Notes from some of our previous research council studentship applicants

- This version of the document is up to date as of 28 October 2014
- If you are attending an interview for an externally funded studentship, please email Gideon.rubin@kcl.ac.uk with any additional questions / tips after you have had your interview. We will add it to this document to help other students.
- Research Design Service (RDS) also provides advice and mock interviews for fellowships funded by NIHR, for more information follow the link below http://www.rdslondon.co.uk/

Good luck!

NIHR studentships

**Applicant 1**

The questions for me were very project specific, 2 interviewers, one qualitative, one public health. Around 60-80% on methodology.

Reflexivity in qualitative research.

Data analysis and power (ensuring I knew my basic stats).

Why I chose biobanking as the decision for decision-making capacity for research to be assessed.

Generalisability of results based on my sample.

Would my supervisors, given their different backgrounds ‘get on with each other.’

Choice of supervisors, especially given one hadn’t supervised a PhD before vs his very extensive background of research in this area.

Research management and governance meetings.

Ensuring I had stats training in my training package.

My future career intentions - what I want to get out of it.

Explaining the ethics complexities of the project.
Applicant 2

It's hard to know exactly which answers they liked or didn't like, as you basically don't get any feedback from the panel (obviously they were happy overall to give me the award). They were extremely hard and picky with me - so you really do need to be prepared for battle and to prepare for the worst possible questions! Also I think they liked it when I defended myself and spoke about how I had approached my supervisors to go for the fellowship, and showed I had independence and initiative as a researcher, and wasn't just someone who could only carry out other people's ideas.

Initial questions purely on research design e.g. how would I judge an efficacy study was warranted based on the feasibility data

How could I show any differences in readmission rates if baseline rates were too low

Very odd trick question from someone on how my proposal differed from my supervisors research portfolio - basically he seemed suspicious it was actually my idea and wanted me to defend myself as wanting to be an independent researcher (I didn't hold back on this one!)

What if staff are not in a position of "equipoise" around the intervention (i.e. that they would be superkeen and not want anyone randomised to the control)

How could I ethically justify the control condition given people would "just" get social activity intervention

Final question was from the chair who asked about who would be collecting the outcome measures, which I took to be a question about assessor bias.

Applicant 3

I was asked a lot about my training programme: what courses? when? and why? I had as much of this as about my project.

Where did I see my clinical and research career going in 5 yrs, 10 yrs? Then oddly what my employers think of my intentions?

The rest were project specific. In my cohort study, what if people had disease symptoms at time 1, wouldn't that mean that they would be depressed at time 2, etc.

They asked about primary and secondary outcomes for my series of case studies with an experimental design and to explain what this was.

They also asked about who would help with my qualitative interviews as both my supervisors are more quantitative.
Overall much easier questions than any of the mocks and surprisingly the panel was very friendly and smiley!

**Applicant 4**

Possibly these questions would make a bit more sense if the reader knew a small amount about the project. This is my plain English summary:

Management of patients in control groups of randomised psychotherapy trials can be contaminated by new treatments under investigation. Cluster (group) randomisation can be used to avoid such contamination but means recruiting more patients than individual randomisation. Simulation studies informed by data from existing mental health trials will be carried out to develop a decision tool to compare the efficiency of cluster versus individual randomisation. The secondary aim is to refine statistical techniques used in the analysis of trials to account for contamination. These would lead to the design of more efficient trials and improved estimates of the effects of treatment.

Is it important for you to know about the process by which contamination takes place?

How would you quantify the "spirit" of motivational interviewing?

What's the "base way" of measuring contamination?

How would you model the data for cluster and individually randomised trials? I.e. which parameters will you include in the simulation?

You have said that you will be attempting to account for contamination in the analysis of D-6, which is cluster randomised. Will you need to take into account correlation within clusters when doing this analysis?

Why aren't you trialling the contamination measure in an individually randomised trial (instead of D-6, which is cluster randomised)?

How will your training plan address specific gaps in your knowledge of Stata programming, e.g. use of 'mata' in Stata?

Do you know much about the research of Ian White in Cambridge that has looked at how to account for treatment non-compliance in the results of trials? Will this be relevant to your research?

Can contamination go from control group to active intervention group (as well as the other way round as you have defined it)?

What about addressing bias (as well as efficiency) of trials?
One of the panel members (who was not a lead interviewer) made a suggestion of an individually randomised trial that might provide me with a measure of contamination. He also asked me about whether this research was applicable to other areas of medicine apart from mental health. He then talked about a trial of a health service intervention, which had used cluster randomisation. My impression was that this trial has used cluster randomisation because the intervention was being applied an organisational level (e.g. a GP practice).

Can contamination occur at patient level (as well as therapist level)?

**MRC Clinical Research Training Fellowship**

**Applicant 1**

Here are some questions from my MRC CRT Fellowship interview in March 2014. As you can see, most are quite specific to my methodology.

Why are you recruiting from the non-clinical population?

Give us an example what you’ll actually be measuring in ESM

How are you going to make claims about causation with ESM – surely it’s just associations?

So you’re saying that all types of psychosis involve threat – what about manic psychosis?

What are the feasibility questions will you be asking in the clinical study?

What information will you obtain to inform future sample size?

Oh, and my favorite... I see you are already a Dr, so you’re trying to become a double Dr?! (chuckle chuckle). (which lead on to what are your career intentions?)

In terms of interview procedure, it was...

- 3 mins presentation from me, no slides/handouts allowed (timer beeps)
- 7 mins questions from questioner 1 (timer beeps)
- 5 mins questions from questioner 2 (timer beeps)
- 5 mins open questions from rest of the panel (timer beeps)
- Goodbye. No opportunity to ask them questions
- Interview result received by email 3 days later
- Small paragraph of interview feedback received by email 2 weeks later