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REVISITING THE ARCHIVES – OPPORTUNITIES AND CHALLENGES: A CASE STUDY FROM THE HISTORY OF GERIATRIC MEDICINE

Joanna Bornat, Parvati Raghuram, Leroi Henry

Abstract

Using two data sets in parallel, generated at different times by different researchers, the case is made for the re-use of archived qualitative data. Two sets of oral history interviews one, dating from 1990-1, with doctors and others who pioneered the development of the geriatric specialty in the early years of the National Health Service, the other, ESRC funded during 2007-9, with South Asian doctors who came to work in the UK and found work in geriatric medicine, are subjected to parallel investigation. The article argues that by considering the two sets of interviews together, each informs the other, leading to reconceptualisation and unexpected links between the data sets, new research questions and finally suggests additional dimensions to issues relating to the ethics of secondary analysis.

Keywords

Secondary Analysis, archived data, South Asian doctors, geriatricians, oral history

Introduction

The secondary analysis of archived qualitative data has become a focus for methodological debate (Hammersley 2010; Moore 2007). The requirements of funding bodies that all data is archived centrally, a growing awareness amongst academics that the implications of data preservation are not just of interest to archivists, as well as the continuing importance of key concerns that were systematically studied a few

decades ago (Johnson et al 2010) has led researchers to return to old data in new ways. However, definitional issues around terminology (Hammersley 2010), whether this data should be considered primary or secondary (Moore 2006) and the issues faced during re-use (Silva 2007) have all come under increasing scrutiny.

This article makes a contribution to the field of secondary analysis by considering ways in which data may be reconceptualised, new questions asked and ethical tensions revealed. Driving our discussion is the assumption that secondary analysis can take many different forms and that how data are approached will determine what the outcomes of re-use are.

We focus on a particular kind of re-use: the revisiting of an existing archived study and the development of new research questions from this alongside a new, parallel, set of data. Our research topic is the contribution of South Asian overseas-trained doctors to the development of geriatric medicine ¹ in the decades following the setting up of the NHS. The article begins with an overview of different approaches to secondary analysis. This is followed by a description of our study and the ways in which we came to reconceptualise data and ask new questions by linking two data sets. We end with some observations relating to ethical issues raised by our re-use of another researcher's data. The re-use of archived qualitative data has the potential to bring about change in understandings of researchers and their research findings, both primary and secondary. In this article we show how such changes were identified and the implications of the changes for the processes of re-use for researchers and their data.

Forms of re-use

The nature and status of secondary data in research has become increasingly contested (Hammersley 2010). In reflecting on their own, as well as others', research practices researchers have variously emphasised the production of the original data, the reuse of that data, the positionalities of those reusing this data and the importance of interpretation rather than data per se in inflecting the findings of secondary analysis. At the heart of these discussions is the unanswered question of whether archived primary data should be treated as secondary data or primary data. However, as Libby Bishop (2007) suggests detailed discussions of actual research processes and reflection on the practice of research, very often act to blur the boundaries implied by the primary/secondary binary. Indeed, as we will go on to show there are varieties of re-use which cover the primary-secondary spectrum, complicating the basis for the methodological divide.

There is no one form that re-use can take as the ingenuity and creativity of researchers' imagination demonstrates (see for example *Sociological Research Online* Special issue on the 'Re-use of qualitative data' 2007; Sealey 2009; Winterton & Irwin 2011). The nature and availability of data, questions asked and serendipitous nature of an enquiry result in many variations. In what follows we outline three types of reuse, 'Replicating', 'Re-analysing' and our own and, we would argue, new approach: 'Parallel investigation'.

Studies which replicate go back to original data with the aim of repeating the project, keeping as closely as possible to the earlier study. So for

example Johnson et al (2010) sought to replicate Peter Townsend's 'Last Refuge' study, using similar research instruments to investigate life in care homes, sixty years after his original study (Townsend 1962). Their aim was to take a longer term view of changes in care home provision than is more usually the case by using the original Townsend study as a blueprint for a repeat study of current care homes. Studies which replicate are able to take a longitudinal view of variables which may or may not contribute to change, noting the effects of time in relation to the research design and the consequent findings. In effect replication produces two separate studies, comparatively linked by topic and methods but always with the possibility of producing new ideas and new data.

Studies which reanalyse, work with deposited data, applying new questions with the aim of generating new evidence from that data. Fielding and Fielding make use of Cohen and Taylor's 1960s study of maximum-security prisoners (1972) in Durham prison. They explain their interest in re-use as being 'to see if the data supported additional themes' They insist that they were in no sense seeking to 'challenge...the ontological status of the data' (2008: 85). Indeed they included comments by Cohen, who was given a draft of their article, in their discussion of their re-analysis. Although Cohen disagreed with some of their conclusions they felt that they have been able to 'extract further analytic purchase from research on a group seldom exposed to fieldwork' (2008:92). Similarly, re-using data deposited at the UK Data Archive, by Paul Thompson and Mildred Blaxter, Bishop searched two historically situated sets of interviews, for investigation of changes in domestic eating habits, in order to explore the differences between primary and

secondary use of data (Bishop 2007). Though finding that distance from the original context of the archived interviews was a limitation, she points out that all research, whether primary or secondary will create new research questions and ‘further data collection’ (Bishop 2007:11.2).

