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Using Visual Vignettes: My Learning to Date

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Abstract

Cancer survivors report a gap in work integration advice from healthcare professionals. This occurs despite physicians routinely providing comment upon survivors' work abilities to insurers and employers. In order to understand the phenomena of survivors' work integration from physicians' perspectives, a vignette methodology was used. Vignettes were chosen as a means to explore physicians' perspectives in a non-confrontational and sensitive manner. Vignettes, composed of photographs and narratives reflective of survivors' lived experiences of work integration were presented to 10 physicians during individual interviews. In this manuscript, I outline my experience using vignettes, the learning I have achieved, and the modifications I intend to make before again similarly using vignettes with another stakeholder group. In this study, receptive participants expressed enjoyment of the real-life nature of the vignettes through which significant insights into the phenomena were successfully gleaned. In this case, vignettes were an effective means to sensitively explore physicians' perspectives of cancer survivors' work integration. Yet, considerations that I will undertake prior to the next stakeholder inquiry include incorporating findings from the physicians and modifying the presentation of survivors' findings to be more applicable to that next stakeholder, reconsidering the number of vignettes used as well as the terminology and delivery mechanism, and refinement of questioning format

Keywords

Vignette Methodology, Physicians' Perspectives, Cancer Survivorship, Return to Work

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Using Visual Vignettes: My Learning to Date

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Cancer survivors report a gap in work integration advice from healthcare professionals. This occurs despite physicians routinely providing comment upon survivors' work abilities to insurers and employers. In order to understand the phenomena of survivors' work integration from physicians' perspectives, a vignette methodology was used. Vignettes were chosen as a means to explore physicians' perspectives in a non-confrontational and sensitive manner. Vignettes, composed of photographs and narratives reflective of survivors' lived experiences of work integration were presented to 10 physicians during individual interviews. In this manuscript, I outline my experience using vignettes, the learning I have achieved, and the modifications I intend to make before again similarly using vignettes with another stakeholder group. In this study, receptive participants expressed enjoyment of the real-life nature of the vignettes through which significant insights into the phenomena were successfully gleaned. In this case, vignettes were an effective means to sensitively explore physicians' perspectives of cancer survivors' work integration. Yet, considerations that I will undertake prior to the next stakeholder inquiry include incorporating findings from the physicians and modifying the presentation of survivors' findings to be more applicable to that next stakeholder, reconsidering the number of vignettes used as well as the terminology and delivery mechanism, and refinement of questioning format. Keywords: Vignette Methodology, Physicians' Perspectives, Cancer Survivorship, Return to Work

I sought a methodology that would incorporate emotive and poignant cancer survivors' findings from a previous study phase (Morrison & Thomas, 2014) as a means to sensitively and effectively explore the perspective of other stakeholders, including physicians and industry representatives, about the same phenomena. The phenomenon under study is cancer survivors' work integration (WI). In a preliminary phase of this study, cancer survivors' experiences of WI were explored using photovoice methods. These findings were a combination of narratives and photographs. Since both the existing literature and the participant survivors point to a gap in WI support, a non-confrontational climate would be critical to ensuring a respectful and open exploration of these other qualitative stakeholder inquiries, especially since these other stakeholders are perceived as potentially holding prime roles to provide WI support.

To address this issue of sensitivity, I selected vignette methodology. Through the use of this methodology, I could use a combined representation of narratives and photographs and provide a non-threatening means to explore participants' overt and covert perceptions, beliefs, and attitudes (Hughes, 1998). Schoenberg and Ravdal (2000) have identified that researchers who use vignette methodology find that they can come to an enhanced understanding of behaviour by firstly appreciating participants' awareness, attitudes, and beliefs. Although not widely employed, vignette methodology has been effectively used across a variety of disciplines and populations, including physicians (Corbett, Foster, & Ong, 2009; Hooper et al., 2008) and other healthcare providers (Atwal, McIntyre, & Wiggett, 2012; Denson, Winefield, & Beilby, 2013) educators (Copeland, Birmingham, DeMeulle, D'Emidio-Caston, & Natal, 1994; Han, 2010), minorities

(Easter et al., 2007; Hodgins, Millar, & Barry, 2006), and the general public (Cook & Wang, 2011; Hogg, 2011) including children (Barter & Renold, 2000; Dixon, Murray, & Daiches, 2012).

