice, patients or pills. A key focus, then, became disentangling research and research findings from their immediate applicability to practice and examining the wider lifeworld in which patients' and professionals' beliefs and behaviours are formed and performed.

Although many healthcare professionals' educational background is peppered with psychology and sociology, they rarely stray from a positivist paradigm - although they may wander into the realms of post-positivism on a liberal day. One truth, posited by an object and only revealed through the scientific method of experimentation, repetition and validation is how most healthcare practitioners are trained to understand the world and is ascribed the most value in practice. The concept that there is more than one theory of knowledge can be jarring. Exploring different paradigms in an attempt to understand reality, and the way things are (i.e. ontology) is an area that is very rarely discussed or considered once healthcare professionals leave education and get into practice. For APR, adopting a constructivist lens changed what he understood medicines to *be*. By accepting a framework of multiple-constructed truths, how could he be sure that the evidence supporting the supply of medicines was 'true'? Without being able to rely on the familiar confidence intervals and statistics as markers of 'truth', supplying and recommending the use of potentially lethal pharmaceuticals, suddenly, became a lot more difficult.

Although healthcare professionals are under increased pressure, in a healthcare landscape characterized by increasing managerialism and target-driven working conditions (Hanlon 2000), an engagement with different epistemological positions can dramatically alter the way research outcomes are understood and applied to practice. Discovering constructivism, the theory that meaning and knowledge are built through subjective conscious perceptions of objective characteristics, can result in a fundamental shift in epistemological and ontological beliefs. Ferguson, when discussing phenomenology, describes this shift as ‘not a new way of studying reality but the consciousness of a new reality’ (Ferguson 2006: 25). Taking a constructivist approach, a capsule of paracetamol, for example, can be understood as more than its ‘objective’ properties - its colour, size, shape, and ingredients. Instead, a constructivist approach also includes the subjective understandings of what the capsule, and its properties, *mean* to patients - a remedy, a choking hazard, a hassle. Dingwall and Wilson (1995) echo this and discuss the way in which the tablet starts as a blank canvas for patients and is inscribed with social meanings by practitioners through discourse and interaction – in their case, pharmacists. As a pharmacist, ‘inscribing social meaning’ was not something APR had identified as part of his everyday work. That the social constructs of an object only exist when they are perceived through subjective consciousness and are valuable in understanding what a medicine is, presented an alternative approach to evidence-based practice. That these constructs can only be accessed through experiences, and so qualitative research, is a far cry from the familiar double-blind Randomised Control Trials (RCTs) characterised as the pinnacle of evidence-based practice. Acknowledging that systematic reviews are used as the ‘gold standard’ of science and medical knowledge in just *one* particular paradigm out of many, presented itself as something of a eureka moment.

Epistemological Flexibility

For healthcare professionals, being flexible in the epistemological approach taken in research is challenging given that the majority of practice is focused on positivist understandings of the social world. Given this, the development of a sociological imagination, although difficult, may be ultimately beneficial for other healthcare practitioners embarking on sociological research. Based on APR’s experience of such epistemological flexibility and disciplinary mobility, we examine ways in which the challenges of epistemological flexibility can be addressed by practitioners moving into, or looking to incorporate, a more constructivist framework in their research.

Returning to APR's own experience of disciplinary mobility, constant reflection and multiple modes of learning helped considerably. In particular, writing down what Wright-Mills calls 'fringe thoughts' helped unfamiliar notions and theoretical frameworks develop substance, which then snowballed into understanding; for example understanding the vocabulary of epistemology and how the different paradigms are presented. Looking up the definition and synonyms of words helped too, as did considering what the polar opposite would be for the theories trying to be grasped (Wright-Mills 1954). Put briefly, phenomenology is founded on the process of bracketing off and *transcending* pre-existing prejudices and biases (Moustakas 1994). Bracketing in phenomenology involves reflecting and removing any pre-existing or pre-conceived ideas about a phenomenon; setting aside judgments about the natural world to enable the essential structures of a phenomenon to be understood (Creswell 2007; Moustakas 1994). Taking a transcendental phenomenological approach and practicing 'bracketing' were also employed to develop a sociological gaze. Bracketing out or identifying preconceived understanding of a phenomenon, and rejecting these assumptions, enabled me to be reflexive in the analysis of data.

