

# Caring for the Underserved: Using Patient and Physician Focus Groups to Inform Curriculum Development

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**Background.**—Training pediatric residents to care for the underserved is a recognized curricular need. A literature review revealed that curricula specific to caring for the underserved tend to focus on specific medical diagnoses rather than physician or patient behaviors.

**Objective.**—To collect and evaluate information essential for developing a curriculum to teach care for the underserved.

**Methods.**—Focus groups were conducted to identify themes responsive to the question, “What does a physician need to know to care for the underserved?” Each of 3 focus groups met twice. The physician group included 5 pediatricians and 3 family practitioners. There were 2 patient groups: one Spanish-speaking (N = 13) and one English-speaking (N = 8). Content analysis was used to identify themes from each of the focus groups.

**Results.**—Prevailing themes from the 3 groups were communication/respect, cultural issues, and frustration with systems, such as health insurance, transportation, and health delivery systems. Patients expressed an almost universal wish for physicians to listen to them and to attempt to “understand my life.” Physicians expressed concerns with lacking the time to establish quality patient relationships and the need to serve multiple roles. The groups did not discuss issues related to specific medical conditions.

**Conclusions.**—Physicians and underserved patients identified communication/respect, cultural issues, and frustration with systems, such as health insurance, transportation, and health delivery systems, as important factors in caring for the underserved. Curricula to teach care of the underserved should include these themes.

**KEY WORDS:** education; focus groups; underserved populations

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Although the term medically underserved is difficult to define concisely, it includes individuals and populations that lack access to necessary health care services. The factors associated with being underserved include poverty, long travel distances, limited transportation, poor literacy or limited English proficiency, and differences in race, ethnicity, or culture between patients and providers.<sup>1–3</sup> Underserved populations suffer from greater morbidity and mortality compared to other populations.<sup>2–5</sup>

The Residency Review Committee (RRC) for Pediatrics has recognized the need for physicians to train to learn how to provide care for the underserved. One of the focus areas for community experience (Section V. B. 5a) is “community-oriented care with focus on the health needs of all children within a community, particularly underserved populations.”<sup>6</sup> At the same time, various studies

have documented the need for improved training curricula with regard to care of the underserved.<sup>7–8</sup> A 1999 study of Yale pediatric residents found that “40% . . . reported feeling ineffective [in an underserved clinic,] not feeling comfortable with helping families with psychosocial difficulties, an inability to be helpful to families because of their psychosocial difficulties and a sense of futility in the work they performed in clinic.”<sup>2</sup> Another study, based on a 2001 national survey of primary care residents, revealed that residents felt less prepared to provide services for common clinical issues to the underserved compared to mainstream patients.<sup>9</sup>

Only a few curricula concerning the care of the underserved have been published. Those that have are not based on findings from research involving both physicians and patients.<sup>10–12</sup> One study demonstrated that medical providers identify different needs for community health compared to members of the community.<sup>13</sup> Published curricula focus primarily on the medical diagnoses common to underserved populations, such as tuberculosis, anemia, AIDS, and failure to thrive.<sup>10–11</sup>

In our pediatric and family medicine residency programs, community and academic preceptors are central to teaching residents the majority of issues related to care of patients in primary care settings. Our model has been to develop curricula for presentation to continuity preceptors who, in turn, are expected to use these concepts to teach their residents. As we began to develop our curriculum

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**Table 1.** Selected Questions From Question Guide

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- What types of issues do you encounter when trying to get treatment for your children?
  - What is the biggest barrier for getting treatment?
  - If you could change one thing to make things better, what would it be?
  - Is there something your doctors are doing that is very good, that works well, that they should keep doing?
  - What does underserved mean to you? How would you define it?
  - When you treat the medically underserved, what kinds of things come up?
  - What barriers to giving good care come up for you when treating the medically underserved?
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for care of the underserved, we suspected that patients and physicians might have different ideas regarding the important issues involved in this care. To explore this question, we conducted focus groups of patients and physicians to identify the issues that these two constituencies regarded as important for physicians to be familiar with as they provide care to the underserved.