After providing some context for this study, I present an overview of vignette methodology including its advantages, limitations, and considerations found in the literature. Thereafter, I will present the concerns that remained for me in the use of vignette methodology and the employed resolutions. In summary, I will reflect on the learning acquired during this phase of the study and the modifications to be made before I again use vignette methodology in a similar exploration with industry representatives. My intention in preparing this manuscript is to aid other researchers who may similarly be looking for a means to sensitively explore important stakeholders' perspectives.

Context

In an effort to situate this study and the decisions made related to the vignettes, I provide some context of the current problem facing cancer survivors as it relates to their WI. In a dearth of advice from health professionals, most cancer survivors report having to independently navigate decisions regarding work (Nitkin, Parkinson, & Schultz, 2011). Among many, these decisions include whether to work through treatment or take leave as well as when and how to return to work. Stanton (2006) identified that in order to enhance survivors' work integration (WI), medical personnel need to become better informed and facilitate the necessary referrals to address cancer-related ramifications including fatigue, cognitive limitations, and pain. While oncology-focused rehabilitation services continue to be developed, previous authors have suggested that survivors and their naturally occurring team of physicians and employer representatives could more effectively manage WI with enhanced knowledge (Nitkin et al., 2011; Wells et al., 2013). Furthermore, by enhancing physicians' awareness of cancer patients' working realities, more patients would likely be able to work through treatment and achieve earlier and more successful WI (Wada et al., 2012). However, there is currently not only a lack of support services for survivors, but also a paucity of intervention-based research concerning WI in cancer survivorship (Canadian Partnership Against Cancer, 2012; Stanton, 2006).

With the ultimate objective of designing an effective intervention to facilitate survivors' WI, I am undertaking three key stakeholder inquiries. In Phase 1, twenty cancer survivors reflected on their experiences of work following cancer via participation in a qualitative photovoice study. Then, in Phase 2, physicians' perspectives of survivors' WI were explored. This manuscript was prepared following the Phase 2 physician inquiry and before Phase 3. In Phase 3, industry's perspectives, inclusive of insurers and employers, will similarly be explored. These three stakeholder inquiries will inform the development of a WI intervention that will then be pilot tested.

Consistent with the existing literature's assertions of a gap in survivors' WI support, Phase 1 survivor participants observed that physicians readily completed required insurance forms, supported leave from work, and openly collaborated with survivors concerning WI planning such as a work return schedule. However, little concrete WI advice was provided (Morrison & Thomas, in press, 2014). A sampling of survivor participants' quotes are presented:

As far as I can remember with work it was always me asking the questions. Even at the very beginning I was asking, "Do people work while they're going through treatment?" ...[The physicians] would answer if I asked the question but no one ever said to me this is what you should do. They're uncomfortable with that...I

kind of get it. They're focused on the cancer, right? That's their thing and fair enough that's their job [Carol]

My oncologist, we talked about it a little bit...He said, "If you need to go on long term disability, if this is stressing you, do what you need to do. If you have issues, I can give you a letter, you go on long term disability, and you can go off on disability. You can do what you need to do. If you want to work, you feel like you can work, by all means" [Donald]

When I brought up the subject they all said, "There's no hurry." But I kind of felt I should be going back to work. I don't have chemo, why am I not working?... I thought there was going to be more counsel or more support along those lines. There wasn't. Then when I got a couple weeks in and thought, oh, this is going too fast. I talked to my doctor. I gave her a heads up and it was like okay, we'll slow it down. And I kind of said this is what I think it should look like and my family doctor wrote it in her letter and then that's what they did [Kathy]

