Family Practice
© Oxford University Press 1996

Vol. 13, No. 1
Printed in Great Britain

The key informant technique

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Marshall MN. The key informant techniques. *Family Practice* 1996; **13**: 92–97.

Background and objective. This article considers the role of the key informant technique as a qualitative research method and examines the potential contribution of the approach to health care research.

Method. The principles underlying the technique and the advantages and disadvantages are considered, illustrated with examples from a range of social science studies.

Results and conclusion. An example of the author's own use of key informants in a study of the professional relationship between general practitioners and specialists is described.

Keywords. Key informants, qualitative methods, professional relationships.

Introduction

A key informant is an expert source of information. The key informant technique is an ethnographic research method which was originally used in the field of cultural anthropology and is now being used more widely in other branches of social science investigation. This article considers the principles of the technique and the criteria that an ideal informant should fulfil. The advantages and disadvantages are described and examples of the use of key informants from non-medical and medical research studies are given. The use of key informants in health care research is illustrated by the author's study of the professional relationship between general practitioners and specialists.

Background

The technique is well described by Marc-Adelard Tremblay in Field Research: a Sourcebook and Field Manual.[1] Most members of any community or society do not know the full repertory of forms, meanings and functions of their culture. Key informants, as a result of their personal skills, or position within a society, are able to provide more information and a deeper insight into what is going on around them. Tremblay calls such individuals "natural observers". They are interested in the behaviour of those around them, they observe the development of their culture and often speculate, or make inferences about, both. Sjoberg and Nett[2] describe such individuals as "strategic informants". They consider two types of informant; those who demonstrate exceptional characteristics but conform to social norms within their society, and those who present more extreme attitudes and views, referred to as "marginal men". All key informants are regarded as extraordinary by those around them and usually, but not invariably, occupy a position of responsibility and influence. This status should have been achieved, rather than ascribed to the individual.[3]

Tremblay[1] highlights the characteristics of an "ideal" key informant:

Role in community. Their formal role should expose them to the kind of information being sought by the researcher.
Knowledge. In addition to having access to the information desired, the informant should have absorbed the information meaningfully.
Willingness. The informant should be willing to communicate their knowledge to the interviewer and to cooperate as fully as possible.
Communicability. They should be able to communicate their knowledge in a manner that is intelligible to the interviewer.
Impartiality. Key informants should be objective and unbiased. Any relevant biases should be known to the interviewer.

Of these five criteria of eligibility, only the informant's role in the community can be determined with certainty in advance. Once individuals who perform key roles are detected, the other four criteria should be considered in order to ensure that only the most productive informants are interviewed. The extent to which each of the criteria are met is likely to determine the usefulness of the information gained by the interviewer. A flexible approach to key informant selection has been advocated by Howard,[4] who considers that different selection criteria can be applied according to the needs of the particular study. Burgess[5] also emphasizes the

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importance of selecting informants with a wide range of views.

Advantages and disadvantages of the technique

The principle advantages of the key informant technique relate to the quality of data that can be obtained in a relatively short period of time. To obtain the same amount of information and insight from in-depth interviews with other members of a community can be prohibitively time-consuming and expensive.[6]

Potential weaknesses of the key informant approach have been described.[3] Informants are unlikely to represent, or even understand, the majority view of those individuals in their community and any difference in status between informant and researcher can result in an uncomfortable interaction. The identification of key informants may be in error because some societies may attract people who wish to improve their status but do not have the necessary skills of a true key informant. Inform*ants* have been differentiated from inform*ers*, who are more likely to be biased and to have their own agenda.[6] Key informants might only divulge information that is politically acceptable and social rules could discourage the researcher from publishing potentially sensitive data which may be ascribed to a particular informant. Spradley[7] has highlighted the problems resulting from the relationship between the researcher and the key informant, which, in some circumstances, can become very close and may result in the informant almost becoming part of the research team. He suggests that the informant's interests, sensitivities and position within their community should be respected, that care should be taken not to exploit them and that written reports should be made available to them prior to publication.

