Descriptive title: Practice educators' experiences of supervising two students on allied health, practice based placements.

Abstract (word count 250 excl headings)

Introduction Literature suggests that supervising two students together on clinical placement (2:1 model) has a place in practice based education, helping to increase placement capacity, improve the learning experience for the students and possibly improve departmental productivity. The aim of this study was to explore Allied Health Professional (AHP) practice educators' experiences of using the 2:1 model.

Methods This qualitative study used an interpretive, phenomenological approach to data collection and interpretation. Thirteen AHPs with experience of practice education were recruited and either interviewed one to one or involved in a focus group. Data was recorded, transcribed verbatim and analysed using NVivo 7 computer based software.

Results The practice educators reported mixed views regarding the 2:1 model. Emergent themes suggested success of supervising two students may have a greater relationship with the attitude and philosophy of the practice educator than to profession or clinical setting; that many practice educators had initially used the 2:1 model in response to a short notice request from the universities to accommodate more students and that practice educators were unclear as to whether the 2:1 model impacted on their ability to get through their workload.

Discussion The findings suggest that the unplanned nature of the model's initial use may have tempered views on its success. Also, success of this model appears to bear a greater relationship to the attitude and approach of the practice educator and the support they have from colleagues to manage the students learning and other work place duties, than specifically related to profession or clinical setting.

Key words: practice-based education, allied health professions, student placement models, placement learning, qualitative research

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Introduction

Practice based education is considered a principal component of medical and health care practitioner education[1], as it provides students with the opportunity to develop skills and experience in a variety of clinical settings[2]. Internationally, increasing challenges in providing sufficient and high quality practice placements for pre-registration students have been recognised, with staffing shortages, fiscal constraints, increasing complexity in health service and education sectors and rising student numbers being cited as some of the sources of these challenges[3].

Defining the 2:1 model

In practice education, the term the "2:1 model" has been used to describe the process of two students being supervised by a single practice educator[4-8]. However, in the literature the terms peer-assisted [9,10], co-operative[11], collaborative[12], or collaborative group[13] learning have at times also been used to describe the same phenomenon. For the purposes of this research, the term 2:1 will be used throughout. The use of the 2:1 model has previously been explored in practice education, with specific reference to the capacity of placement provision, the quality of the student learning experience and staff productivity (which includes clinicians' and students' time spent with patients, administration tasks and teaching).

Capacity for placement provision

Many professions, particularly the disciplines of allied health, have elected to explore the value of this model as a result of increases in pre-registration student numbers and therefore a greater need for clinical placements in health care settings[4]. Assuming that a 1:1 model (one practice educator and one student) is the norm, the 2:1 model certainly has been cited as a practical solution to the problem of placement capacity[1,4,6,10].

The student learning experience

By placing students in a clinical setting together, they will have the opportunity to learn co-operatively[1], thus enhancing the learning experience[5,14] by facilitating development of theoretical knowledge and skills through interaction with colleagues, by improving communication[15] and reflection skills[16] and consequently clinical competence[12]. This argument is supported by the theory of social learning, which posits that people learn from observing others[17]. This theory was further developed by Rotter (1954)[18], who suggests that much of human behaviour is acquired through social interaction. One qualitative study found that physiotherapy practice educators and students perceived interaction with peers enhanced the quality of placement learning[5]. A retrospective comparison study by Ladyshewsky et al (1998) compared the clinical competence of two groups of physiotherapy students and their clinical instructors (one group using a 1:1 model of practice based education and the other using a co-operative/ 2:1 model)[11]. During this study, student participants and clinical instructors were asked complete a questionnaire of 12 statements designed to assess the quality of the teaching and learning experience. From their findings they concluded that the 2:1 model enhanced students' competence in patient evaluation, treatment, communication and professional behaviour[11]. However, it is important to recognise that this was a small sample and some methodological limitations existed, therefore the limited generalisability of these findings should be recognised.