Some scholars argue that a true and complete sense of 'epoché', that is bracketing off previous beliefs and prejudices, cannot be achieved. However the practice may still be beneficial by identifying biases and 'opening up' to the idea of a different paradigm of knowledge. Discourse analysts and linguists may argue that one can never truly transcend all previous knowledge and prejudices about a given subject, if the same language is used to describe it (Moustakas 1994). An example of this from the perspective of a clinician might be the word 'intention'. As a pharmacist the word intention might mean a 'plan', perhaps pertaining to a patient's plan for discharge from hospital or pharmaceutical care but in the context of phenomenological research, intentionality refers to a fundamental process of experience. Intentionality is a corner stone of phenomenological research and refers to the 'focus of attention', describing the process where a consciousness *intends* towards an object (Crotty 1998). Subjective processes of conscious perception (that is knowing, judging, remembering, desiring) are *intended* towards the objective characteristics of the object (that is its size, shape, colour). The resultant consciousness or experience is constructed from two sources; the subjective perception and the objective characteristics. Relating this back to the perspective of a positivist clinician, a single word can have very different meanings when it is employed in different epistemological frameworks. Being 'open' to a new paradigm of

knowledge involved a degree of epistemological, and personal, ambiguity as the supposed certainty and superiority of RCTs and evidence-based medicine, which had characterised APR's education and practice up to that point, was sacrificed (or at least critiqued) in favour of constructivist framings. As Voltaire is often quoted, 'doubt is not a pleasant condition' (Buckingham, Burnham et al. 2011: 146); and certainly transferring and doubting accepted frameworks of knowledge from clinical practice into social science research was further complicated through the negotiation of multiple identities.

Identity Management in Research

The gear change from a positivist way of understanding medicines adherence to a constructivist approach necessitated a critical examination of the researcher's own role within the project and its findings. If research is approached from a positivist perspective, researchers would be looking to gather objective findings, control for biases and remove themselves as much as possible from the research encounter to elicit an objective 'truth'. However, in developing a constructivist approach to the question, researchers must acknowledge that they will always influence the research, as they are part of the social world that they are researching. For APR this was difficult to accept as he had always practiced, like many clinicians, in an environment where care must be standardised, objective, and fair. Being disciplinarily mobile and moving into the social sciences from a heavily positivist background, we began to critically reflect on the role of the clinician in research.

This reflection on the clinicians' role in the research process is primarily centred on researcher identity and, in particular, the tensions between the two disciplines, and subsequent identities, which are straddled by those undertaking social science research as practicing healthcare professionals. The social reality we inhabit is dynamic; discourse changes between our friends, our colleagues, our family and our healthcare professionals, as Goffman and others have described in their work on role theory (Berger 1963). Familiarity with this phenomenon was established through comparison with a similar phenomenon seen in clinical encounters, often referred to as 'white coat syndrome'. This phenomenon describes the effect that a healthcare practitioner's perceived status can have on interaction and, indeed, the patient's physiological state in reality. The white coat phenomenon arguably stems from the disjointed interaction between patient and practitioner, arising from unequal power and expertise distribution (Dingwall and Pilnick 2011). This unequal power dynamic can

mirror that between participant and researcher. Within research, clinicians' identity as registered and practicing healthcare professionals is a key issue, in that data collection and rapport with participants may change fundamentally if participants are aware of the clinicians' professional role. Just as the identity of the clinician influences what a patient says and how they behave in clinic, participants can also be influenced by the researcher and adapt behaviours to meet the perceived expectations of the researcher. It is well documented that characteristics of the researcher may influence the research encounter (Savvakis and Tzanakis 2004). A positivist position would attempt to limit this influence to ensure objectivity and validity and this was certainly APR's initial inclination during the research design process. However, the constructivist position is to accept this influence as a rich source of data and manage it openly (Ansdell and Pavlicevic 2001). To refer back to our current study investigating patients' lived experiences of taking medicines as they are prescribed, the role of the researcher is critical in ensuring that the data captured is a representation of the everyday lived experiences of participants, rather than participants' attempts to satisfy the model of a 'good patient' to a pharmacist.