These narratives exemplify a common experience among survivor participants and are in accordance with the existing literature. That is, despite physicians routinely commenting on survivors' work abilities at the request of insurers and employers, survivors receive little advice and are therefore left to independently navigate important WI questions. Each of these survivors depicted above sought WI advice from his or her physician, but in the absence of legitimate guidance the reality was that the WI plan was left to be managed by the survivor. In order to understand physicians' perspectives, beliefs, attitudes, and behaviours contributing to the gap in WI support reported by survivors, a non-threatening inquiry method was required. Simply asking busy physicians why they are not providing WI counsel was not considered a manner conducive to thoroughly understanding the phenomena, and may in fact have met with some resistance and potentially caused some offence. By couching the inquiry in the emotive lived experiences of survivors presented through vignettes and at third person distance, vignette methodology presented a favourable option for undertaking the inquiry with physicians.

Participants and Procedure

Phase 1 participants identified two predominant groups of physicians with whom they had contact during their cancer experience: oncologists and family physicians. In Phase 2, these two physician groups were specifically targeted using purposive sampling (Thorne, 2008) as information-rich sources. Five oncologists and five family physicians with an active role with cancer survivors were recruited for participation. Participant physicians completed individual, in-person, semi-structured interviews. Appropriate ethics approvals were sought and consent processes respected. Following a short demographic survey, individual interviews were conducted using the prepared vignettes. The interviews were audio-recorded and transcribed for later analysis. More details pertaining to the participants, methods, and findings may be reviewed elsewhere (i.e., Morrison, Thomas, & Guitard, 2014).

Literature Review

Vignettes are carefully designed short stories about a specific scenario presented to informants to prompt discussion related to their perceptions, beliefs, and attitudes (Finch, 1987; Hughes, 1998; Schoenberg & Ravdal, 2000). While previously used predominantly in quantitative survey research, more recently, researchers have increasingly been using vignettes qualitatively to explore thinking processes toward better understanding behaviour (Charles & Manthorpe, 2009; Hughes, 1998; Schoenberg & Ravdal, 2000). By precisely crafting the vignette, focussed responses can be elicited to a germane issue under exploration (Schoenberg & Ravdal, 2000). Vignettes, intended to represent a real life event, may encompass past research findings, and are most frequently presented in written, narrative forms (Denson et al., 2013; Finch, 1987; Hughes, 1998). Researchers may read written narratives to participants to mediate low literacy levels or permit telephone interviewing (Cook & Wang, 2011; Ganong & Coleman, 2006). Variations in the presentation of vignettes have also included audiotaped and videotaped preparations (Carta et al., 2013; Copeland et al., 1994). Byrne and Hennessy (2009) combined narrative text with illustrative photographs. Vignettes can be presented remotely via technological means such as CD ROM or internet, during individual interviews conducted either in-person or via telephone, or during focus groups (Charles & Manthorpe, 2009; Desautels & Jacob, 2012; Frey, 2000; Hooper et al., 2008). While emphasis is usually upon the verbal exchange through dialogue following presentation of the vignette, other methods have included a “draw and write” exercise employed with children (Dixon et al., 2012).

With careful design and delivery considerations, vignettes can effectively be used with individuals with low literacy, cognition compromise, and minority cultures (Davila, Reifsnider, & Pecina, 2011; Hodgins et al., 2006; Hughes & Huby, 2002). For children and adults alike, vignettes have the potential to enhance engagement and be an enjoyable and creative sharing experience due to their story-like nature (Dixon et al., 2012; Schoenberg & Ravdal, 2000). Vignettes can be designed in the third person; in other words, asking how would or should a fictitious other react given a presenting scenario (Finch, 1987). This depersonalization can facilitate personal disclosure and also address ethical concerns in referring to behaviour of peers (Byrne & Hennessy, 2009). Individuals can segue into their own personal experiences if they wish, but by using a third person presentation, sensitive topics can be explored with less inhibition at a comfortable distance (Barter & Renold, 2000; Schoenberg & Ravdal, 2000). The often hypothetical nature of vignettes can allow a distance conducive to unpacking beliefs and perceptions, particularly regarding sensitive phenomena (Hughes, 1998). Due to this safe distance, vignettes can be less threatening (Barter & Renold, 2000; Easter et al., 2007; Finch, 1987; Hughes, 1998). Vignettes can be designed to focus specifically on a narrow, socially situated topic to be explored in some depth (Finch, 1987; Hughes, 1998; Schoenberg & Ravdal, 2000). Responses can straddle socially desirable responses by including what vignette characters should do, but then also what they are likely to do (Denson et al., 2013; Hughes, 1998). Finally, use of vignettes can be less expensive and conducted more quickly than observational studies and have been shown to be an effective way to detect subtleties and nuanced knowledge of which only insiders are aware (Hughes & Huby, 2002; Sumrall & West, 1998).

