

Innovations in Continuing Education

Use of Focus Groups for Identifying Specialty Needs of Primary Care Physicians

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Abstract: *Focus groups were chosen as a needs assessment device to obtain first-hand information from primary care physicians about their interests and needs. The focus group process was used because it generally enables opportunities for discussion with immediately critical commentary, allowing participants to build on and to expand on each other's ideas. Focus groups would also provide a "triangulated" approach to our needs assessment process by having participants provide answers to questions that a previous survey had revealed. Ultimately, we were interested in the beliefs held by primary care physicians concerning their interest in specific medical topics. Knowing about similarities or differences in perspective would greatly inform our curriculum development and instructional development processes. We found a general similarity of interests among the four specialties—family physicians, general internists, pediatricians, obstetrician-gynecologists—participating in the four focus groups. There was a noticeable variety of beliefs within each specialty group. Further, across the four focus groups, a significant overlap of opinions and ideas was observed. The focus group process, these differences, and implications for our project are discussed.*

Key Words: Continuing medical education (CME), focus groups, needs assessment, primary care

For a new continuing medical education (CME) initiative being undertaken at the University of Illinois at Chicago College of Medicine, we selected focus groups as a major part of our needs assessment process. We chose focus groups because we wanted to determine what subjects primary care physicians believed would benefit them in their pri-

vate practices and as managed care "gatekeepers." We were hoping that primary care physicians would be interested in learning more subspecialty concepts and skills but we were uncertain about that expectation. Focus groups were chosen since they provided an opportunity for multiple discussants to share views in an interview format leading to what we hoped would be immediately useful information.

Review of Literature

Focus groups have been used for over 50 years by social scientists, in marketing, and, more recently, in health care. They were first described by Bog-

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ardus in 1926.¹ Since then, the method has been used frequently in marketing, where its purpose has been to determine what strategies work best to foster buying decisions and to specify buyer cohorts.² Additionally, focus groups have been used to "analyze target population's wishes, views, problems, fears, beliefs, vocabulary, defense mechanisms; and to share communications in advertising campaigns."³ They have been used successfully in the social sciences and in educational planning.³⁻⁶ More recently, the method has been used for needs assessment, qualitative research, and evaluative methods in health care and in CME.⁷⁻¹⁸

We found many practical definitions for focus groups,¹⁹⁻²² but the one that seemed best to direct our vision was offered by Frey and Fontana²³:

A focus group interview is a qualitative research technique that includes 8-10 persons brought to a centralized location to respond to questions on a topic of particular interest to a sponsor or client. The interview is led by a 'moderator' who keeps the respondents 'focused' on a particular topic. The focus group is generally conducted for applied purposes and, therefore, would be classified as a pretest vehicle. It is ordinarily conducted in a setting formally established for the interview; the moderator is directive, and the interview questions are purposive and usually somewhat structured. (pp. 29-30)

We chose focus groups because of several potential strengths. One strength lies in the focus group's effective use of small group dynamics that allow interdependent development of ideas with simultaneous critical evaluation of those ideas by group participants.³ During the focus group interview process, the researcher should be able to gather affective data about feelings and opinions on a subject, problem, or experience and expectations held by interviewees about the subject or program. Through the group process, participants can develop a critical level of intensity and sharing that ultimately leads the members of the focus group to build upon and expand on each other's ideas and comments.

In this way, focus groups are useful time savers. They also can be less costly compared to intensive individual interviews or structured survey interviews,⁷ both significant strengths. Furthermore, while intensive individual interviews can be extremely useful, they lack the dynamics that are the hallmark of group work.

In health care and in continuing health care education, focus groups have been found to be useful tools for determining needs,^{3,6,8-12,20} as a planning process,^{9,15} for program evaluation,^{10,14,17} and in research.^{6,23} As a research method, focus groups can be employed to provide data "triangulation." They allow the participants to analyze their own survey data and provide answers to questions that the survey revealed.

Finding better ways to determine needs has been a consistent recent theme in this journal and elsewhere. New paradigms for CME have been called for. One paradigm²⁴ enjoins the continuing educator to attend to collaborative planning efforts that are both responsive to physician learners and to CME providers. In their description, Moore et al.²⁴ note that the future should bring a model of continuing education in which "learners [are] responsible for identifying, with considerable precision, their information needs based on practice circumstances or developmental requirements" (p. 12). New paradigms aside, the very real practicality of the increasing availability of information to physicians makes the motivation of physicians to attend a formal course specifically designed for their needs and to increasingly involve themselves in self-directed learning more likely. As Mann and Ribble²⁵ note, "there is a need to create a system for access to useful learning resources ... there will be a concurrent need to study documented self-directed and other [author insertion] learning activities to assist learning needs assessment, and to raise physician awareness of their own ... learning activities" (p. 85). The authors took these admonitions seriously. This paper reports the use of focus groups as one stage of a CME needs assessment process.