In her account, Bishop also refers to opportunities to engage with the original researcher when re-using archived data. This is an issue which Evans & Thane raise in connection with their re-use of Marsden’s study ‘Mother Alone’ (Marsden 1969), as part of an investigation into unmarried mothers in Britain between 1918 and 1995. Going back to the original interviews they were able to see how much research methods had changed and, consequently how the data and conclusions drawn were different in significant ways. For example, Marsden did not record his interviews and included his own personal comments on the women he interviewed. Evans and Thane were shocked by the tone of some of these, arguing that such comments were revealing of Marsden’s own attitudes and ‘those of his time’, which would now be ‘thought to be unacceptable’ (Evans & Thane 2006). They corresponded with Marsden and include his responses in their discussion of his study, pointing out that secondary analysis needs to be aware of the influence of different prevalent research practices over time. Later in this paper we take up the issue of the representation of the original researcher.

By ‘Parallel investigation’ we are referring to studies such as our own which use both secondary and primary data analysis with data sets which are complementary and overlapping in key aspects, but separated in time. They have different research questions and are situated in different research contexts. Working in parallel offers opportunities for cross-

referencing – both empirically and in relation to subjective meanings – on the part of researchers and researched. Working with two data sets, we were able to ask questions of an archived data set by linking it to a newer set of interviews. This allowed us to reconceptualise that original data and the issues which it raised and thus arrive at new understandings of it and of those interviewed. In return, analysis of the archived set generated questions for the newer data set not originally anticipated. In what follows these exchanges are described in more detail. Parallel investigation also raises ethical issues as we will then go on to discuss.

Two data sets

The two data sets held in parallel are Margot Jefferys' interviews with the 'Pioneers of Geriatric Medicine'¹ undertaken in 1990-91 and a set of interviews with South Asian overseas trained doctors generated between 2008 and 2009.² They were created separately, at different times and by different researchers; however the second, newer, data only came into existence as a result of the existence of the first.

The Jefferys data set

Our interest in South Asian doctors' role in the development of the geriatric specialty began when one of us was editing a chapter by Professor Margot Jefferys, for inclusion in a collection, *Oral History, Health and Welfare* (Jefferys 2000). Margot Jefferys and her colleagues interviewed 72 people in 1991 who had 'made a significant contribution to the developing specialty' (2000:78). The interviewees included politicians, senior medical civil servants, social workers and therapists and leading members of key voluntary organisations. However, the main group was 54 geriatricians, mostly retired but some still working. Eighteen had been born before 1914, the majority had qualified as

doctors before the Second World War. The oldest was 92. All, except one South Asian overseas trained doctor, were white. The audio recordings and summaries of the guided life history interviews were deposited in the British Library with all but a couple open to researchers.

As an editor of the published collection, Joanna Bornat noticed that a number of the interview summaries mentioned 'Indians' or 'my Indians' or South Asians. A more systematic search of the Jefferys' data for references to South Asian doctors revealed other examples where Margot Jefferys' pioneers were describing their then junior colleagues. Here for example is Professor John Brocklehurst, a prominent geriatrician who had been president of British Geriatrics Society and had been awarded the Society's Founder's medal in 1990:

All the junior staff I had were trained in India or Pakistan. Many of them had come over; they were junior, their knowledge of medicine was very limited in relation to British medicine, many of them had language problems and so it was a matter of educating them too. And, on the whole, they were very nice people who were keen to learn but it did mean that it was a constant... when you had an English person. English-trained doctor life became much simpler I must say.⁴ (John Brocklehurst, Jefferys interview, 1991)

These data presented interesting possibilities for further research. Here was a very much marginalised specialty in which it seemed a probably quite marginalised group was working, yet apart from one doctor, they were not present amongst the group of people interviewed.

What had the presence of ‘Indians’ and of South Asian doctors, meant for the specialty? This question was pursued in an ESRC funded project alongside other research questions:

1. What issues of career, training, and work satisfaction did South-Asian trained doctors face in geriatric departments over the last 50 years, and how have they changed over this period?
2. What strategies for negotiating racism, cultural stereotyping and career hierarchies did members of this group develop, and what have been the experiences of those who have not been as successful?
3. What intercultural treatment issues arose for doctors from other cultures, at a time when a more holistic approach to care provision for older people was being developed?
4. What are the methodological, theoretical and ethical implications of comparing two data sets collected at different times and for different purposes?

Secondary analysis would enable us to search the Jefferys data set with these new questions drawing out newly identified data. Her interest had not been postcolonial relationships, nor was she explicitly interested in the South Asian doctors’ careers. By going back to her data we were reconceptualising her findings, introducing an interpretation which took the South Asian doctors from the margins of narratives of the specialty to centre them in the story in a new way².

We were of course conscious of our debt to Margot and to the pioneers in having produced the original accounts but we were also aware that we were risking not only the recasting of those interviews but a reappraisal

of those doctors' professional standing and possibly that of Margot Jefferys as well. Where others (Evans & Thane 2006 and Johnson et al 2010) could discuss archived data with the earlier researchers (Marsden and Townsend respectively), we were not able to do this because of Jefferys' untimely death in 1993. As we go on to show this inability to discuss our data with Jefferys affected our approach and understanding of some of her data.

The South Asian sample

The new sample of 60 interviewees comprises 40 retired and 20 younger South-Asian qualified geriatricians (SAG interviews). Recruitment was carried out by a variety of means: advertising in the newsletter of the British Geriatrics Society (BGS), once before and once after the start of the project; snowballing; purposive searches of internet sources such as hospital websites and doctors directories for particular categories of geriatricians (e.g. women); and from our networks as researchers.