Examples of the use of key informants

Several examples of the use of key informants are found in the fields of anthropology, sociology and psychology, and increasingly they are being used as a research technique by the professions allied to medicine. Few examples of their use as a research methodological approach are apparent in the principal peer-reviewed medical journals but the use of 'opinion leaders' has been advocated as a method of implementing the findings of research.[8] Nevertheless, some examples will be cited of their application as a qualitative approach to traditional bio-medical subjects.

The key informant approach is one of the most important research methods for social anthropologists, indeed many anthropologists focus entirely upon accounts gained from their informants.[9] Medical anthropologists have used key informants to access different members of the community, for example, to determine the role of traditional healers in the treatment of sexually transmitted diseases in Mozambique.[10] In the field of sociology, key informants have been used to determine the effects of interviewers' own opinions about ethnic minorities and foreigners on their subjects and to describe the biases that might influence the researcher's approach.[11] They have also been used as part of a health needs assessment for Arab-American immigrants.[12] The technique has been applied by therapists to investigate empowerment of the elderly[13] and by social workers to study the care of the disabled elderly.[14]

The key informant approach has been utilized in an incidence study of schizophrenia in Ireland.[15] The authors interviewed priests and teachers, who had an exceptional knowledge of individuals within the community, in order to identify people who had been treated for major psychiatric illness. They compared the information with that obtained from hospital records, found a high correlation and concluded that the technique was feasible and valid. Ventres *et al.*[16] approached key informants who were professionally knowledgeable about resuscitative issues, in order to examine the organizational and communication factors affecting do-not-resuscitate decisions. Key informants were used together with surveys and in-depth interviews to determine the effectiveness of media support for an alcohol education programme in New Zealand.[17] This involved a case control study comparing the opinions of informants in the study and control cities.

It appears that the key informant technique is becoming increasingly popular in health care research and could have a useful role, complimenting other qualitative approaches.

An example of the use of key informants in a study of the professional relationship between general practitioners and specialists

The author has used the key informant technique in a study currently being conducted within the South and West Regional Health Authority. The study aims to describe the professional relationship between general practitioners and specialists, including areas of good working practice and misunderstanding, and to compare and contrast the relative attitudes towards their roles and responsibilities in patient care, their image and prestige, their opinions of the organizational structure of health care and their visions for the medical profession in the future. A variety of research methods are being used in addition to the informants, including in-depth interviews, focus groups and a survey. An overview of the key informant stage of the study will demonstrate the quality of data that can be collected

using the technique, over a relatively short period of time.

The medical profession has a key role in the provision of health care and the use of resources and the way that specialists and general practitioners relate to each other is a fundamental component of the primary-secondary care interface in the United Kingdom. The profession has been described as a distinct group within our society,[18] with a hierarchical structure that can result in divisions and conflicting interests.[19] This structure led the author to believe that the key informant technique could be a productive tool for investigation and made it easy to identify potential subjects for the study. The aim of the first stage of the study was to interview key people acting within, and interacting with, the profession in order to describe their views of the present state and possible future of the relationship between specialists and general practitioners.

Methods

Potential key informants were considered by the author and the project supervisors on the basis of their ability to fulfil the selection criteria described by Tremblay.[1] Individuals from a range of academic, representative and managerial bodies were selected, at a national, regional and local level.

Subjects were invited to participate by letter, followed by a telephone call to arrange a convenient time and place for the meeting. The duration of the interviews was between 30 and 40 minutes and they were conducted by the author, one using the telephone for practical reasons, but the others face-to-face. An outline interview schedule was used, based upon the literature review, and the schedule was modified on the basis of previous interviews. The participants were free to deviate from it and the interviewer intervened only to clarify issues or introduce a new theme. The interviews were audio-taped and transcribed by the author. The first two tapes were fully transcribed but the rest only partially, since the thematic analysis did not warrant full transcription. The validity of the coding and interpretation was checked by external validation of a selection of the original tapes and transcripts by an experienced qualitative researcher and also by respondent validation by all of the informants. Minor modifications were made as a result of this process.