### METHODS

We used patient and physician focus groups to generate ideas responsive to the question, "What does a physician need to know to care for the underserved?" Three focus groups were conducted, one involving physicians, one involving Spanish-speaking patients, and one involving English-speaking patients. Each group met twice. An independent, trained facilitator led the groups. One of the authors (R.A.M.), a bilingual, bicultural communications PhD candidate, served as an assistant facilitator and recorded verbal and nonverbal interactions during the group sessions. Two standardized discussion guides were utilized, one for the provider group and one for the 2 patient groups. Discussion guides for the second round of focus groups were developed after the conclusion of the first round. Sample questions are listed in Table 1; the complete guides are available from the authors.

### Recruitment

Participants for the patient focus group were recruited from local community health centers (CHCs) by their primary care physicians. CHCs provide care for a large proportion of the underserved population of Salt Lake City. Demographic data, including zip code, type of dwelling, citizenship, time in the United States, insurance status, number of people in household, employment type, household income, and language spoken at home, were collected at the beginning of the patient focus groups using a questionnaire.

Participants for the physician focus group were recruited via telephone calls and direct communication with the authors. Physicians were invited to participate if they had practiced family medicine or general pediatrics for at least 2 years and had clinical teaching appointments at the University of Utah. Selection of eligible physicians was done purposefully<sup>14</sup> to insure representation from different practice groups in Salt Lake City. The physicians completed a demographic questionnaire prior to the focus group, in-

formation obtained included years in practice, type of practice, percentage of insured and underserved patients in practice, services available in or near practice, and languages spoken at practice.

A consent form was read aloud to each focus group, questions were answered, and all participants gave written informed consent prior to beginning the focus group. The University of Utah Health Sciences Center Institutional Review Board approved this study.

### Sampling Frame

We employed the techniques of triangulation and member-checking to corroborate the data among the 3 groups to enhance the reliability of the results.<sup>15</sup> The first session was devoted to developing themes responsive to the question, "What does a physician need to know to care for the underserved?" During the second session, the facilitator reviewed the major themes identified by the groups to confirm that the initial themes were accurate (Table 2). There was no disagreement with identified themes. Then the facilitator reviewed the patient-identified themes for the physicians and the physician-identified themes for the patients. The goal was to allow the 3 groups to reach a consensus on critical curricular items.

### Data Collection, Management, and Analysis

During the sessions, R.A.M. recorded verbatim the verbal and nonverbal interactions. Independent notes were taken by W.L.H. and S.E.C. After each focus group, the facilitator, assistant facilitator, translator, and those investigators present reviewed the sessions and identified the most common themes. Based on a systematic review of the frequency, intensity, extensiveness, and specificity of the comments, R.A.M. identified the themes and prepared a written report. The report was reviewed by 4 (W.L.H., S.C., S.V.H., S.E.C.) of the investigators, who, after comparing it with their own notes and impressions, created their own independent list of themes. Finally, this group discussed, compared, and developed consensus regarding the most common and relevant themes. There was minimal disagreement among the investigators in achieving consensus.

### RESULTS

The Spanish-speaking patient group included 13 adults, 11 of whom were from Mexico and 2 of whom were from Peru. There were 2 men in the group. Their times of residence in the United States ranged from 1 month to 15 years. None of the patients were US citizens, and most were undocumented. Eleven returned for the second group. The English-speaking patient group included 8 adult participants, 3 men and 5 women. Five were non-Hispanic Whites, one was African American, and one was a Latina. The English-speaking group included 1 participant who was legally disabled, 5 who had children, and 4 who had chronic medical conditions.