If participants are made aware that a social researcher is also a practicing healthcare practitioner (in this case a clinical pharmacist), there is a risk of a particular kind of front-stage performance (Goffman 1959) in which participants take on the role of 'compliant' patients (Richards and Emslie, 2000). In doing so, the interaction itself may be renegotiated to become less of a research encounter and more of a clinical intervention. This presents a challenge in a wider context for researchers who are also practitioners, in deciding on their own presentation of self, their role within the research encounter and the social expectations and ethical demands of that role.

Presentations of the Self

This paper now turns to discuss the practical and ethical implications of presenting the self as clinical and non-clinical, briefly describing the ethical conflict generated from dual-identities engendered through regulatory organisations and professional bodies that represent clinicians and researchers.

Goffman's seminal work on the presentation of the self in everyday life clearly provides a key theoretical point of departure (Goffman 1959). He described the phenomenon whereby as

humans our identities are fluid, contextual and dynamic. Presentations of the self include how we dress, how we speak, and our facial expressions, to name but a few, and represent the negotiations of expressions that *we give* (intentionally) and that *we give off* (unintentionally). Our expressions are in turn internalised by those around us, who, based on their previous exposures and assumptions, construct an impression of us. The impression, Goffman argued, is a manifestation of our perceived identities, on which, others can expect or elicit specific stereotypical behaviours or roles.

Richards and Emslie (2000) describe this in interview interactions. They compared what similar cohorts of participants said in interviews with a GP (Richards) and a sociologist (Emslie), noting that the identity of ‘GP’ overshadows the personal characteristics of the interviewer, suggesting that “who respondents *think* you are affects what you get told” (Richards 2000: 75). Perceived identities and impressions then, inform the behaviours of those around us, dependent on their preconceived expectations of the identities we have expressed. The expressions that *we give* then, represent the identities that we wish to project to those around us. This could be wearing a stethoscope and white coat to express clinical professionalism. The expressions that *we give off* may be our body language or tone of voice, which might, equally, express clinical professionalism and feed into the expressions *we give off* unintentionally to those around us. In turn, those around us would identify us as clinical professionals and may alter the expressions *they give* to elicit responses and behaviours that they associate with the identity of a clinical professional (Goffman 1959). As a pharmacist, this meant consideration of the expressions that APR *gives* or *gives off* and meant being aware of how he reacted or did not react to participants’ disclosures about medicines use or misuse during interviews.

Presenting the self as a Pharmacist-Researcher

Presenting the self as a pharmacist has the potential to remove the distance from the participants’ usual healthcare structures that a non-clinical researcher might have. In presenting the self as a practitioner, participants may locate the researcher as an actor within ‘the system’. Although many patient advocate groups increasingly focus on addressing the imbalance of power, knowledge and resulting communication barrier between healthcare professionals and patients, Dingwall and Pilnick (2011) have recently suggested that this imbalance of power persists. When researchers, then, present themselves as practitioners,

there is a risk that this imbalance would translate to research encounters outside of the clinical space. This would change the context of the data collection process, potentially engendering more of a paternalistic relationship in which patients may feel accountable to the researchers as a representative of the healthcare system. Effectively this would negate the advantage of qualitative research as conducted by a social scientist that is not part of the healthcare system. If the researcher sits inside of the usual healthcare structures and professions, participants may more carefully manage their own identity to present themselves as a 'good patient'. Similarly, the context of the interaction may shift from research to clinical intervention.

Presenting the self as a practitioner also carries risks of inadvertently altering participants' behaviour after the research encounter. In this case, participants may feel the need to change the way they take their medication after the research as a result of their medicines use behaviours becoming problematised because they are the topic of study. In other words, because participants have been asked *by a practitioner* to discuss their medicines use, this may indicate to participants that there is something wrong, or at least worth studying, about their medicines use which may lead them to altering their behaviours. The risk that participants will change their medicine-taking behaviour due to influence from the research is potentially reduced if participants are unaware the researcher has a clinical background. There is an additional challenge for clinical researchers in maintaining this neutral presentation of self, which is not to slip into their role as a clinician and start to proffer healthcare intervention or advice. For a pharmacist, this may manifest itself as recognising prescription medicine misuse and giving the participant advice about how to use their prescription medicine. If participants are to be unaware the researcher has a clinical background, researchers should ensure their body language, facial expressions and tone-of-voice are consistently neutral in response to what the patient discloses in line with their given off non-clinical identity.