Altogether, 180 South-Asian geriatricians were identified as potential interviewees of whom 72 initially agreed to participate in the research. However, due to work commitments twelve informants subsequently withdrew.

The sample consisted of geriatricians who qualified from India, Pakistan, Bangladesh, Sri Lanka and Burma who had been employed in England and Wales. To ensure that the majority of our sample had some contact with contemporaries of those interviewed by Professor Jefferys we aimed that two-thirds of our participants should have entered the UK labour market in 1976 or before. As such, the informants were aged between 41 and 92. All but five were male. One woman was over 60 (compared to 41 men) and the remaining four were in their early forties (compared to 7

men). According to our informants this reflects the gender-age profile in the discipline over time.

We originally intended to interview both consultants and non-consultant career grade doctors (NCCG). However, as the latter often did not answer requests, declined to participate, or were unable to participate due to lack of time and interest, only one NCCG was interviewed. As 41 per cent of informants, and over half of the retired doctors were recruited through snowballing, we may have replicated a bias in our sample towards relatively 'successful' geriatricians. This is an issue while researching a doubly invisible group (retired and in less prestigious specialties) and also illustrates the contradiction between making a public record of achievement of South-Asian geriatricians and ensuring representation across the medical hierarchy. Although snowballing led to geographical clustering of interviewees in the north west of England, North Wales and the West Midlands this clustering reflects the distribution of South-Asian geriatricians in the 1960s to 1990s.

A difference between the two data sets that we had not anticipated lies in the contrasting attitudes which participants had to making their interviews open for consultation in the British Library. Where Margot Jefferys' interviewees, apart from two, appear to have had no reservations about deposit, our sample included 26 who requested anonymity. A further six asked for editing. It could be that the 'pioneer' label given to the Jefferys' interviewees added to their already prominent status and their commitment to placing achievements on record. By contrast, many of the South Asian doctors, though no less pioneers, were

more cautious about making a personal statement and about commenting on colleagues and situations they had worked in.

The data sets were analysed separately, using a grounded theory data analysis strategy in each case. Ten key transcripts from the Jefferys' dataset were identified by the team on the basis of prominence of the interviewee (BGS office or award holder) or the frequency they were mentioned by the South-Asian informants. These were then reviewed and salient quotes coded. All the transcripts were uploaded into NVivo 8 and analysed through extensive text searches using terms such as 'India', 'overseas' etc –the results of these searches were saved as Nvivo nodes with the most relevant also coded as Jefferys' quotes. Similarly for the SAG transcripts, the research team discussed ten transcripts, drawing out key themes emerging from the interviews which formed the basis of a common coding strategy using thematic coding trees and free nodes. The process of coding was iterative: new themes that emerged in later interviews were added while codes which were either unused or repetitive were discarded.

For each SAG interviewee attributes relating to basic demographic data (age, country of birth and gender) were assigned in NVivo. These attributes were then computed and cross-tabulated to produce basic statistical analysis, tables and graphs of the sample.

Reconceptualising a data set – finding links

The two data sets provided us with interesting information about colonial connections between the UK and the Indian sub-continent. At a personal

level, unknown to us until late in the project, was the fact that Margot Jefferys was born in India. As we were to discover when we interviewed her son, Peter Jefferys, she came from a family which had connections with India going back two generations. Her grandfather was in the Indian Civil Service and her father had been first principal of the law college in Madras.⁵ Amongst the 54 doctors she interviewed, at least six had been born on the sub-continent and another six had worked there at some point in their lives (including army service). The pyramidal structure of the medical hierarchy meant that many doctors found it difficult to obtain a consultant post in the UK. As a result they took up opportunities in the Colonial and Dominion Services, which still had openings in the late 1940s and early 1950s. However, this service shrank as the colonies gained independence and doctors were forced to return to the UK where their lack of contacts and their late entry into the new NHS meant that they had to settle for less desirable postings, such as those offered by geriatrics. The colonial connections were, therefore, particularly significant in this discipline.

There were other connections too between the two samples. We were aware that the medical profession is one of the 'socio-cognitive communities' that have a long history of international movement between continents. Mobility is a well established and accepted part of individual professional development (Raghuram 2009). Our interview schedule included questions about medical training. On being asked if any of their medical school lecturers had worked in the UK, almost all confirmed that they had been taught by staff who had received postgraduate medical qualifications in the UK.

Here for example, is Dr Suchel Bansal, talking about his medical education in Uttar Pradesh, India, before he arrived in England in 1973:

And had your lecturers been to the UK at all, do you know?

Yes they did. I think in medicine I think this is one of the reasons I came to this country because in India because I was high flyer in medicine I passed MBBS, I was second in position in the university in medicine. And then after that I did MD, which is post graduation four years course. I did MD in medicine, which was a requirement to be a teacher. If you want to be a teacher in medical school you have to have to have that. And that's what I wanted to do. I wanted to teach in medical school. I wanted to become professor of medicine basically. And one of the thing – I mean MD was requirement, but if you had MRCP⁶ beyond that, that was an added thing, although not officially recognised but it was considered to be a good thing. And few of our teachers who had MRCP we used to look at them with awe 'God MRCP. I must have it. Would I ever have it?' That sort of thing. (laughs).⁷ (Dr Suchel Bansal, SAG interview, 2009)

Close reading of the interviews reveals many ways in which individual biographies involved movement between continents. This was a new conceptualisation of the original Jefferys' interviews which also contributed to the construction of a historical and social complementarity linking these data sets.