Staff workload output

Ladyshewsky et al (1998) also suggest that the 2:1 model may provide some advantages with respect to the workload output of staff and students within a department[11]. Their comparison study considered workload output of clinic based physiotherapy staff and their students. Both student and clinical instructor participants were asked to record time spent on patient care, administration and teaching activities. The workload output was calculated as the total number of minutes per hour spent by student or their educator with patients or on other work activities. This was then offset against the time spent on learning and teaching activities. Consequently, the net productivity was the time which was directly spent with patients

or on other work tasks. The productivity of staff and students working within individual (1:1 model) and co-operative (2:1 model) placements were then compared over two successive years and across multiple clinical centres, they were also compared against a baseline of clinical instructor alone. The findings suggested that although practice educators in both learning environments reduced their normal levels of productivity to supervise students, the productivity gains, resulting from the presence of the students compensated for the practice educators' reduction. Moreover, such gains were greater with the 2:1 model[11]. However, as no attempt was made in this study to measure or record quality of patient care, these productivity gains may not have resulted in benefit for the patient. It also should be recognised that student groups and sites were not matched, so one cannot be certain that to make this comparison between the 1:1 and 2:1 models was valid.

This research aimed to explore the lived experience of practice educators from three professions who had chosen to adopt the 2:1 model and to contrast their experiences with practice educators who had an awareness of the 2:1 model, but had specifically chosen not to adopt it. Additionally, the research aimed to explore the transferability of the model across professions and clinical settings and to attempt to ascertain what actually contributes to or detracts from the success of the application of the 2:1 approach in practice education.

Method

In order to gain deep understanding of the practical use of the 2:1 model amongst practice educators who had an understanding of its impact on clinical practice, a qualitative interpretive phenomenological approach to the study design was used.

Recruitment

Purposive sampling was used to recruit participants from three allied health professions within NHS Scotland (Occupational therapy, physiotherapy and speech and language therapy). The initial study design had assumed the higher education institutions to hold a central database of practice educators who had used or were providing 2:1 model placements; however, this was not the case. Consequently, a

wider recruitment process via e-mail had to be adopted. As the administration staff at the higher education institutions were not at liberty to disclose to the research team the contact details of the clinical educators they held on records, it was agreed that the administrators would forward an e-mail from the research team detailing the research purpose and plan to all practice educators on the higher education institutions' databases*. A detailed participant information leaflet was sent at this stage. Interested potential participants were then asked to contact the research team and at this point the process of identifying information rich participants was commenced. As a consequence of this e-mail being forwarded to practice educators via the secondary parties of the higher education institutions, it is not know the absolute number of recipients of the information. However, all administrators did confirm that they had sent the e-mail to all staff involved in arranging practice based placement. As all higher education institutions across Scotland that provide AHP (Occupational therapy, physiotherapy and speech and language therapy) courses were included in the initial cascade, it is it was made clear that the invitation to participate reached was wide reaching as there was a large response from practice educators from across numerous geographical area, clinical setting and profession. Additionally, attendees at an information sharing session about models of practice education were identified and invited to participate.

Although the primary goal of the recruitment process was to identify practice educators who had used the 2:1 model, numerous responses were received from practice educators who had a good understanding of the 2:1 model, but who had elected not to use it. Moreover, the content of their responses suggested these people were an important source of information and should be included in data collection. Although not initially part of the study design, this naturally emerging group was consequently invited to participate in a focus group, so as to capture their views.

All participants were provided with an information sheet, the opportunity to ask any questions, and were asked to complete a consent form. Participant information was dealt with in accordance with the Data Protection Act 1998.

* It was not possible to determine how many people this original e-mail was sent to as it was cascaded via Higher Education Institution administration staff. However, based on discussion with these staff, it is estimated that in the region of 600-800 AHP staff may have received this request.

Design

To ensure information rich participants were recruited to the study, criteria were set defining essential attributes necessary- these included: experience of practice education and an understanding of the principle of the 2:1 model in practice education. Telephone screening was used, allowing the researcher to identify details about each potential participant's experience and background and therefore select a mix of practice educators from different professions and different backgrounds, for example: adult, paediatrics, acute hospital, out-patient services and community. Ultimately, 13 practice educators participated in the research. See figure 1 for an algorithm of the recruitment process and table 1 for a description of the participants' clinical settings.