The physician group included 5 pediatricians and 3 family medicine physicians. Two of the physicians dropped out between the first and second sessions and

**Table 2.** Summary of First Round of Focus Groups, Confirmed by Participants at Beginning of Second Round of Focus Groups

Major Topics	Responses
	Community Group English
Financial issues	Expense limits care. Doctors do not know costs.
Communication issues	Doctors do not listen and do not always show respect.
Negotiation with doctors	There is no negotiating care with doctors.
Emergency services	Too expensive.
Transportation	A significant obstacle for getting to the doctor, at all and on time.
Getting appointments	Hard to get an appointment. The front desk staff is rude.
	Community Group Spanish
Emergency services	Cost too much.
Financial concerns	Many patients go without care because they cannot afford it.
Appointments	American system more concerned with sick care than preventive care.
Translation issues	For specific incidents, language was not a barrier.
Well child care/prenatal care	Overall patients are satisfied.
Barriers to care	Transportation, insurance, financial, language. Lack of information about clinics and insurance.
	Physician Group
Transportation	Patients have difficulty getting to appointments.
Language	Makes communication difficult. Those that do speak another language are often overburdened.
Communication and respect	Doctors need to learn how to show patients respect, how to better communicate with them.
Financial	Doctors do not know what services cost.
Immigration	Doctors do not know much about visa status and the ramifications.
Communication	Doctors are only adept at educating patients if they have a long-term relationship.

were replaced with physicians who had been in practice for similar lengths of time. The physicians had been in practice for periods of time ranging from 4 and 26 years. The group reported a range of experience in caring for the underserved from “very little” to “substantial” experience.

Three dominant themes emerged from the 3 groups: communication/respect, cultural issues, and frustration with systems, such as the health insurance and health care delivery systems.

### Theme 1: Communication and Respect

All groups identified the issues of communication and respect as important. Physicians were concerned with language barriers; patients were concerned with general communication and listening skills. Patients commonly indicated that physicians did not listen and that their physicians interrupted them or diagnosed them before they had finished talking. Patients voiced a reluctance to bring up negotiations about care, preferring to wait for the physicians to do so. Respect from the office staff was very important to patients. Some commented that the front desk staff are “always rude, and really strict” and that “they’re real despots.” The Spanish-speaking group said that they considered a physician’s attempts to speak Spanish a sign of *respeto*, or respect. Patients expressed an almost universal wish for physicians to listen to them and to attempt to “understand my life.”

One physician said, “For medically-underserved people, they don’t know how to communicate.” Another said that communication is the hardest thing to teach. Most of the physicians were concerned about language barriers; this finding was contrary to patients’ statements. Physicians also understood that people need and want respect and that the best way to show respect is to get to know the patients: “People need you to show respect for them.

They want respect. I need to know how to do that. It’s not about overly pampering people but understanding people so I can show them respect.”

### Theme 2: Cultural Issues

Cultural issues were mentioned in all groups but were less often a focus of discussion in the patient groups compared to the physician group. The English-speaking group expressed the concern that physicians (although perhaps of the same race) were from a different culture and that physicians needed to learn about the “low-income” culture. A patient commented, “Poor people want to be treated just like any other human being.” Physicians felt uncomfortable with their knowledge about specific cultures. They thought that teaching residents to listen would be the most effective teaching method for residents to learn more about a patient’s life and culture. Table 3 lists selected quotations relevant to this theme.

### Theme 3: Frustration With Systems

The most prevalent theme across all 3 groups was frustration with systems. Tables 4 and 5 list selected quotations. The complexities and problems of the medical system itself were brought up in both groups. Patients wanted more information about how the medical system works and how to access services. Patient groups identified the theme of *continuity* as important to them (eg, “having a single physician who knows you” and “getting the same doctor twice would be nice”). Physicians identified lack of time to establish quality patient relationships and difficulty in serving multiple roles for their patients and clinics as problems with the health care system.