Table 1 Journals Reviewed for Preliminary Needs Assessment

American Journal of Medical Science	1996 Suppl
Annals of Internal Medicine	1996
Archives of General Psychiatry	1993-1996
Family Physician	1994-1996
Journal of the American Academy of Dermatology	1996
Journal of Geriatric Psychiatry	1996
Journal of Pediatric and Child Health	1996
Journal of Pediatric Health Care	1996
Journal of Pediatrics	1996
Journal of the American Medical Association	1996
Journal of Family Practice	1974-1996
Journal of General Internal Medicine	1993-1996
Journal of Internal Medicine	1996
New England Journal of Medicine	1992-1996

Methods

Focus Group Objectives

A series of four focus groups was conducted in order to identify the extent to which primary care physicians desired CME to increase their ability to refer less; determine the extent to which four sets of primary care specialists (family physicians, general internists, general pediatricians, and obstetrician/gynecologists) share perceptions; discover topics and subjects desired for CME given the changes discussed; and compare the perceptions of focus group participants with those of survey respondents.

Recruitment of Focus Group Participants

There are six medical centers and hospitals affiliated with the University of Illinois at Chicago College of Medicine, each with a vice-president for medical affairs or a director of medical education serving as representative members of the planning committee of a CME project aimed at meeting various needs of primary care physicians. These six individuals were requested to provide the authors with a list of primary care physicians with privi-

leges at their hospital. The request specified the four specialties that should make up the list: family medicine, general internal medicine, general pediatrics, and obstetrics-gynecology. Four of the six hospitals complied with the request within the time frame necessary, with the lists provided to the program office.

Letters were sent to every physician on each hospital list inviting them to participate in the focus group. The letter gave a brief description of the project along with an explanation of the focus group process. Interested individuals were asked to contact the project coordinator, who then worked with each of the respondents' office staff to arrange a mutually agreeable time at their hospital. Focus groups were organized to last about 60 minutes, although three lasted slightly less. One, the first, was about 75 minutes in duration.

A total of 42 physicians participated in four focus groups. Thirty-two physicians were either family physicians, general internists, or pediatricians. Five obstetrician-gynecologists and five subspecialists also participated. It is unclear how the five subspecialists heard about or became interested in the focus groups, but their participation proved interesting, if not noteworthy. Other than the initial focus group, attendance was similar at each of the hospitals.

Focus Group Process

Prior to conducting the focus groups, a topical frequency analysis was completed. It consisted of hand searching titles of articles in seven primary care and seven additional specialty journals (Table 1) from 1988 to the present. Titles were then organized by diagnosis, disease, procedure, or other major medical topic. The assumption behind this process was that the subjects with the highest frequency would mirror the needs of the physicians who regularly read those journals. This analysis provided an additional needs assessment and the focus group planners with background information for focus group facilitation. The data were intended to be used by the facilitator (MHG) to direct discussion, should that be necessary.

Upon arrival at the initial focus group, participants were handed a grid that contained the major subject headings identified in the title search subsumed by specific diseases and subjects. Participants were asked to indicate topics that represented greater than 80% of their practice, less than 20%, and so on by checking the appropriate box. A large 3.5 × 5 foot version of the grid was placed in the front of the room with the intention that as the respondents were asked to indicate those responses that represented the greatest frequency of patient visits, the facilitator would indicate with hashmarks a running count of their responses. This activity was used to draw out the participants. However, experience quickly proved that the activity was inefficient and that direct questions and positive group process and leadership skills facilitated complex interactions by participants leading to a large number of responses. The grid approach was not used in the remaining three focus groups.

Data Collection and Data Analysis

All of the focus groups but the third were audio-taped. In that session, the tape recorder inexplicably failed to operate. Throughout each session, careful notes were taken to serve as a method of

clarifying data observed on the tape recordings. Data from the third focus group were analyzed on the basis of these notes. After all four focus groups were completed, patterns of topics were identified. These provided an indication of major needs as described by the 42 participants. This assessment summary was shared with the project planning committee. The committee corroborated the findings and identified several additional ways of organizing the data. In this way, the final hierarchy of needs was created. This hierarchy was later compared with summary findings from a national written survey among primary care and other specialists.