Figure 1: Recruitment algorithm

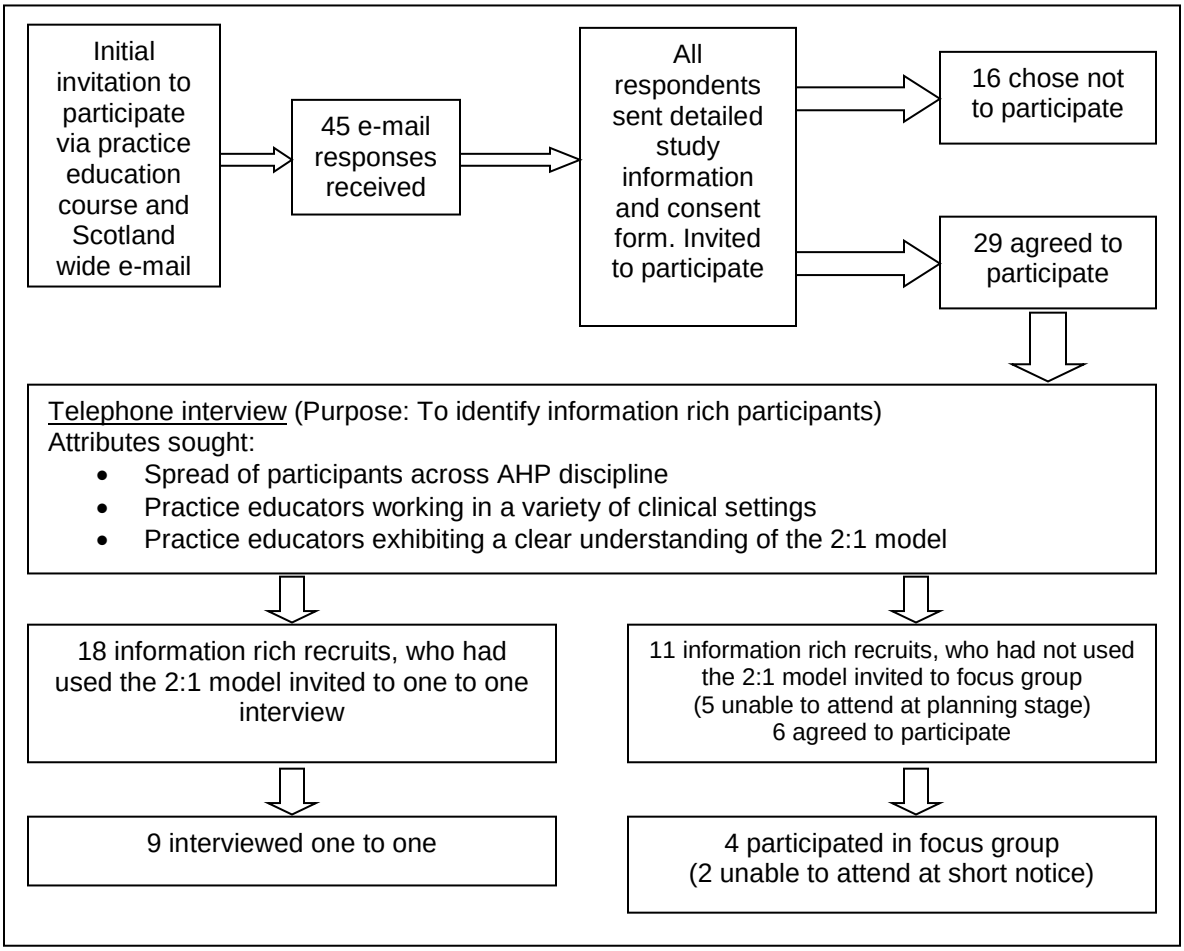

Table 1: Participant representation across profession and setting

Profession	Number represented	Clinical settings
Occupational therapy	4 (2 interviewed, 2 in focus group)	Community, acute paediatrics, adult mental health inpatients
Physiotherapy	6 (4 interviewed, 2 in focus group)	Community, outpatients, acute respiratory care, orthopaedics, paediatrics
Speech and Language therapy	3 (all interviewed)	Community paediatrics, hearing impairment service, adult acute medical

Due to the wide geographical spread of participants with experience of the 2:1 model, all were interviewed on a one to one basis. Additionally, the emerging group of practice educators with an understanding of the 2:1 model, but had chosen not to use it were offered the opportunity to participate in a focus group. In order to maximise attendance, this was held in a mutually convenient location and travel costs were met.