Health payment systems were prominent in patients’ minds; many patients stated that they could not access the medical system because of its cost. Patients wanted physicians to ask about their resources (or lack thereof) and

**Table 3.** Direct Quotations Reflecting Communications, Respect, and Cultural Issues

Issue	Group	Quotation
Communication	Parent	“Communication is one-sided. I’m talking but nobody’s listening.”
	Physician	“Patients have difficulty communicating with my staff or even at the supermarket.”
Respect	Patient	The front desk. “They’re real despots.” “The best way to do it is to treat low-income people like they’re human beings . . . not just a case.”
	Physician	“People need you to show respect for them. They want respect. I need to know how to do that.”
Cultural issues	Patient	“In Peru, I can get a PAP smear, here I have to pretend to be sick to get an appointment.”
	Physician	“Understanding where they come from.” “Language . . . it’s a huge time thing.”

to know the costs of services and medications. Patients wanted physicians to know that they are resourceful: “Sometimes it takes a couple of days [to get medicines], because we call relatives in Mexico that get medicines in Mexico, it’s a lot cheaper.” Many patients did not understand how to access public resources.

Physicians were concerned that they might be providing unequal care if they chose a less expensive alternative for low-income patients. Physicians identified a need to know what office visits and services cost. Physicians spoke about a lack of knowledge about Medicaid and Medicare. Most physicians had only a rudimentary understanding of public health systems, and what understanding they did have seemed to be based on their personal experience in assisting members of their own families.

Both patients and physicians cited problems with the transportation system as a concern. Patients reported spending half of a day on the bus or being unable to make appointments at all. Physicians reported awareness of transportation problems but did not know how to help. Transportation issues were cited as a reason for being turned away from medical care and for not accessing medical care. Neither patients nor providers identified knowledge regarding specific medical diagnoses as an important theme.

**DISCUSSION**

Using focus groups as a methodology for curriculum development elucidated a variety of important topics for a curriculum to serve the underserved. When we asked physicians and underserved patients what physicians need to know to care for the underserved, they identified com-

munication/respect, cultural issues, and understanding the health payment, transportation, and health delivery systems as the most important factors.

Previous research and curricula have been useful in understanding the medical diagnoses common to underserved populations; we undertook this research to build upon this knowledge base.<sup>10-12</sup> In our focus groups, physicians and patients were less concerned with medical issues than with system and social issues. Perhaps these physicians have already been teaching and practicing good medical care for underserved patients and now perceive the need to focus on system and social issues.

Curricula are often based on medical literature reviews, the educators’ beliefs about what must be taught, and relevant guidelines.<sup>16-17</sup> Our needs assessment focused on the needs of our learners: physicians and patients. Our research uncovered a different perspective than did prior methodologies with regard to what curricular topics should be addressed when teaching about care for the underserved. Previous qualitative studies have identified transportation, medical payment, literacy, language, and cultural issues as barriers for care.<sup>1-5,18</sup> While the results of our study are similar, the context expressed by patients is slightly different. Patients and physicians indicated that not only are these issues barriers to care but that physicians need to learn to assist patients in overcoming these barriers.

By asking both patients and physicians about the needs of the underserved, we found that, regardless of race and ethnicity, patients consider themselves to come from a different culture than their physicians. Our patients believed that if physicians could understand their patients’ culture

**Table 4.** Direct Quotations Reflecting System Issues

System	Group	Quotation
Health care delivery	Patient	“Getting the same doctor would be nice.” “In an emergency, I don’t call. I can’t afford it.”
	Physician	“A lot of us don’t know about other resources in the community.”
Transportation	Patient	“Even having a bus pass is hard because of bus times and schedules.”
	Physician	Patients have trouble . . . “Physically being able to get to appointments. Not having a car.”
Payment	Patient	“Doctors could ask if you can afford the medications or not. He can prescribe something, but if we can’t afford that it won’t matter.”
	Physician	“I have no idea what an appointment or other services cost. That’s an issue.”