Findings

The principal purpose of these focus groups was to identify beliefs held by primary care physicians regarding their interests in specific medical topics. We were particularly interested in knowing what similarities or differences might exist among the four specialties represented. Knowing about similarities or differences in perspective would greatly inform our curriculum development and instructional development processes. We found a general similarity of interests among the four specialties: family physicians, general internists, pediatricians, obstetrician-gynecologists. However, there was a noticeable variety of beliefs within each specialty group. Further, across the four focus groups a significant overlap of opinions and ideas was observed.

The four focus groups proved extremely interesting particularly since the information obtained was only partially what we expected to find. At the onset, it was our expectation that the primary care physicians attending the focus groups would be interested in directing us to provide programs similar to what is prominently marketed by CME providers. It was expected that the facilitator would be requested to develop review courses as well as a variety of episodic events based on a series of topical items. Instead, he was consis-

tently requested to provide courses that would "teach" physicians "in depth."

Each of the four focus groups argued for courses that would provide skills and in-depth information. As one participant noted, "there are already lots of review courses I could attend. What I think is needed are courses which will help to teach me information which I don't know." Others in this focus group, as well as in other focus groups, noted the necessity for retraining. These were consistent themes across the four focus groups. Such themes were not specialty specific.

It is a hallmark of focus groups that when one individual happens upon an idea, others who would agree follow and substantiate that point of view. We observed an interesting example of this process. One physician participant commented that "when we speak about the mental health of our patients, we are ignoring the obvious similar needs of ourselves and our colleagues. You ought to have programs which teach us how to deal with the stresses we feel today because practicing medicine is just not the same as it used to be." This comment was followed by a discussion that pointedly questioned the possibility of reducing stress among physicians. It led to the recommendation by this focus group's participants that the planned programs offer a structure that would emphasize patient and physicians in side-by-side discussions. In other words, the unique qualities of this particular set of physicians in this particular focus group created a model for instruction that would have appropriate treatment and management strategies for the patient along with comparable and contrasting life strategy approaches for the physicians themselves.

This unique approach to identifying and solving physician problems was not duplicated in the three other focus groups. Nonetheless, the recognition of the importance of anxiety and depression was profound in each as were the identification of other issues that were enhanced as a result of the focus group process. For example, in two different groups, the matter of "hands-on" teaching was discussed at length. In one of these groups, a par-

ticipant spoke about what she thought made primary care physicians different by noting that "we like to learn by doing." Whether or not that is generally true may be moot. More pertinent is that in her group, her comment spurred a conversation that threaded and spun from the need for proper breast examinations, to proper endometrial suctioning, to doing good pap smears, to evaluating fractures in X-rays, and finally ending up in a discussion regarding the practice of various kinds of screening activities. Throughout this conversation, the group's impetus fueled itself. A number of excellent programmatic ideas, as well as topic issues, were identified as a result of this particular focus group's energy and considerable ideologies.

Another group's self-sustaining process led to an interesting discussion of the role of the non-primary care physician in today's health care culture. This conversational motif stemmed, most directly, from discussion of the increasing numbers of HIV patients one participant was experiencing in his practice. The mention of HIV led in a relatively rapid fashion to brief forays into the need for increased training in infectious diseases, the newest advances in antibiotics, the new oral agents, and other cutting edge issues in diabetes, new drugs, and lytic agents for cardiology patients, and, finally, to a duplication of the hands-on discussion in another focus group described above. It seemed to the facilitator that this conversation was covering the waterfront of primary care. This observation was put to the group in the sense of a statement followed by a "what do you think?" question. The responses ultimately led to questions of "just how far one could go in specialty medicine when one is not a subspecialist."

Conclusions

- As seen here, focus groups may present problems to the CME researcher and at the same time lead to fortuity. Opportunities we gained from the four focus groups that we ran have led to a breadth of ideas for our specific CME programming con-

cerns. However, because the participants were so clear and direct about their interests and their needs, as program planners we felt somewhat constrained. Not all ideas can be implemented, and those ideas that are implemented may not completely fulfill the expectations of the focus group attendees. This may be a drawback of focus groups. In several of our groups, the facilitator, who was also one of the program planners, developed an affinity with the group members as a result of the group's energy and ideas. Their energy charged him but he felt somewhat guilty about not being able to achieve those affiliative needs.

Our focus groups provided a great deal more information than we expected. We anticipated and found a setting where idea generation for teachable topics took place. Many ideas were obtained with substantiation for why those topics would be worthwhile, including how topics should be programmatically interwoven. But, in addition, what was very new for us was the extent to which the physician participants explored the space that surrounds a given topic. This awareness has led to our decision to continue using focus groups as a major element in our needs assessment processes.

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