The predominant criticism leveled at vignette methodology is their static nature, void of dynamic interaction and feedback innate to social circumstances. As a result, some suggest that vignette methodology may not accurately uncover how individuals actually act (Barter & Renold, 2000; Dixon et al., 2012; Schoenberg & Ravdal, 2000). The nature of building a vignette requires

that priority is given to some elements over others and thus, when compared to real life, may poorly reflect an authentic social situation (Hughes & Huby, 2002). As a result, transferability of the findings is limited (Hughes & Huby, 2002). Vignettes must necessarily be brief in order to be memorable, especially imperative when being used with children or individuals with cognitive compromise such as intellectual disability or early dementia (Hughes & Huby, 2002). Careful vignette design enhances participants' perception of relevance and authenticity (Hughes, 1998). To that end, while vignette methodology may be less expensive and time-consuming to conduct, significant time and careful consideration must be undertaken in creating believable virtual cases that resonate with participants (Hooper et al., 2008).

Vignettes can be completely hypothetical, or draw upon previous research findings or real-life events (Charles & Manthorpe, 2009; Hughes, 1998). While the characteristics of the vignette are determined by the focus of inquiry, such as DSM-IV diagnostic criteria, the vocabulary as well as the abstractness of the presentation must be suitable for the target participants (Hodgins et al., 2006). For example in their study with 8- and 9-year-old children, Dixon et al. (2012) ensured that the vignette vocabulary was suitable for children of this age. In a related vein, Hughes (1998) ensured that the vocabulary used with drug injectors was their own. To enhance the believability of the vignette, Finch (1987) avoids eccentric characters and disastrous events, and rather depicts mundane life events. This implies that vignettes are best constructed in consultation with insiders and professional service providers and purposefully crafted to enhance participation in part by creating a safe distance from sensitive topics (Atwal et al., 2012; Brown et al., 2010; Davila et al., 2011; Denson et al., 2013; Hodgins et al., 2006). Vignettes should include adequate context to provide participants with understanding but yet sufficient vagueness to prompt them to fill in the blanks from their own perspective (Hughes & Huby, 2002). While brevity is necessary for some contexts such as with children, some other forms may involve a longer, continuous story that builds in a step-wise manner throughout the inquiry (Barter & Renold, 2000; Davila et al., 2011; Hughes, 1998). When using one longer, building vignette, Finch (1987) cautions against more than three changes to a story line as more changes may become confusing. Alternatively, several shorter vignettes such as that of seeking physicians' perspectives of different aspects of cancer survivors' WI used in this study, may be designed to depict different aspects of the feature topic (Barry & Greene, 1992; Coker, 2005).

Phase Two Vignettes

I developed seven short, topically focused vignettes. Each vignette represented an emergent theme from Phase 1 participants' WI experiences following cancer that bore some relevance to the role of a health care professional. The vignette topics included social connectedness with others at work, accommodations to facilitate WI, protection of boundaries between work and other meaningful life roles, emotional distress associated with WI, determination of appropriate timing for WI, the importance of a positive frame of mind related to WI, and the dichotomously anchored continuum between privacy and disclosure at work. Two sample vignettes, pertaining to social connectedness and the timing of return to work, as well as prepared discussion probes, are included in Figures 1 and 2. The vignettes were composed of context-establishing text, as well as Phase 1 participants' acquired photographs and accompanying narratives. Images and words contextualize each other, forming different representations than either can as effectively represent separately (Pink, 2007). In this case, the photographs served to enhance the emotive nature of the presented topic. Due to the nature of the participants being physicians, no specific attention was attributed to


vocabulary, but consideration was given to their role as a health care professional and the limited time available for participation given physicians' busy practices.