**Table 5.** Subcategories of System Issues

Subcategories	Representative Quotation
Health care delivery	
Complicated system	“The medical care system is too complex. Some people just don’t know how to get through the system.”
Lack of available services	“Lack of information about available clinics. If people could help out, instead of papers and pamphlets, it would be a lot better.”
Focus on acute services, not on prevention	“In Peru, I can get a PAP smear; here I have to pretend to be sick to get an appointment.”
Physicians unaware of many services	“A lot of us don’t know about other resources in the community.”
Transportation	
Cost of services high	“I take a few credits in the University of Utah senior education program; that way I get a free bus pass.”
Complicated system	“Even having a bus pass is hard because of bus times and schedules.”
Time	“Transportation is a problem, especially during winter.”
Physicians unaware of system complexity	“Public transportation takes half a day.” “I don’t know where the closest bus stop is to my clinic.”
Payment	
Complicated system	“I want to know where Medicaid is taken and what medicines are covered by Medicaid. It is hard to learn about it.” “Many of us just don’t ask, especially if we’re new. We just don’t know to ask.”
Too costly	“Doctors could ask if you can afford the medications or not. He can prescribe something, but if we can’t afford that it won’t matter.” “Low-income people can’t afford it. People don’t access the medical system.” “We just can’t go (for emergency care). People like us fall between the cracks in the financial situation.”
Physicians’ lack of knowledge of cost of services	“I have no idea what an appointment or other services cost. That’s an issue.”
Physicians lack knowledge about payment systems	“I didn’t understand the Medicaid system until I had to help my mom . . . if doctors could be taught what regular people go through.”

and their individuality within that culture, the patients would be better served. Focusing on individuality and viewing the “underserved” as a distinct culture may provide a framework for curricular development within a cultural context. Teaching about respecting individuals and their individual culture is a lesson that is appropriate for all learners.

Physicians struggled with the concept of the “underserved.” During the first focus group, physicians discussed the concept and initially identified the underserved as people who lack resources to get medical care, who face barriers accessing services and institutions, and as people with low socioeconomic status. Later the physicians asked, “underserved compared to what?” Finally one said, “it’s when I can’t provide the care I *want* to provide.”

Our clinical and educational experience had led us to believe that a key component of teaching the care of the underserved would require that preceptors assist their trainees in exploring their individual attitudes. In order to help understand what those attitudes might be, we chose focus groups, because they permit an in-depth analysis of values, attitudes, meanings, and ideas.<sup>14–17,19,20</sup> Surprisingly, we found few attitudinal issues and instead found gaps in knowledge and skills. From an educational perspective, it is easier to teach knowledge and skills associated with caring for the underserved than to teach attitudinal change. Many physicians lacked knowledge regarding health payment, transportation, and health delivery sys-

tems, and they did not know how to navigate these systems.

While conducting our focus groups, it became clear to the participants and the investigators that the “systems” designed to care for the underserved are imperfect. Therefore, even if physicians understand these systems, they and their patients may remain frustrated with the systems. Physicians can advocate for changes in the systems that are dysfunctional, but until the systems are more functional and easier to use, the best care for an underserved patient or any patient is to help him navigate this imperfect and cumbersome system.

### Limitations

Focus groups have many limitations; they are small and their results may not apply to other populations. Qualitative research inherently carries bias in the selection of the subjects.<sup>14–16,19</sup> Our questions, while open ended, may have skewed the results from the medical diagnoses to social systems. A nonmedical trained facilitator led the groups and may have understood the nonmedical issues more clearly than the medical ones. Selection bias may have influenced our results regarding translation issues. Non-English-speaking patients often have poorer health outcomes, in part because of translation issues.<sup>1,21</sup> Physicians reported translation as being an issue in caring for the underserved, but the Spanish-speaking patients did not. These patients were recruited from the CHCs in which the majority of the staff and physicians speak Span-

ish. During the second round of focus groups, we clarified this issue because we were surprised it had not been discussed. Patients often use family members as translators and would not discuss private matters through a family translator.

### CONCLUSIONS

The application of focus group methodology to curricular needs assessment allowed us to identify the needs of our learners and to tailor our curriculum to their needs. Physicians and underserved patients identified communication, respect, cultural issues, and frustration with systems, such as health insurance, transportation, and health delivery systems, as important factors in caring for the underserved. Inclusion of these themes is essential when creating a curriculum to teach care of the underserved.

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