Asking new questions

The two data sets show similarities in the experience of both groups of doctors as they described and explained how they came to be working in one of the least well regarded specialties. However, by aligning the interviews, differences also emerged and these led to avenues for interrogation of the original Jefferys' data that had not been intended when those interviews were originally set up and conducted.

First the similarities:

John Agate this time describes his entry into geriatric medicine in 1953:

When I was in the RAF, which was for four years, I knew it was a short service commission and would come to an end, and I began to look around for physicians' jobs, but everybody was coming out of the forces in those days and there were about 150 applicants for every physician's job. I got short listed for about 15 jobs, but they all said 'You've had a very peculiar career up to now, I don't think you're quite on the right ladder. We won't accept you, but good luck...

This would be about 1953 yes. So I said to myself I must look around for a specialty which is not overcrowded - I mean I would have liked to have become a cardiologist because I had a lot of experience of cardiology, but everybody else in the world wanted to be a cardiologist then and my chances would not have been very good. So I looked around for a specialty which was not overcrowded.

Psychiatry was suggested, but I didn't want to become a psychiatrist. So I suddenly thought of my experiences in the

chronic sick wards of the East London hospitals and said 'Well, I do know a bit about old people and I think there is a new specialty of geriatrics just starting up'...

A few weeks later the first job, apart from the one I've just described, advertised in the world I think for a geriatric physician was advertised in the medical press for Bradford, Yorkshire. And I said 'Well, if I'm going ahead with this idea, I'd better apply for it though I don't know anything about Yorkshire or Bradford'. So I applied for it, not actually having had any formal training in geriatrics because it was impossible to get any training in geriatrics: there were no senior registrars, there were no registrars in geriatrics, I don't know how you got it. So I went up to, it was actually Harrogate, and was interviewed by some splendid people, one of them was Professor Sir Ronald Tunbridge of Leeds University and one was a surgeon from Bradford, an elderly man called Peter McEwan who had very firm and sensible ideas about what was needed for the elderly. He himself was elderly and partly disabled because he got an infected wound and developed paraplegia as a result of actually operating on a septic patient. So he knew something about it. And these people said 'Well your background is splendid, you may not know anything about geriatrics as such not having practised in geriatric wards as a qualified doctor, but we'll give you the job with pleasure'. So I got it there and then⁹. (John Agate, Jefferys interview, 1991)

The Jeffery's interviews provide us with invaluable insights into the early years of the NHS and prevailing attitudes and assumptions as to the health care needs of frail older people. They also, share a common narrative. If doctors part way up the hierarchy with an atypical history of medical education wanted to get ahead, then one way to achieve seniority was to pick an area of healthcare that was not popular. Geriatric medicine, psychiatry and general practice were the areas of great need and where there was least competition (Smith 1980; Rivett 1998; Webster 2002; Simpson et al 2010).

Dr Bansal tells a very similar story of his entry into geriatrics, two decades later:

I knew nothing about geriatrics when I came here. I did not know what geriatrics means. (Laughs) I'd never heard of this term before. I came here, when this guy, as I said to you, the guy who took me under his wing in Aylesbury, when I used to talk to him what would I apply for and all that. I said 'Well I want to do medicine'. He said 'OK, you can try there but it's very tough in medicine. Very few jobs here. Too many people. But you might like to apply in geriatrics as well'. I said 'What is geriatrics?' I knew nothing about it. What it was. I had to find a job. And that's what it was. So I knew nothing about geriatrics whatsoever. I did not know what geriatric meant.¹⁰ (Dr Suchel Bansal, SAG interview, 2009)

Doctors like Agate and Bansal had experience of working in the lower and middle ranks of the profession and both faced difficulties because

they had a non-standard training history, in relation to the expectations of the UK medical establishment. However the similarities extend only so far as the excerpt from an interview with Dr Morag Insley, one of the few women included in the Jefferys' sample indicates:

No. I didn't even have my own houseman in those days you see. I shared with the general physician in Newport, which was very nice of him to allow me to share with him. I had my own registrar.

Just one registrar?

One registrar, yes. Usually they were from the Indian sub-continent, and some were better than others.... But some of my Indians were very good indeed...Most of them, yes... I mean there was only one who was a real shocker and I didn't give him a reference he was so bad... and I had to leave them a good deal on their own because I just couldn't be everywhere at once. But mostly I was quite lucky.

Some of them weren't brilliant clinically, but some of them got their Membership. But mostly I got on quite well with them and I tried to make them welcome in this country and sort of take an interest and met their wives and invited them round for curry suppers and that sort of thing, you know.