The interviews and focus group were semi-structured, with a framework of question fields developed from the research questions and the literature. Before data were collected, the interview guide was critically examined by a group of expert qualitative researchers with experience in health care education and employed as researchers by NHS Education for Scotland; the interview process was piloted by the researcher with a volunteer practice educator. The schedule and process were then discussed and refined by the authors.

Data collection

All semi-structured interviews were carried out in a private room and digitally recorded. Additionally, the researcher completed a reflexive diary after each interview, documenting key points from the interview and any circumstances that may have influenced interactions between researcher and interviewee. All recordings were transcribed verbatim.

Interview Guide

- Open question about experience of student supervision.
- Why participant chose to supervise two students concurrently.
- How supervising two students compared with supervising single students.
- Influences, training or support received for using the 2:1 model.
- Impact more than one student had on:
    - the practice educator (Workload, stress, other tasks, teaching)
    - the students (Benefits, threats, companionship, competition)
    - the patients (Stress, attention)
    - the department (Space, productivity, other staff, contribution)
    - the wider profession (Placement capacity)

- Attributes of:
    - the practice educator
    - the students (year, university , standard)
    - the patients
    - the department (Specialties conducive to this approach)
    - the wider profession (attributes across professions)

    …that were necessary for successfully managing the 2:1 model

[Focus group questioning took this structure and concentrated on reason for not adopting the 2:1 model and explored perceptions supporting decision.]

Data analysis

An inductive, content sensitive approach to analysis was adopted using the computer software package NVivo 7. This involved the researcher reading and re-reading the transcripts, in order to become deeply familiar with the text. Then line by line coding was carried out, identifying phrases that offered meaning. These were then grouped and re-grouped and as broader themes emerged, it was possible to present the meaning of the experiences reported by the interviewees.

A number of measures were adopted to maximise trustworthiness of data collection and interpretation. Firstly, referential adequacy (an archived record) was ensured by the recording and verbatim transcription of all interviews. To ensure accuracy of the transfer of the spoken word to text, all transcriptions were

checked against the recordings and a sample of five interviewees verified copies of their transcriptions as accurate representations of what was said.

In order to ensure trustworthiness of the interpretation process, a clear and transparent account was maintained by the use of NVivo 7. Additionally, the interpretation was critically appraised and verified by a panel of expert qualitative researchers with experience in health care education and employed as researchers by NHS Education for Scotland. It is further supported by the inclusion of direct quotes to illustrate the identified themes.

The interviews and the focus group were analysed separately and so shall be presented separately.

Findings

From the interview data, five key themes were identified during the analysis process, these were:

- Motivation for adopting the 2:1 model.
- Experience across AHP professions and settings.
- The impact of the 2:1 model on the practice educator.
- The perceived impact of the 2:1 model on the department and patients.
- The perceived impact of the 2:1 model on the students.

Motivation for adopting the 2:1 model

Practice educators felt obliged and responsible for providing student placements. For many, the first experience of adopting this model was done without particular planning, often either due to a shortfall of placements or a direct request from the universities.

"I think the main thing that has made us do this is the pressures on placements and the fact that everywhere is desperate for placements … and I think if there hadn't been that kind of pressure coming down from on high…don't know if we would have necessarily… done it."

Speech and Language Therapist, medical in-patients, interviewed

Despite the unplanned nature of the first 2:1 experience, many felt that this was a model they were happy to use again.

"I wasn't sure how it would work, but in actual fact, it was very positive and I found it works better with two students."

Physiotherapist, orthopaedic in-patients, interviewed

Most practice educators reported adequate support and training from the universities to supervise students, but that training was not specific to the 2:1 model.

"As I say, the support's always there from the universities. I wouldn't say anymore support than usual, you know, but each student would have their own tutors… who would visit them, so that wouldn't be a problem either."

Occupational Therapist, community elderly, interviewed

Experience across AHP professions and clinical settings

Generally, the practice educators perceived the 2:1 model to be more positive than negative.

"It can … be very, very helpful for the students and they can see a different way of doing things… it can really open their eyes up."

Speech and Language Therapist, medical in-patients, interviewed

However, those that had had a negative experience when supervising two students at once had found it particularly challenging.