Figure 1: Sample Vignette: Lisa's Social Connectedness

Vignette

Social Connectedness

Although Lisa's employer invested in equipment to allow her to work from home during her various cancer treatments, Lisa attended the office several times per week for half days as her appointments and tolerance permitted. For Lisa, the sense of being connected to others at work was of utmost importance.



It's my coffee cup...I realized maybe about a month and a half ago that one of my friends was still making the full pot, expecting me to come in at any time...there was always a full pot of coffee on...he was making the coffee just in case I came in. So how nice is that?


Each vignette was prepared in a hard, laminated copy and presented to the physician participant to read independently. The vignette was left with the participant throughout the ensuing discussion. Questioning probes, presented verbally, were prepared to stimulate discussion, but open discussion was encouraged. Probes varied between second person presentation such as, "What advice, cautions or encouragements would you have for Lisa?" to a more generic presentation, "When a physician is faced with completing forms, such as those for an insurance company, how should a physician arrive at the suggested time frame governing the return to work?"

Figure 2: Sample Vignette: Josée's Timing of Return to Work

Vignette

Timing of Return

Although Josée continued to battle clinical anxiety, she came to recognize that returning to work was part of her recovery process.



I was taking care of my mental health but I felt like I was more on vacation and I started to feel uncomfortable...I'm not taking care of the treatments or anything and so I was debating July too early, September too late so first of August...July was a healing month and then I said, okay, the next stage of my healing process was a return to work.

Data Analysis

There has been a variety of qualitative data analysis methods used in vignette studies: constant comparative method (Copeland et al., 1994; Corbett et al., 2009), content analysis (Barry & Greene, 1992), thematic content analysis (Atwal et al., 2012; Hodgins et al., 2006), thematic analysis (Easter et al., 2007; Hogg, 2011; Schoenberg & Ravdal, 2000), a framework approach (Chur-Hansen, Taverner, Barrett, & Hugo, 2005), narrative approach (Jones, 2008), and template analysis (Atwal et al., 2012). Within the context of this wide variation in analytic approaches, I decided to use an interpretive description approach to this study. Interpretive description is best

used when there is a practice goal and the analysis is grounded in what is known and not known empirically about a phenomenon (Thorne, 2008). By using this qualitative research analysis approach, the researcher can name and reference well-founded logic which is especially applicable to clinical domains, specifically health. In correspondence with the other qualitative analysis methods found in the vignette literature, researchers working within an interpretive description methodology also perform an inductive analysis of the data. In this study and with the aid of NVivo 10 (2012), a qualitative data analysis software, I undertook the data analysis of the verbatim interview transcripts with the objective of developing a thematic description (Thorne, 2008). Through the thematic description of key findings, supported by participant quotes, I could provide insight into physicians' perspectives on the critical phenomenon of cancer survivors' WI (Morrison et al., 2014; Thorne, 2008). A thorough description of the analytic procedures, methods used to enhance the trustworthiness of the findings, and the findings themselves lie outside the purpose of this manuscript and may be reviewed elsewhere (i.e., Morrison et al., 2014).

Commentary

The rationale for selecting vignette methodology for this qualitative stakeholder inquiry was the ability to employ previous findings combined with the safe distance and non-threatening approach to unpacking participants' overt and covert perceptions, beliefs, and attitudes about the germane issue of cancer survivors' WI (Barter & Renold, 2000; Hughes, 1998; Schoenberg & Ravdal, 2000). After reviewing the literature, I had three remaining concerns: ensuring that the survivors' lived experiences were fairly presented in a manner that would encourage explorative dialogue, effective use of participant physicians' limited time, and participants' responses to the vignettes. Guidance in addressing these particular concerns was less well-developed in the literature. I now present my decisions, experiences, and learnings.