And I think they appreciated that. Some of them, we've stayed friends with, kept in touch with for, you know, right through the years.¹¹ (Morag Insley, Jefferys interview, 1991)

Dr Dasgupta, provides a contrasting narrative from the perspective of one of the 'Indians' seeking a way to find support in achieving his membership:

And afterwards, after nearly completion time came then I started applying for jobs you see. And then I was more assured at the time I've got part one MRCP so I'd be preparing for part two and that's a big thing in those days. And then in India MRCP was looked as very high, in the highest order, important diploma. So I started applying and got a job of SHO in general medicine at Barton Road Hospital, Dudley you see. And that's a nice hospital and I went for interview and consultant was (inaudible) Dr Kubik you see. He was very good. He used to say 'What is your ambition?' and I said that, he said 'You have to work hard'. I said 'I will do that' ... I can't remember where else I went, but mind you in those days sometimes it was not very difficult to get a medical job ... If you are good at it, if you work hard ... Because in those days as you know there are not many consultants in each department and they wanted junior doctors who would work hard without any grumble or anything and who are good at it, you see. That's what I used to see. And they wanted to know the sincerity and approach you see. So probably that was second job I went but I got it.¹² (Pranab Dasgupta, SAG interview, 2008)

Dr Insley is describing how she built her geriatric department with the help of overseas-trained South Asian junior doctors whose contribution is presented as marginal and uncommitted and with an account which

suggests a rather distant treatment of them as trainees. By contrast, Dr Dasgupta, from the perspective of someone, who at that time, was lower in the ranks and without any apparent network of support highlights the significance of hard work and a fortunate encounter with a consultant who was prepared to support his training. Showing commitment and being noticed for hard work is a recurrent theme in these doctors' accounts as is the lottery which determined where they might end up with a job. Most describe their first few months in the UK as a series of moves around district hospitals, away from high status teaching hospitals in London and the south east of England, where they took short term locum jobs in a variety of medical specialisms trying to find a way into posts or departments which might offer them some kind of future progression through an appointment that included time for training.

Working with two data sets in parallel has enhanced re-use. Though the Jefferys' interviews illustrate the origins of the specialty and the conditions under which it was developed, by positioning them with the South Asian doctors' accounts, new interpretations become possible. We returned to the Jefferys interviews with questions relating to the links between the UK and the Indian sub-continent and re-read the transcripts, searching, amongst other things, for accounts which inform enquiries into recruitment, training and patronage (Raghuram et al 2010). This process informed our own interviewing strategy as it unfolded and we became increasingly aware of the significance of place and recommendation in the process of becoming a member of a profession which laid great stress on the value of being 'local' (Raghuram et al 2009). In these and other ways we found ourselves asking new questions of the Jefferys data as we sought to account for the influence of elite

statuses and experiences of difference which could variously be understood in terms of racism and discriminatory practices (Bornat et al 2009).

Ethical implications of re-use

It was in relation to this last issue that we began to consider the ethical implications of data re-use. Though we had adopted necessary ethical procedures, including Open University and NHS reviews, and had obtained consent from all the SAG participants, when it came to analysing the two data sets we found that there were added ethical dimensions that neither ourselves, nor our reviewers had anticipated. Earlier, we mentioned the dialogue which developed following Evans and Thane's (2006) comments on Marsden's approach to research, drawing from this the need to be aware of the effect of time in relation to acceptable research practice. Temporality is indeed an issue, but reading, and listening, drew our attention to further aspects which we now go on to discuss using Margot Jefferys' interview with John Brocklehurst, but letting the extract run on a little further. In developing this discussion we have been helped by the approach of Bishop and her discussion of the ethics of re-use (2009).

Margot had asked Professor Brocklehurst about difficulties he had encountered in building his department at Withington Hospital, Manchester, in particular referring to resources and struggles over 'bed-blocking' (see Bornat et al 2010). He went on to explain the situation he had been dealing with, prompted by questions from Margot:

All the junior staff I had were trained in India or Pakistan. Many of them had come over; they were junior, their knowledge of medicine was very limited in relation to

British medicine, many of them had language problems and so it was a matter of educating them too. And, on the whole, they were very nice people who were keen to learn but it did mean that it was a constant... when you had an English person. English-trained doctor life became much simpler I must say.

Yes, because of the deficits both due to cultural differences

Yes, and particularly in professional knowledge and the way in which they would go about writing up cases and all the rest of it. So it was a matter of teaching Asian doctors most of the time, and many of them went on, I mean most of these doctors stayed in this country, many went into general practice, quite a few went into geriatrics in fact as the time went by.

What were the most difficult things? Was it to get them to see problems as broadly as you wished them to?

Yes, I think to take an overall view of a case and not get involved in one diagnostic aspect because old people do suffer from various things and they all contribute to their problems. And to have a sort of ordered writing up of the cases and to be able to tell you exactly what was happening the next day or the next week. These were all difficulties.

Yes. What did you think mainly explains the difficulty of recruiting people from an English background?

Well, the problem had been that after the war there was thought to be an excess of doctors and the Willink Committee¹³ recommended that there should be a cutback in the production of British doctors. ...by the time this was really becoming effective, there was a very large amount of emigration of doctors because the National Health Service didn't pay very well and a lot of people went to America and Canada, and I think there was the loss of about 400 doctors a year or something to Australia, South Africa and so on. And this came about at about the same time as the cut-back in numbers of doctors was beginning to tell in the production of juniors, so there was a very great shortage, a huge shortage. And this was filled, of course, by Asian doctors coming over to this country, again to improve their prospects so there was a kind of perpetual move around the globe of people trying to do better as it were: British doctors going to America and the Asian doctors coming to Britain.¹⁴ (John Brocklehurst, Jefferys interview, 1991).

There is much in this particular exchange that we could draw on: the account of building a geriatrics department in the 1960s and 1970s; the specific impact of a particular decision made by government; and the description of migratory movement by doctors into and out of the UK. Empirically this excerpt, and others like it, is rich in information and insight. However, we use this extract to draw out points relating to three

ethical issues: the positioning of research subjects; extending consent and the reputation of the primary researcher.