"It felt like it was a fairly constant seven hours of one asking you, then another asking you, and I felt that I was getting pulled in a few different directions."

Physiotherapist, hospital musculoskeletal out-patients, interviewed

Interviewees expressed a range of views about the benefits and shortcomings of this model of practice education and there were certainly no experiences that seemed to relate specifically to any one profession. From the point of view of the clinical setting, interviewees from diverse areas such as acute hospital wards, out patient departments, and community domiciliary settings reported successes and some difficulties when using the 2:1 model. No one setting seemed to be more or less suited to the adoption of this approach of practice education. However, the practice educators did place good team working, supportive colleagues and space as being of paramount importance for this approach to be successful.

"I don't know that it's just necessarily the attributes of one particular person that make it work, I think the entire team need to be involved in order to make something like that work."

Physiotherapist, acute respiratory in-patients, interviewed

Participants reported that placements can offer wider opportunities than simply hands on experience, and it was up to practice educators to be open minded and flexible about such learning opportunities.

"I think you also have to be open about the fact that the opportunities needn't just be patient contact, there can be other things you feel that you just do on a daily basis that you feel the student should be experiencing as well."

Occupational Therapist, community paediatrics, interviewed

One interviewee acknowledged a need to provide a greater number of student placements, but that this could be to the detriment of students' education.

"I know you could look in the long term of yes, we're training future physiotherapists, but are we training them to the same high standard, if we have two at the one time?"

Physiotherapist, hospital musculoskeletal out-patients, interviewed

The impact of the 2:1 model on the practice educator

Some practice educators could see benefits in having two students concurrently. However, far more reported extra work, significant planning and administration and the requirement to be extremely organised.

"Two students instead of one, which obviously is more of a workload in terms of your reporting back on how they've done."

Speech and Language Therapist, paediatric out-patients, interviewed

Stress was reported by many of the practice educators to be a consequence of the increased workload.

"I know at that time, I was very stressed, very tired."

Physiotherapist, acute respiratory in-patients, interviewed

There was a belief that practice educators needed certain attributes in order to manage the 2:1 model. These attributes included: confidence in their clinical skills, having focus, energy, being organised, patience, creativity, flexibility, being positive and an awareness of what is going on in their department.

The perceived impact of 2:1 model on the department and patients

In general, taking students was challenging, however efforts were made to ensure students felt welcome and that service delivery or quality of patient care were not negatively affected. In the main, practice educators felt patient care was uncompromised by the introduction of a 2:1 model of education for their students, although this success did seem dependent on being able to relying on other staff within the team.

"Having enough people around to cover, 'cos obviously when I'm seeing students I'm not seeing as many people as I would normally see, so I'm relying on someone else in the team picking up some patients for me."

Speech and Language Therapist, medical in-patients, interviewed

Other benefits to the department were an increase in discussion, sharing of fresh ideas and a feeling that additional services were offered while students were working in the department.

"[The students] possibly talk more with other students… then I think it can open up lots of really nice discussions."
Speech and Language Therapist, hearing impaired paediatric out-patients, interviewed

Conversely, it was generally believed that throughput was either unaffected or reduced by the presence of two students in their department.

The perceived impact of the 2:1 model on the students

The practice educators felt it was vital for students to be provided with individual feedback and that consistency in feedback was extremely important, although not always easy to achieve.

"I wouldn't say that one had more opportunity than another. Well, we certainly tried not to allow that to happen, to make sure that each student had, erm, opportunities to carry out the objectives that they needed for the placement, you know."
Occupational Therapist, community elderly, interviewed

Despite recognition that students may feel an element of competition or threat from the existence of a peer on placement with them, many interviewees described increased student confidence, peer support, the opportunity to work together, and to share knowledge as benefits for students of the 2:1 model. Although, it was noted that caution needed to be exercised when students were teaching each other, as there was a risk that incorrect information could be passed between them.

"It is good to have a bit of peer support but you are having two inexperienced people trying to teach each other whereas having one experienced clinician teaching the student, if one of them is saying something that's not correct, then how does the other one know that it's wrong, kind of thing?"
Physiotherapist, hospital musculoskeletal out-patients, interviewed

There was acknowledgement that students of different standard or year could influence the leaning experience of their peer, but there was no consensus as to whether the influence would be positive or negative.