Results and discussion

A brief overview of the results is provided in order to demonstrate the breadth and depth of information that was obtained in a total of less than six hours of interview time. In line with the established approach to qualitative data, the emphasis of the results is upon describing the broad spectrum of views obtained and not upon 'average' or 'representative' opinions.

The key informants fulfilled most of Tremblay's[1] 'ideal' characteristics. By definition, they all had a formal role which exposed them to information about the relationship between specialists and general practitioners and they were all willing to co-operate and communicate their opinions during the interview. The quality of ideas and richness of information varied between informants and was related largely to their background; some gave a historical perspective, others a political one, some emphasized clinical aspects of the relationship, others a managerial view-point. The key informants with a managerial background showed good insight and sensitivity to medical professional issues. Few statements were made which were inconsistent, either within the interview or with public statements made by the informant outside the interview. Influences or biases relating to the professional background of the informant were acknowledged by the informant and by the interviewer and all of the informants demonstrated a willingness to express opinions that were not always politically sensitive. The few inconsistencies, biases and politically-correct statements that were made were acknowledged but not pursued by the interviewer since none of them was likely to influence the aims of this stage of the study.

Thematic analysis of the transcripts revealed four key themes: the positive features of the current relationship between general practitioners and specialists, the negative features of the current relationship, possible ways of improving the relationship and visions of the future for the two branches of the medical profession.

The informants conveyed a generally positive impression of the way that general practitioners and specialists work together, though several of them felt that commentators from within and outside the profession were inclined to focus on a small but vocal minority of individuals who highlighted the problems in the relationship. The positive aspects were illustrated by examples of joint guideline development, interface audit and discussion groups between local clinicians. Professional loyalty to each other was felt to be strong and lack of mutual respect was considered to be the main cause of any examples of a breakdown in the relationship. The orientation of both specialists and general practitioners was felt to be changing; the former becoming more psychosocially orientated and the latter more technically skilled, taking on procedures previously conducted by specialists. Nevertheless, the different perspective that generalists and specialists bring to patient care was considered to be a strength that should be retained. There was felt to be a better understanding of the general practitioner's role by the specialist:

> "it's becoming much more overt, that as the reforms have taken shape, the GP's role has become much more obvious to the hospital side and a much greater awareness of the need to take general practitioners into the system and not ignore what goes on outside"

The introduction of the NHS internal market, though initially disruptive, was felt by most of the informants to have had some positive effects on the profession. Some of the informants felt that the changes had shaken the profession and encouraged it to look at its core values, others considered that there had been an improvement in communication and mutual understanding. Fundholding was considered to have changed the balance of power and influence within the profession but none of the informants considered that this power was being abused:

> "There was a element in the early stages of fundholders settling old scores . . . but I think these relationships are settling down and I think there is more balance in the relationship . . . most clinicians have risen above that battle and the dialogue between hospitals and GPs is about the best medical care for patients"

These opinions were expressed despite the stated opposition by several of the key informants to fundholding.

The key informants required more prompting to consider the negative aspects of the inter-relationship but when encouraged, several areas were highlighted. One of the informants felt that there was still a large gap between the two branches of the profession:

> "There's a lack of understanding about what the real world is; a lot of consultants don't understand what the real world facing GPs on a day to day basis is, and a lot of GPs now go into practice from a very junior position in the hospital, they think they know the pressures that specialists are under but they don't understand what the new world is really like"