The positioning of the researched

We came to the project through a reading of the Jefferys' interviews which led us to expect to hear of racist behaviours and practices within the NHS in the interviews with the South Asian doctors. At first sight, as we go on to explain later, this is what we felt we were reading in the transcript and listening to the recording. Elsewhere (Bornat et al 2009) we have discussed how an oral history approach to elite interviewing traditionally presumes success and authority as starting points, with an assumption that ethnicity identified in terms of visible difference is associated with discriminatory practices. Our project transgresses these assumptions with its focus on a group of doctors with presumed high status, who are identifiably different to the majority population and, additionally, working in a marginal and low status area of medicine. This confusing of categories has been of interest to us, but it does not necessarily fit with the perspective which our interviewees have of themselves, several of whom made this clear to us.

The South Asian geriatricians whom we have interviewed are almost all consultants, several are also professors and some have considerable local standing for their contribution to medical services in the area in which they have practised. They do not regard themselves as oppressed. Like the Jefferys sample their motivations for taking part were in relation to the public record, identifying the role of doctors such as themselves in contributing to the development of the specialty and medical care of frail older people. Inviting people to consider whether or not they had been

exposed to discrimination therefore proved tricky in the interviews. What we eventually drew from the interview data was that many were no stranger to discrimination or to racism but that they framed these experiences according to specific circumstances. So, for example, we were told that being physically or verbally attacked in the streets or even in hospital settings such as A&E was part of ordinary everyday UK life, to be expected, though not accepted. On the other hand, incidents where their professional reputation was threatened or questioned were more likely to be attributed to racism. So for example, the interview panel that selected a 'local boy' with lesser qualifications would be explained as racist, similarly when being passed over for merit awards and being excluded from the UK medical networks, both formal and informal (Raghuram et al 2009). However, a compounding and complicating factor was the status of geriatric medicine which many cited as their main site of struggle for recognition. Thus awareness of societal ageism and racism combines in these narratives to present a many-layered experience of difference and oppression (Bornat et al 2009). For researchers such as ourselves, wanting to maintain engagement with participants while seeking to uncover and explain the development of the geriatric specialty, these sensitivities presented informative and significant ethical challenges.

Extending consent

The research questions we listed earlier meant that our interpretation was likely to be dissimilar from the focus of the Jefferys interviews. Reading through the transcripts there is no evidence from the direction of questioning that the main focus of her project was the situation of South Asian overseas-trained doctors and it is even less likely that questions of racism or discriminatory practices were being investigated. It could

therefore be argued that our re-use of the Jefferys data is beyond the scope of any consent which those interviewees gave and indeed a strict interpretation of the UK Data Protection Act (DPA), 1998 implies this (Erds 2011). The archiving of those interviews opens up the original contributions to analyses which were not explicit at the time they were set up. Ethically this could be problematic, but only if archived qualitative data are treated differently to other historical sources as Erds points out (2011). The re-use of sources by biographers, literary critics and historians is regarded as normal when seeking out fresh interpretations and enriching understanding (Bornat 2003; Corti et al 2005). Setting on one side the potential restrictions which some literal interpretations of the DPA's principles impose, it could be that social scientists are adding to a climate of over-protection. Coming late to these literary and historical practices, they bring their own particular research inhibitions with them: creating a 'silent space' (Thompson 2000). Any re-use is likely to introduce new questions, new concepts and new interpretations as secondary researchers introduce their own particular 'cultural habitus' their own 'informal and intuitive element...acquired over time in fieldwork (Hammersley 1997:138-9). As such social scientists add to knowledge generally while inevitably extending the scope of consent given in relation to specific projects. Indeed as Bishop points out, consent can only ever be 'partial (as) No-one can actually provide full information about how research will be done, or no research could get done (Bishop, 2009: 263).

Guarding reputations

Finally, there is the question of the reputation of the original researcher. Readers of the excerpt might have noted the tone and wording of the questions being asked by Margot Jefferys. She mentions 'deficits',

difficult things’ and ‘difficulty of recruiting English people’ all of which appear to problematise the employment of South Asian overseas-trained doctors. Given Margot Jefferys’ reputation as a fair-minded, progressive and humanitarian, member of the research community, the exchanges read uncomfortably. Was she perhaps revealing a side to herself that had not previously been visible, or was she perhaps tuning in with her interviewee, perhaps even colluding with him with views that they both shared? Of course it could also be that her questioning style might have been adopted as part of a strategy to deliberately draw out her interviewee. We might also want to allow for temporality, the choice of words being determined by the time context of the interview.

Margot Jefferys’ main aim was to investigate how the pioneers built the geriatric specialty under difficult conditions. From the viewpoint of Margot and her research participants’, the employment of South Asian doctors was symptomatic of resource problems that had to be overcome to redress the poor status of geriatric medicine more generally. In this way she could be seen as adopting the dominant professional discourse of the 1960s and 1970s when major recruitment of South Asian doctors was taking place. This narrative is evident in contemporaneous archived documentation. Within the later context of 1991 her approach was more measured than that of the earlier debates where references to difficulties of recruitment to northern industrial towns and the reputation of the specialty were expressed in directly discriminatory language.¹⁵

Indeed, when John Brocklehurst was interviewed again in 2009, he followed a similar line and tone of explanation:

I was wondering what your view was of the recruitment of south Asian doctors. I mean did you have a particular view of...?

Erm, not really. I mean that was the reality, that was the way it was, it seemed unfortunate that there weren't enough home trained people who were interested in coming in to the specialty and so this was er, a very happy, or not always happy, but mainly happy and useful alternative I suppose.