"[The students were] quite different- both, from personality through to clinical skills, very very different. Erm, the benefit of that, was probably that the struggling student knew what they had to try to achieve and aspire to be, because the other student was exceptionally competent."
Physiotherapist, community learning disabilities and mental health, interviewed

"I felt I could have done more with her [a stronger student], we could have progressed things on a wee bit more, if I didn't have the other student [a weaker student] to try and bring up to speed. Erm, I think he could have done better if I had more time to spend with him in the first week or two."
Physiotherapist, hospital musculoskeletal out-patients, interviewed

Focus group findings

The focus group participants who all had an understanding of the 2:1 model, but had chosen not to take on two students together on placement did report views that were similar to those expressed by those who had been interviewed about their experience of supervising two students concurrently. For example, on the topic of motivation for adopting the 2:1 model a focus group participant raised a question regarding the need for the 2:1 model- suggesting that if colleagues who did not provide placements did so, there might be fewer requirements for some practice educators to supervise multiple students concurrently.

"I think, that if every professional provided a placement, would we really have a need for a two to one model? I think there's professionals who are opting out of providing placements."

Occupational Therapist, mental health in-patients, focus group

Also, some were concerned about students receiving less hands-on experience, insisting this to be the primary purpose of practice based placements.

"If the student's coming out to actually practice techniques and assessment, they actually need to be with the patient, and if you physically do not… do that, then they're not actually getting the clinical contact time."

Physiotherapist, community musculoskeletal out-patients, focus group

However, the focus group participants did value peer assisted learning and despite the practical challenges many of them faced in offering 2:1 placements, they did report that students from different sites would often come together to participate in joint learning activities, thus allowing them peer learning opportunities, even though the practice educators supervising them were each only responsible for single students.

"That's what we are looking at with the two students on separate sites… in separate departments, is bring them together for a time, that they can bounce ideas of each other."

Physiotherapist, community musculoskeletal out-patients, focus group

Finally, stress on the practice educator was also reported as an anticipated impact of the 2:1 model by the focus group participants, thus they felt strongly that this was not something they wished to become involved in.

"just trying to accommodate two students would be, you know, quite a pressure on yourself and the patients, as well."

Occupational Therapist, elderly in-patients, focus group

Discussion

This research has achieved its aim of exploring practice educators' experiences and views of the 2:1 model of practice education and adding depth to the understanding of this phenomenon. The findings add to existing literature by describing the context within which AHPs practice educators have implemented the 2:1 model in a practice education setting, how they are tending to use it and describes practice educators views on how the model affects their ability to do their job whilst supervising two students concurrently.

Context within which the 2:1 model was used

This study found that practice educators' first experiences of the 2:1 model were largely a pragmatic response to short notice requests from universities to accommodate extra students. Despite the literature suggesting the 2:1 model could be a planned and valid means of improving the learning experience for students[1,5,14-16], these findings suggest that its use was often unplanned, and not part of an intentional strategy to facilitate learning. However, in spite of the unplanned nature of these first experiences, several practice educators found the approach effective and seven out of the nine interviewed elected to use it again. It is possible therefore, that an unplanned approach limits the potential of the 2:1 model to impact on the learning experience and in situations where it is more strategically adopted, the impact may be greater.

A further contextual issue that this study highlights is that the practice educators' believed that they have an obligation to supervise students, but they are aware of some colleagues who do not share this responsibility. This might suggest that practice educators believe that this model is more about increasing placement capacity than improving the student learning experience.

Profession, setting and how practice educators use the 2:1 model

One aim of this study was to explore whether any particular profession attributes or clinical setting seemed to be conducive to the implementation of the 2:1 model. The study found that the practice educators' approach and attitude to this model may affect its success, whereas, neither profession nor the

setting within which the practice educator was based seemed to produce greater success or challenges. For example, practice educators who considered their department as a broad learning environment and the staff they worked with as providers of key support with various duties directly and indirectly related to student supervision, seemed to consider the 2:1 model as conducive to student education. Conversely, the practice educators who used the 2:1 model in a more didactic, 'apprenticeship' way, rather than adopting the collaborative learning strategies that are documented as being successful in the literature[1,5,7,8,10-12,15], seemed to experience greater difficulty with the 2:1 model and expressed greater concerns about the quality of learning experience for the students and the quality of service delivery for their patients. Comparing the negative experiences reported in this study to the value of the 2:1 model reported in some of the literature[4,8,10-13], it appears that the success of the 2:1 model is largely dependent on the practice educator and the support they receive from the departmental team as a whole, rather than being specifically related to profession or clinical setting.