Palmeieri and Stern (2009) discuss the role of honesty in the professional-patient relationship, citing themes of shame and protection as justification for accepted untruths in the clinical setting. A clear demonstration of presentation of self in everyday life occurs when patients present themselves by saying something that is not necessarily true to obtain services or medication or in this case, tell a pharmacist what they want to hear (Palmeieri and Stern 2009). Identifying the researcher as a part of the healthcare structure has implications on the nature

of the data that is collected, arguably making it more about what participants think the researcher wants to hear, and patient-professional interaction.

Presenting the self as a Researcher Only

On the other hand, presenting the self as a non-clinical researcher, having distance between the researcher and the researched, could be justified as being important to optimise data collection and minimize researchers influencing participants' usual healthcare or service use. Presenting the self as a researcher-only has negative consequences in that clinicians lose their healthcare expert status and right to offer the participant advice about their medication. This initially does not seem like a significant loss, after all, the clinician is only 'giving up' this status during study encounters. Indeed considering methodological frameworks, philosophies and the actual method of conducting an interview, the Vancouver School of Doing Phenomenology stressed the importance of 'not losing awareness of context and self as a researcher' (Halldorsdottir 2000). In this the school is advocating a demarcated awareness of the self as a researcher and the self as a clinician. The 'suppression' of the clinical identity, however, presents a conflict if a participant discloses a particular issue during a study encounter that the expert status of a clinician could help resolve. For example if a participant disclosed that they were taking two medicines which carry a high risk of drug-drug interaction and negative effects, as a clinician and pharmacist, it would be socially acceptable and appropriate to recommend withholding one of the medicines to avoid patient harm. In an encounter where the self is presented as a non-clinical researcher, would it be socially appropriate to alter the patient's pharmaceutical regimen? A researcher who is not also a clinician would not be expected, or might not have the necessary expertise, to offer prescription advice. Could clinicians presenting themselves as non-clinical researchers potentially be giving up an ability to reduce harm? In a situation when a patient discloses a danger to themselves through an inappropriate use of medicines, pharmacist or clinician status could be useful in preventing harm to the patient in a way which social researcher status may not. As well as being a practical and methodological dilemma, this also presents an ethical issue.

A Question of Ethics

Whilst Richards and Emslie (2000) show the presentation of self can impact data collection, ethical tensions can also prove problematic. In the context of a pharmacist conducting social science research, there are two sets of, often competing, ethical considerations to be followed simultaneously. On the one hand, the customary social science standards formalised in the British Sociological Association's Ethics Standards and on the other hand, the General Pharmaceutical Council Ethical Standards set out by the pharmacy regulatory body.

Clinicians conducting research will have expertise of, what they see as, poor healthcare behaviours and participants may disclose these during the research encounter. As a clinician there is an expectation that we will intervene to improve the participant's health behaviours, in the interest of the patient's wider healthcare outcome. This is mandated in the ethical standards of the regulatory body with the General Pharmaceutical Council (GPhC) Ethical Standard 1.7, stating that pharmacists should 'be satisfied that patients or their carers know how to use their medicines'. This obligation to intervene in medicines misuse directly contradicts the norms of social research in which focuses on understanding every day and normal behaviours even when those might be considered deviant or 'incorrect'.

Registered pharmacists are therefore statutorily obliged to work with patients until they are clinically satisfied that the patient knows how to use their medicine correctly. Such intervention, however, would shift the nature of the encounter from research to clinical involvement, from elicitation to intervention. The British Sociological Association's Ethical Statement 25 speaks of caution of participants forgetting they are being studied in relation to consent. If the interview is re-negotiated into a clinical intervention, rather than elicitation, we risk the patient forgetting they are being studied and breaching sociological ethical standards. Additional ethical frameworks and opinions, such as the professional pharmacy body the Royal Pharmaceutical Society, the NHS Research Ethics Committee and institutional level ethics committees, might add further contention.