When you say it was unfortunate, you think, what was it unfortunate in relation to?

Well I suppose at that time, one felt that the, erm, the role of the physician or a general practitioner, did relate quite clearly or, to the sort of social milieu in which he or she was working and their experience, their knowledge of that, their experience of that, also their ability to be understood easily by patients. I think those were some of the, the reservations which people had, in the beginning.

And you felt this was something that this particular group of doctors might not, be successful at?

Yes, in a higher proportion than a home produced product I guess, yes, was true yes.¹⁶ (John Brocklehurst, SAG interview, 2009)

It is worth considering a list of possible explanations as it had not been our intention to undermine the reputation of Margot Jefferys when we went back to her data. In his interview, her son Peter Jefferys, provided a description of someone who had maintained contact with India and with Indian colleagues throughout her life, visiting India and generally valuing her friendships and childhood there. Peter Jefferys also pointed out that the people selected for interview was in part determined on the basis of ‘direct personal knowledge of who were the movers and shakers in social policy terms, in care of the elderly because she often would have known them, or known people who worked alongside them’¹⁷.

If the excerpt from the Jefferys and later interviews presented Professor Brocklehurst in a less flattering light we were also unexpectedly to acquire a more rounded picture of his role, from several South Asian doctors we interviewed. One suggested:

Well when I was in University Hospital of South Manchester I got a very good training. We had the Professor Brocklehurst. I think if I have to name one geriatrician living, two living geriatrician, I will name Brocklehurst and Peter Millard, both retired of course, are the best in the country at the moment...

OK and so in what ways did Professor Brocklehurst influence your ideas of caring for older people?

Professor Brocklehurst had a wide range. He was a very kind man. If you wanted anything he will say ‘Why don’t you see me in my office?’ And he will talk to you very patiently,

advising you 'Is there anything I can do about you. Do you need some help?' Just like your parents. Oh yes. I wish there were more people like Professor Brocklehurst ...

And the people you mentioned were all South Asian, the influential people in the North West, and I was wondering why you thought that there were so many prominent South Asian geriatricians in that particular region?

... So if geriatric medicine has developed in the whole of - I am not talking of London, I'm talking of outside London - only one person could be named - Brocklehurst, yes. I think his name should be put on a plate and put in every geriatric hospital, Professor Brocklehurst, he did a lot for this, yes. Very nice person, yes.

And under Professor Brocklehurst there seemed to be quite a lot of South Asians?

Yes, oh yes.

So what I was wondering is why it is that there were a lot of South Asian doctors who became geriatricians in that area?

Well I have to say this. He liked people from overseas very much. There were people, how I should put it? They may not, couldn't care less. For example, I met one professor, I described earlier on, in Liverpool [he mentions an example

of direct discrimination]. There's another one, he was in Birmingham... I went to see him while I was in Birmingham. He gave me ten minutes of his time and said 'Could you see my secretary after that?' And that was the end of it. Not everybody likes foreign doctors. Professor Brocklehurst was one who liked foreign doctors very much along with doctors from this country of course. You know. Because he had a knack of knowing that who needs extra help, you know. Yes.

And do you think that overseas doctors need extra help?

By extra help I meant extra fillip, to proceed, you know. For example, if he knew that Dr Chaudhuri was a very good doctor he will say 'Could I help you? Do you want to go to Canada? Somebody rang me from Canada'. Because people will ring him from Canada, from USA, from Australia. 'Have you got any boy, because somebody want to go on holiday for one year or something?' 'Oh yes' So he will ask Dr Chaudhuri 'Will you go?' So similarly, he asked me 'What are your plans?' I said 'I want to visit USA, learn and give lectures and see what is the set up there, how it differs from England'. 'Oh all right, go' and he helped me. But it was not universal. Like anything else it can't be universal. He will know immediately and will ask direct question with the people who could be helped. So that was his beauty, yes, yes.¹⁸ (Ragu Shukla, SAG interview, 2008)

With a parallel, overlapping set of interviews we have been able to link interviewees across time and juxtapose accounts in a way that has enriched the process of re-use and in so doing present a more complex and more richly contextualised understanding of a particular dialogue. The recruitment of overseas-trained doctors in the NHS had been treated to a great deal of critical scrutiny (Smith 1980). It could be that in the Jefferys and Brocklehurst interview both protagonists were finding a way to discuss a difficult issue with awareness that their words might later be exposed to more public discussion. As indeed they have. With this in mind, the exchange between Margot Jefferys and John Brocklehurst might instead be read as an exploration of a known area of rapid change within the specialty and NHS more generally rather than simply an example of problematic language and communication.

Conclusion

Our re-use or secondary analysis of archived data has led to a new research project and a reconceptualisation of that data, with questions new to the archived data and informative to the newer data. This kind of re-use which involves parallel investigation offers a novel way of addressing old questions in new ways. It also fundamentally unsettles the divide between old and new data as both sets of data are used to reflect, and build on each other. True dialogue between these data sets ultimately also unsettles the division between primary and secondary data as both become recontextualised through juxtaposition and comparison. In this paper we have also explored some of the issues faced in this kind of mutual repositioning of two datasets. We suggest that there are particular issues around interpretation, consent and ethics that are raised through this juxtaposition.