Fair Representation of Survivors' Experiences in Manner Encouraging of Explorative Dialogue

The vignettes, representing Phase 1 survivors' experiences of work return, were grounded in real experiences. Survivors' first person narratives served to personalize these experiences. I combined participants' acquired photographs and quotes with text intended to provide context for the reader. I selected the content for each topical vignette from several options as survivors often presented photographs and descriptions of similar experiences. My choices were made based upon the clarity of concept represented by the combination of photograph and narrative. Many physician participants expressed a positive reaction to the survivors' experiences and the strong symbolism that resonated from the photographs and quotes. The content of the vignettes appeared to provide the participants with a connection to the reality and gravity of the presenting issue. For example, Family Physician (1) opined:

The vignettes are a very nice way to do an interview rather than just asking how do you feel about education versus privacy.

Oncologist (1) appreciated the facilitated insight enticed by use of the vignettes:

I like it...it kind of opened my eyes that I've never been trained in this aspect of cancer care.

Effective Use of Participants' Limited Time

From the Phase 1 inquiry with survivors, many themes emerged as important topics to be discussed with other stakeholders. Decisions needed to be made on a prioritization of these issues relevant to a discussion with the physicians and then on a manageable number to discuss during a reasonable period of time for one interview. The reviewed literature showed that the number of vignettes traditionally used varies from one (Charles & Manthorpe, 2009; Cook & Wang, 2011; Copeland et al., 1994; Denson et al., 2013; Hodgins et al., 2006; Hughes, 1998), sometimes with several building stages (Davila et al., 2011; Finch, 1987) to two (Atre, Kudale, Morankar, Gosoni & Weiss, 2011; Chur-Hansen et al., 2005; Dixon et al., 2012) or three (Butrick et al., 2011). There are, however, a few examples in the literature of a greater number of vignettes being used such as Corser and Furnell (1992) who used six vignettes, Barry and Greene (1992) who used seven, and Coker (2005) who used eight. I found no specific guidance about an ideal number of vignettes, although Finch (1987) did suggest no more than three story line changes in a long vignette. After testing the vignettes and interview protocol, in the end, I developed seven vignettes. The plan was to present as many vignettes in each interview as time (suggested 1 hour duration) permitted by the amount of dialogue the presented vignettes encouraged. Vignettes were to be rotated to ensure discussion of each vignette with a variety of physicians.

In order to guard against potential limitations of technology, the vignettes were prepared in hard, laminated copy. There was thus an evident stack of the seven vignettes brought to each interview. I question whether there may have been an element of "processing through" the evident stack by some participants. Such a process-orientation may have abbreviated the depth of discussion. There were some physicians who purposefully demonstrated curiosity to see and discuss all vignettes. These interviews, by participant choice, extended past an hour up to a maximum of 75 minutes. I remain with questions as to whether more in-depth discussion may have occurred with fewer vignettes and whether a form of technology in which the number of remaining vignettes could not be seen would elicit a lesser process-orientation. In fact, all seven vignettes were presented in each interview.

The vignettes were discussed freely, as well as with the assistance of prepared prompts, until there appeared to be nothing more to be added. Some vignettes resonated more with individual participants than others and resulted in more extensive discussion. Once the discussion on that vignette's topic appeared to be finished, I collected that vignette and presented the next vignette. An advantage of this technique was that there was a structured means to change the topic of discussion in a manner conducive to the interview. There was still some cross-referencing that occurred between vignettes during the interview. Although the structure allowed a means to change from one topic to the next, the vignettes also became interconnected in a meaningful way that encouraged reflection at a higher level about survivors' WI.

While most participants either continued to hold or strategically placed the laminated vignette in specific proximity for continued reference, there were a couple of participants who handed it back to the interviewer early during the discussion of the vignette. These were the same individuals who appeared to quickly scan the contents and not attend for any significant time to the images. There was a perceived difference in participants' receptivity, but it is not clear to me whether this was a reflection on the vignettes specifically, or rather the participant's personality or

perhaps other time pressures or distractions inherent in the busy lives of physicians. For example, one of these participants noted the following while discussing life balance issues:

I don't know that the concept and struggle is any different for someone with an illness, per se, versus you and me that are looking at our watch and saying, "We have to get home tonight" or "My [spouse] is pissed cause [he/she]'s waiting for me, and gonna have dinner alone tonight." Ok? I'm doing this all the time [Oncologist (2)]

Support for the vignettes as a methodology was not unanimous, although I am not certain whether this reflects exclusively on the chosen methodology or rather was a function of personality or time constraints.