Avoiding Contention

Ethics Committee Negotiations

Operating within these conflicting ethical and professional frameworks presented several problems – delaying the institutional ethics approval process. This is reminiscent of the NHS ethics process, and indeed ethics process in the US and Canada, in which social researchers

are forced to fit the square peg of constructivist, qualitative research into the round hole of positivist, quantitative clinical research (van Teijlingen 2006, Murphy and Dingwall 2007, Dingwall 2008). Members of the ethics committee focused on APR's obligations to influence medicines use if he became aware of a medicines use issue. Disclosure of medicines use issues to pharmacists carries social, as well as professional and legal, expectations that medicines use issues would be resolved or referred to a general practitioner (GP). In clinical pharmacy practice, the relationship between the 'expert' pharmacist and their patient allows for medicines issues to be resolved directly through expert-novice advice-giving however in a research setting, a social or qualitative researcher may not have the necessary expertise to identify problems with prescribing or the necessary expert-novice power imbalance to give advice or to refer to a relevant authority. The social expectation there, then, is directed away from influencing the participant's usual healthcare and directed towards limiting the influence the research has on the participants' usual healthcare. However when the researcher has registrant status, healthcare expertise and professional obligations, researchers and members of the ethics committee must be able to negotiate a truce between identifying potentially risky behaviour patterns, which regulatory bodies would usually expect clinicians to directly address, and not influencing the participant's usual healthcare as per conventional sociological research.

Final Thoughts

On reflection, many of the issues presented can be considered through positivist and constructivist perspectives. In a positivist gaze, a clinician will always be a clinician regardless of their environmental context or presented self and so would always have their regulatory and ethical responsibilities as a clinician. In a constructivist paradigm however, the clinician's identity is relative to the role within the encounter and the self that they present (Goffman 1959). In a research encounter their identity, responsibility and expectations would then be as a non-clinical social science researcher, and this could be argued to negate any medico-legal obligations. There are clear epistemic, methodological and ethical tensions between the identities of researcher and clinician when attempting to conduct qualitative, social science research.

As highlighted by Banton (2005), social research is influenced by the researcher's personal traits and characteristics; with objectivity in the social sciences only achieved through

interaction with other researchers. As Finlay (2002) suggests, clinical researchers could be encouraged 'to tell 'confessional tales' about dilemmas and decision-making in the research process'. Interacting with other researchers can be reflective in nature; drawing on the experiences of different researchers. Consequently there could be a call for clinicians conducting qualitative research, to reflect and develop a discourse to use in the field, which incorporates both their identity as a clinician and their desire for brutally honest data. Equally a Bourdieuan analysis of inequality in cultural, or disciplinary, capital may be needed to address tensions between clinicians and social scientists, to deliver insights into this issue.

A functionalist analysis of ethical committees, institutions and frameworks may reveal that although manifestly these mechanisms aim to deliver safe and ethical research, latently they produce a sub-culture of clinical researchers who merely 'jump through the hoops' of bureaucracy without thinking ethically about their research. Regulatory bodies, such as the General Pharmaceutical Council and professional bodies such as the British Sociological Association, are in a position to open a dialogue to negotiate ethical practices of pharmacy registrants conducting sociological, qualitative research. The same is also true of other practitioners undertaking social science research who are potentially subject to similar epistemological and ethical dilemmas. Open dialogue between regulatory and professional bodies and, indeed, between researchers themselves might refocus the continued debate around research ethics in qualitative healthcare research.

Conclusion

In conclusion, the identity of many clinicians will be first and foremost as a clinician, but the process of ethics approval, reflection, and review can lead to a realisation that first and foremost, we are just human beings. Developing a sociological gaze, moving away from the quantitative objectivity of a natural science-based health profession such as pharmacy into the realms of largely qualitative social research can be, and has been, a difficult transition and by no means can it be completed easily – if it ever can be completed. Our position, for the time being at least, is that clinicians are just as capable to give sociology a voice as anyone, *if* they can negotiate their position within the research encounter successfully.

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