Working with two sets of data in parallel, we have been able to use similarity and difference across and within both sets of interviews. Lack of “fit” (Hammersley 2010) in the Jefferys data has been compensated for by the construction of a parallel and overlapping set of interviews which have contributed insights to the other, we have thus been able to expand the contextual framing of the ‘pioneer’ and the South Asian geriatricians, while extending the analytical potential of both.

However, we are suggesting that this only became possible because we were working in parallel with two data sets which made possible a multi-voice and thus a fruitful complexity. Listening as researchers, our understanding of what we heard was changed as both sets of participants were repositioned by being brought into contact with one another. So, the Jefferys’ interviews came to be heard as colonial voices, as we noted South Asian references over the life times of individuals. Similarly, the South Asian doctors, whom we had positioned as marginal and experiencing discriminatory practices, repositioned themselves at the centre of the specialty and as being discriminating in their understanding of experiences of racism. Expecting to hear differences, we also found similarities in the two data sets, hearing accounts of establishing medical careers within the context of ageism in health care.

What we draw from this is that both sets of interviews end up being repositioned when faced with each other. The Jefferys’ interviews come to be seen as a part of the twentieth century story of encounters with difference and of racialised expressions of power and control, rather than simply the story of the growth of a new medical specialty. In the same way, the

South Asian interviews come to be heard as stories of success, presence and recognition, rather than only accounts of marginalisation and discrimination.

However, when the questions raised and the interpretations given differ from those of the original researcher and their participants it could be that the consent originally given is no longer appropriate. If consent were to be regarded as placing restrictions on future researchers this could, in our opinion, limit discussion and thus create boundaries to knowledge. However, it could also be that by focusing on South Asian doctors in the original data we are following an ethical imperative which is to do better justice to that original data.³ We therefore argue that new questions are a necessary part of the pursuit of knowledge and scientific investigation so long as conditions for archival deposit are upheld.

By re-using the interviews created for Margot Jefferys' investigation our intention has always been to promote the collection and to further highlight the history of the geriatric specialty. We are certain that this would have accorded with her wishes since, sadly, she was not able to take her study further. However, in doing so we have also exposed her practice as a researcher to forms of scrutiny which might not have been the case had she been a party to our questioning and interpretation. That she might also have been aware of the role of posterity in her research is something we can't know and we are conscious that we too, in time, may also be exposed to similar investigation. We hope that in raising ethical issues we are pointing the way towards good practice in re-use while not seeking to limit debate or critical questioning. Our intention throughout

has been to be ‘*better with/because of* (rather)- than *better than* those who came before us’ (Bracke & Puig de la Bellacasa 2007).

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¹ Archived at the British Library under 'Oral History of Geriatrics as a Medical Specialty' collection (Jefferys) ref. C512 at <http://www.bl.uk/oralhistory>

² Archived at the British Library under 'Overseas Trained South Asian Geriatricians interviews' collection (SAG) ref.C1356 at <http://www.bl.uk/oralhistory>

⁴ Professor John Brocklehurst interviewed by Margot Jefferys, 05.09.1991, Jefferys, ref C512/32/01-2

² New readings of archival data are common in postcolonial studies, see for example Stoler (2009) and working from the margins to the centre is typical also in feminist studies. We are grateful to Niamh Moore who makes this point in relation to our work.

⁵ Peter Jefferys, interviewed by Joanna Bornat and Leroi Henry 18.02.2009 Overseas Trained South Asian Geriatricians interviews, British Library, Sound Archive reference number C1356/48.

⁶ 'MRCP' or Membership of the Royal College of Physicians. Membership of one of the Royal Colleges is a necessary stage in progression towards becoming a consultant. Traditionally Membership examinations are in two parts: clinical and theoretical. Both require time and support in preparation.

⁷ Dr Suchel Bansal, interviewed by Leroi Henry 04.07.2008, SAG, ref C1536/04, track 1.

⁹ Agate, 1991

¹⁰ Bansal, 2008

¹¹ Dr Morag Insley, interviewed by Margot Jefferys, 10. 06.1991, Jefferys, ref C512/36/01-02

¹² Dr Pranab Dasgupta, interviewed by Leroi Henry, 18.03.2008, SAG, ref C135/06

¹³ Sir Henry Willink a barrister who had been Minister of Health in 1943-5 and vice chancellor of the University of Cambridge, chaired a committee in 1955 which was given the task to estimate the number of doctors which would be required by the NHS. The committee wrongly concluded that the system was producing sufficient doctors, in part because they had not taken into consideration the numbers entering and leaving the country. The result was a shortage in supply of new medical graduates (see Rivett, 1998).

¹⁴ Brocklehurst, 1991.

¹⁵ See for example, 'Notes of a special meeting of senior members of the DHSS and RMOs at the Nuffield Provincial Hospitals Trust' discussing 'Medical Manpower Policy in Relation to the National Health Service, 5 June 1975 where it was 'noted that 55% of senior registrarships and 85% of registrarships were occupied by overseas graduates it was apparent that Geriatrics was in imminent danger of becoming an "overseas" specialty. Such a state of affairs was...unfair and unacceptable to the senior citizens of our society. There was an urgent need to decide what should be the fate of the specialty of Geriatrics'. British Geriatrics Society archives, catalogue no: 12/224.

¹⁶ Dr John Brocklehurst, interviewed by Joanna Bornat 20.08.09, SAG, ref C1356/62

¹⁷ Jefferys, 2009.

¹⁸ Dr Ragu Shukla, interviewed by Leroi Henry 30.10.2008, SAG, ref C1356.54.

³ We are grateful to Niamh Moore for this suggestion.