Selections from current literature: focus group technique in chronic illness

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Introduction

This topic is chosen for its potential use as a facilitator of change in a growing population of patients with chronic illnesses for which they receive inadequate care. Patients with chronic diseases are often characterized as ‘difficult’ because of non-compliance, ‘doctor-shopping’ and over-utilization of medical services. These characterizations, combined with patient–physician communication problems, differences in attribution models, disease treated out of context of family, and lifestyle result in frustration and anger in both physician and patient. In this review, I define focus groups, illustrate their use, as reported by several authors, and relate my own experience with groups to facilitate changes in patients with chronic illness.

Defining focus groups

Investigators using qualitative methods use focus groups to explore opinions, knowledge, perceptions and concerns about a particular topic. The composition of focus groups varies but they generally comprise six to 10 persons, with knowledge in a given subject, or with common interests or activities. Group members generally meet for 1 or 2 hours to respond to questions and share personal experiences on a particular topic. This technique has been used widely for library research, corporate marketing, problem delineation and resolution, as well as by the medical profession as a qualitative tool for developing research hypotheses.

Critical factors in the determination of focus group size.


Review

The authors develop basic guidelines for developing focus groups. While there are several critical issues in the focus group method, they have chosen group size as a principal concern. They cite literature pertaining to process, development of ideas, and achievement of the targeted task as they relate to group size. They argue that optimal group size can be determined by four critical factors:

(i) the number of questions asked;
(ii) the allotted time for each question;
(iii) the format of the focus group session; and
(iv) the duration of the session.

Pilot testing is recommended to determine the time required to discuss and clarify each question. Groups using structured formats may function well with larger groups than those with less-structured ones, in which ideas are freely exchanged and experiences shared among participants. Above all, the size of a group should be determined by the aims of the research study.

Comments

This article is reviewed because focus groups are used frequently in general practice research. To ensure methodological rigour that will withstand critical review, guidelines need to be developed, critiqued and tested. From a theoretical perspective, determination of optimal group size requires additional research into the achievement of group tasks and participants’ satisfaction. The four critical factors described in this publication should be considered when deciding the group size. A fifth, not mentioned, of equal importance, is frequency of sessions. This might influence other variables, for example, longer duration and increased frequency might permit larger groups with less structure and freedom to exchange ideas and experiences.

Using focus groups to identify psychosocial issues of urban black individuals with diabetes.


Review

Black individuals are at increased risk for diabetes and its complications. Additionally, black individuals with
Factors uncovered that contribute to the ADL problems were categorized as functional limitations in, and feelings about, performing ADL. Participants expressed feelings of insecurity and stupidity in performing several activities. These feelings were caused by not knowing if they could manage. Participants also stressed the importance of having something meaningful to do. Group members shared strategies for accomplishing ADL such as changing the way an activity is performed, changing routines and moving about in familiar areas. If they use the same bank, they can follow the person ahead to ascertain when it is their turn to be served. They practice skills they might need, i.e. they will get up during the night to practice moving around as if they were totally blind. The groups expressed uncertainty regarding etiology and prognosis of the disease and demonstrated a good deal of ‘misperception’ about these subjects.

Comments
Our profession has a history of paternalism and has tended to focus on perceptions of the physician who would then relate them to the patient. What is refreshing and inherently progressive about utilizing focus groups is the shift of focus to perceptions of the patient. This approach engages the patient and simultaneously validates and addresses their fears. An educational programme designed by eliciting patient concerns is probably more likely to be successful.

Discussion
These articles demonstrate some of the benefits of focus group methodology in eliciting patient concerns and identifying cultural obstacles to change and patient perceptions towards change in general. Readiness to change, specifically lifestyle changes, is a key element in the management of chronic illness. Patient education, through a didactic educational approach, by itself, has been unsuccessful in motivating alterations in diet, exercise, smoking and other maladaptive cognitive, emotional, behavioural or social problems. For example, smokers in the USA are inundated with information regarding the relationship between risk behaviours and cancer, and vascular and heart disease. Epidemiological research has found smoking to be more prevalent among people with higher ‘subjective’ stress. Cessation of smoking, however, is often hampered by uncertainty about how to manage life stress, because patients perceive that smoking reduces stress.

Assisting the patient to identify and explore their desire to improve or maintain their quality of life might facilitate lifestyle change, but this must be done before action-oriented interventions are introduced. Implicit in this statement is the importance of self-realization of individual obstacles and negative consequences of change in the individual patient. In essence, the physician must
facilitate a shift in the perceptual frame for the patient, i.e. a glass half-full rather than half-empty.3,4 The question is which clinical method best promotes lifestyle change. I address this question by personal experience with focus groups to facilitate perceptual changes for patients with chronic illness.

The high volume/low revenue aspect of family practice imposes time constraints on most of us. Clearly, the typical brief physician/patient encounter barely permits assessment of biomedical parameters, answering patient questions, education, developing and outlining management plans, or prescription writing. All of the latter focus on disease, but not on the illness experience or context of the disease.5 Our discipline acknowledges the importance of a less reductionistic approach: the biopsychosocial model.6 Understanding the significance of the patient’s explanatory model, fears and attributions, however, requires listening to their ‘story’.7 Such encounters are often time-intensive processes. The paradox of family practice care is that ‘re-discovery’ of the importance of time spent interviewing patients is negated by economic pressures that force increases in patient volume through decreased time per visit. It is apparent that seeing 12 consecutive patients during every 3-hour session (15 minutes per patient) is inadequate when dealing with chronic illnesses that require modification of lifestyle as a major therapeutic tool. Developing focus group workshops, however, in which the 12 patients meet together with the physician for 3-hour sessions permits time to explore attributions, fears and perceptual frames with the added benefit of group dynamics. While focus groups have been typically used in qualitative research to explore opinions, knowledge, perceptions and concerns in regard to a particular clinical topic, in this case, its focus is the particular patient. The group process might enhance validation, allay fears through shared experiences and alter perceptions through self-realization. Economically andlogistically, the same number of patients may be seen in the same time-frame; the difference being that it is no longer a linear, one-after-the-other process, thus, permitting added interaction time per patient while holding physician time constant. How physicians use this time is dependent on individual interests, training and patient needs, and will ultimately influence outcome.

The premise being tested and underlying the chronic illness focus groups underway in our Department of Family Medicine is as follows: metaphorical exploration of meaning of illness and symptoms leads to individual insight regarding behaviours detrimental to health, thereby promoting better treatment compliance, exercise and dietary habits compatible with improved quality of life and normalization of dependent behaviours that relate to individual illnesses. Groups of 10 to 12 patients suffering chronic illnesses (not necessarily one specific disease) are given a case history with metaphors drawn between ‘patient story’ and the disease. The facilitator asks questions regarding group feelings related to the validity of correlating issues of ‘mind’ with ‘body’. Current literature regarding effects of emotions on immune system function are didactically presented. Through group process, individuals attempt to draw metaphors and, thus, meaning between their own life story and personal illness. While qualitative, these pilot group sessions are extremely well-received. Quantitative studies that demonstrate a relationship to self-realization and alteration in diet, exercise, smoking and other maladaptive cognitive, emotional, behavioural or social influences have not yet been performed.

Clearly, the medical profession must continue to be rigorous in its research and use creative methods to facilitate readiness for change in this ever-enlarging subgroup of the population. Focus groups may be one such method for developing outcome studies with this intent.

References

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4 Jaber R, Trilling JS, Kelso EB. The circle of change: an approach to difficult clinical interactions.