How the 2:1 model affects departmental workload output

Workload output and how it can be quantified is clearly complex and the findings of this study make some contrasting points about the issue. On the one hand, practice educators felt that when two students were on placement together in their department, throughput (which in the main they used to refer to number of patients seen) was either maintained or reduced. Conversely, some did indicate that students provided additional services, which were not ordinarily provided when there were no students in the department; arguably this indicated an increase in work done. Ladyshewsky et al[11] suggested that having one student was associated with advantages with respect to time spent on patient care and other work related tasks, but that the presence of more than one student, as used in the 2:1 model, provided even greater departmental productivity and additional educational benefits. Therefore, on the surface of this research, one could argue that increased patient contact time or additional benefits with regard student learning would be considered a success, however, it should recognised that increased time spent with patients or addition services provided is not necessarily equal improved patient out comes.

Ultimately, the terms workload output, throughput and productivity are wide ranging, difficult to define and are open to interpretation. They can be measured and interpreted in different way and this will influence how “productive” a department is considered to be.

Implications for practice education

In summary, the findings of this study suggest that the 2:1 model has a place in practice education, but that planning, open-mindedness, the ability to maximise the opportunities presented by a clinical department as a place of learning and to maximise the support of colleagues is important to its success. Equally, it is perhaps reasonable to postulate that where the 2:1 model is adopted, but a didactic, apprenticeship approach to the two students is used, it is more likely to prove challenging to the practice educator, the students or both.

It is also noteworthy that the benefits of collaborative learning cited in the literature can be achieved in practice based learning settings other than formal or planned 2:1 placements, as the focus group participants brought students from different sites together for peer learning and support.

Limitations

As the research team was dependant on the higher education institutions for the initial cascade of recruitment information to be disseminated, it was impossible to be certain of how many AHP practice educators actually received and read the information. Consequently, it will never be known how many people actually had the opportunity to become a participant. That said, within this qualitative study of 13 participants, all were considered to be information rich and data saturation was achieved with this sample. Therefore, although this study is not intended to be representative of all AHP practice educators, the findings do add new information to the body of knowledge on this topic.

Suggestions for further research

The findings justify further research into how collaborative learning techniques are actually implemented within the practice education setting, whether via the 2:1 model or other means and how adoption of the

2:1 model affects the workload output of staff and students. Additionally, at the recruitment phase of this project a large number of e-mail responses were received by practice educators expressing views about the 2:1 model, which were at times lengthy and detailed. It was beyond the scope of this study to include these responses in the analysis process, but further work should perhaps consider the use of e-mail as a tool for data collection.

The literature supports the use of the 2:1 model or other similar forms of peer-assisted learning in the practice education of doctors[14,15,19,20], nurses[19] and allied health professionals[5-8,10-13]. Despite this, the vast majority of the literature reviewed this approach from the point of view of a single profession. Not only does this prompt the question of transferability of findings across professions, but also whether learning could take place across professions.

Conclusion

This study adds depth to the understanding of the 2:1 model of practice education for pre-registration AHP students, particularly with regard to how the model is used and how it is perceived to impact on the practice educator, the students, the department and the patients. It highlights the importance of the context within which this model is being used- that is, the sense of obligation felt amongst practice educators and frequency with which the 2:1 model is used to manage placement shortfall at the last minute, rather than being a strategic way of enhancing the student learning experience. The findings would also suggest that the educational philosophy and approach of the practice educator is more likely to define the success of the model than the profession or clinical area of the practice area. These findings are important because they inform how this model might best be used, which in turn impacts on the education of future health care professionals.

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Out takes

although analysis revealed that those who had adopted the 2:1 model (interviewees) and those who had not adopted it (focus group participants) in fact reported very similar views