I made specific decisions in an effort to reduce the burden of participation for the busy physicians. Seven vignettes may have been too many for the one-hour duration but a better means of judging would be the use of technology that eliminated the visible stack of vignettes brought to the interview. By having vignettes with discrete, albeit related, topics of discussion did allow for a helpful shifting of conversation that did not appear to hinder cross-reference between the topics of different vignettes. I found no solution for those dismissive of the vignettes. It may be that these individuals are simply more accustomed and better suited to direct interviewing, although this may also be a reflection of their personality or critical time pressures that no degree of modification of approach would address.

Participants' Response to the Vignettes

As described above, survivor participants previously expressed an unmet expectation that they would receive WI support from their health care team, namely their physicians. In approaching a discussion of survivors' unmet needs, I was concerned that physician participants could be offended by the insinuation that they were falling short of expectations. I therefore attempted to carefully mediate this potential offense and create a safe and non-judgmental interview environment. The first defense was to use the personalized and real experiences of the survivors, as presented in the vignettes, through poignant images and quotes. The framing of the interview questions and probes was another consideration. These strategies are discussed below.

Most participants were receptive and genuinely interested in the symbolism of survivors' images and quotes reflective of survivors' real life experiences. Some participants demonstrated some fun-natured puzzling about the images even before reading the accompanying narrative,

Now this woman is older. Not really old, but she's old enough to have Campbell de Morgan spots...Here's a few wrinkles. Looks like old freckles not young freckles. She's probably in her 50s. I may be totally wrong, it may be someone who's in their 30s that's just so...beaten down by the chemotherapy that she looks old. Or maybe a young looking 80-year-old. (laughs) See how good I am? [Family Physician (2)]

Other participants were captivated by the accompanying survivor narratives. For example, Oncologist (3) noted,

I love that quote. Returning to work is part of the recovery process. That's a very good quote.

For many, participation in the study invoked self-reflection. For example, Oncologist (1) insightfully reflected on his lack of WI-associated training. Upon conclusion of the interview, Family Physician (1) asked,

Are the family docs, am I alone in not addressing this issue?

There were two participants, however, who expressed a disinterest in the vignettes. I am uncertain as to the nature of their indifference, but this may have represented some sense of being off put. These two participants, one oncologist and one family physician, opined that the vignettes were unnecessary to facilitate the dialogue that could have been accomplished by direct questioning. For example, Oncologist (2) noted,

I probably could have answered the questions...[the vignettes] didn't necessarily make me answer any differently.

With the exception of these two physicians, all other recipients were open and appreciative of the content of the vignettes that appeared to provide a rich context in which to position the ensuing dialogue. For example, Family Physician (2) noted,

I think having this context to talk to makes for a much richer conversation and understanding and thoughtful sort of process than just asking questions.

As a second line of defense to the concern about offending the participants, I was intentional in the framing of the probing questions. While some innocuous prompts such as "How do you define life balance?" were purposefully designed in second-person format to encourage personal reflection, I decisively crafted other questions about professional roles to provide some distance in so allowing a more generic answer. For example, one such question was, "Is a patient's life balance under the purview of a primary care physician?" This mixture of questioning, however, was somewhat problematic. The participants tended to answer the majority of questions from their own personal experience and practice regardless of the structure of the question. Thus, even when questions were posed in a third-person format, there was a tendency to answer using first hand, personal experience and opinions. An example is presented below.

TM: How can a physician determine when, and if, return to work is indicated for someone who is experiencing emotional distress?

Oncologist (3): Oh! My rule of thumb is that everybody really should return to work. We know the randomized trials show increased psychiatric morbidity if you do not return to work. Poor people are less likely to return to work, it's been shown in trials as well. Now is that because poor people have a lack of control over work, unlike our lady [Lisa] from number one. Their jobs probably pay less, are probably much less rewarding, like piece pay and so on. Your quality of life from that, is

probably low, but the reality is that's what you were doing before this happened. So yes it should be part of the plan for everybody. But it's difficult.

The tendency of physicians' to answer from their own perspective even when a third person question was asked may provide evidence of effectively establishing a safe and non-judgmental interview climate in which participants were comfortable discussing their personal routines and beliefs.

There were also occasions when intended third-person questions were posed incorrectly by the interviewer in a second person format. This included, for example, "What kinds of accommodations have you been involved with recommending?" Recognizing the error, follow-up questions would then be posed in a third person format: "What accommodations could or should a physician be involved in outlining?" The implications of periodically inadvertently switching between second person and third person questioning is not clear, although it may have presented some confusion. The advantage of a safe distance to explore and respond to a third person formatted question may have been lost by the tendency of the physicians to respond from a first person standpoint and the interviewer's periodic errors in posing questions.

As an interviewer concerned with offending participants by questioning their work performance, the vignettes appeared, at least for the most part, to provide a means to sensitively explore the topic in an effective manner. The nature of questions posed bears further reflection and practice on the part of the interviewer to ensure consistency in approach.

Next Steps

In Phase 3, to commence in the autumn 2014, I will again use vignette methodology. The industry participants will include employers and insurers who have had some experience with survivors' WI. While the survivors' findings, inclusive of photographs and narrative text, will again be the predominant material of the vignettes, I will also consider integrating the findings from the physicians in Phase 2. For example, in describing his frustration with presented insurance forms, Oncologist (3) explained:

Have I assessed how many pounds she can lift, for how many minutes, of course I'm not going to do that . . . I don't know and I don't really care. In fact, if I see that, I'm probably even more likely [to say] that she can't go back to work.

Since the industry representatives will embody two distinct groups, insurers and employers, a vignette may be purposefully created for one and not the other. I do, however, anticipate that the majority of vignettes will be applicable to both the insurers and employers. While some vignettes used in Phase 2 may be maintained for the industry inquiry, I will reconsider the vocabulary of the context-establishing text and question prompts in order to better customize their content for industry representatives without necessarily medical knowledge. While I will not be entertaining the use of a larger number of vignettes, I will consider limiting the number of vignettes to a smaller number than seven. I will also consider displaying the vignettes on a laptop computer to eliminate the observable stack of vignettes. I will contemplate the format of questions and whether they will be posed specifically in second person or third person format. I will again monitor the receptivity of the industry participants to the vignettes and I will specifically query their perceptions of the methodology. I am anticipating some interesting potential differences in the level of receptivity

and perceived usefulness of the vignette methodology between the Phase 2 and Phase 3 participants.

Conclusion

In this article I have presented an overview of vignette methodology, its advantages, and limitations as found in the existing literature. Given the limitations of the literature pertaining to vignette methodology, I have attempted in this article to summarize the decisions I made for this recent study exploring physicians' perspectives of cancer survivors' WI, learnings achieved, and proposed considerations prior to embarking on the use of vignette methodology again in Phase 3 with industry stakeholders. The contrast and comparison between Phase 2 and Phase 3 participants and results may be highly illuminating.

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Appendix

Follow-Up Questions/Discussion

- a. What is your immediate reaction to this depiction?
- b. Should Lisa have been working throughout her treatments or should she have taken time off work completely?
- c. From where should Lisa be working? Home or workplace?
- d. What advice, cautions or encouragements would you have for:
 - i. Lisa?
 - ii. Lisa's employer?
 - iii. Lisa's co-workers
- e. What support needs would Lisa potentially benefit from?

Follow-Up Questions/Discussion

- a. What considerations should be undertaken for the timing of return to work?
- b. Even though Josée continued to battle anxiety, should she have returned to work when she did?
- c. Should return to work be seen as part of the recovery process?
- d. When a physician is faced with completing forms, such as those for an insurance company, how should a physician arrive at the suggested time frame governing the return to work?

Author Note

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