Poor morale across the profession and lack of leadership were cited as barriers to addressing intra-professional issues. Some informants considered that general practitioners were focusing their attention on their own primary health care team and consequently were neglecting their relationship with specialists. They were felt to be less good than their specialist colleagues at addressing the agendas of clinical effectiveness and evidence-based practice and their pragmatism and flexibility was felt by one of the informants to be more of a disadvantage than a benefit. Concern was expressed about whether they possessed the skills to take over certain aspects of clinical care traditionally provided by specialists. The working relationship between the specialists' Royal Colleges and the Royal College of General Practitioners (RCGP) was not felt to be good, with concern expressed about the image and the degree of representation of the RCGP. One of the specialists commented:

> "One of the difficulties that I see with general practice is that only about fifty percent of GPs are members of the college and it would be easier from our point of view if all were members and all had to go through vocational training because then you could influence everyone through your training programmes and everyone would know that the college was saying this is advisable, as we do with our fellows"

Specialists were considered to have a "culture problem" with resistance to changes in traditional working practices and working locations. Their clinical practice and personal well-being was felt by some to be adversely affected by pressure mostly from their managers but also from general practitioners:

> "there's been a power shift, with initially GPs being very frightened to say things in front of consultants because the consultants would slap them down, fairly viciously to latterly when the consultants wouldn't say things in front of GPs because a significant number of them were fundholders and somehow they'd get penalised"

Some of the key informants felt that the health service reforms had highlighted problems in the relationship, others felt that they had caused them. Concern was expressed about the effect of the reforms on patient perceptions of the doctor's role, particularly the effect that fundholding might have on the willingness of the general practitioner to refer to the specialist.

Several solutions to these problems were suggested by the key informants. Re-focusing on the core values of the profession was felt to be important, with less emphasis on short term politically motivated changes and greater emphasis on providing high quality health care for patients. Giving priority to communication was felt to be essential:

> "It always seems to me that if you can get around the table and talk at intervals then you can hammer out an awful lot and the ogres that you suspected on the other side of the barrier seem to be reasonable human beings after all. I think a lot of it is that there hasn't been a lot of contact between GPs and hospital doctors"

Educational initiatives were also discussed. The traditional model of specialists lecturing to general practitioners about highly specialized advances in their field was felt to be less appropriate and considerable discussion centred around junior hospital doctors spending part of their higher professional training in general practice. In theory this was felt to have the potential of improving understanding between the two branches of the professsion but in practice concern was expressed about the duration of higher professional training and the resource implications. Jointly developed clinical guidelines were considered to have the potential to improve understanding and communication between specialists and general practitioners but again practical problems of ownership were felt to be restricting their usefulness at present.

The key informants generally considered that the future of the profession would be driven by scientific advances, demographic changes and social expectations, rather than along the lines of any one systematic plan. Most felt that the fundamental structural and functional features of the current working relationship should be retained, including the referral system, the generalist approach of the primary care doctor and the emphasis on primary health care teams providing care for small sized populations. Power and influence in health care would move from specialists to general practitioners and then to managers.

> "as fast as the power shift came to general practice, the power shift will be taken away from general practice, having smashed the consultants power, which was the real agenda"

Only one of the informants stated a clear vision of the future, suggesting that the focus of health care provision would be a large primary health care centre, serving a population of 30 000–50 000 people. Patients would be registered with a team, rather than with an individual doctor and would have direct access to any member of the team. Extended primary care services would be available at the centre, together with the majority of diagnostic facilities, out-patient services, day-case surgery and perhaps some in-patient beds. Specialists would work along side general practitioners in these community-based centres. Some district general hospitals would close and others would reduce in size, providing in-patient beds only for major surgery, specialized medical problems and advanced diagnostic facilities.

Other key informants suggested more modest modifications to the present system. Some saw a reduced role for hospitals, with perhaps more medical beds but considerably fewer surgical beds. It was suggested that specialists might pass on much of their present role to highly skilled technicians and concentrate on diagnosis and assisting general practitioners with management of complicated medical problems, whilst general practitioners would become more specialized and pass on much of their present role to practice nurses. One suggested that most health care needs would be satisfied by non-medics and a reduced number of doctors would assume a quality assurance role. One of the informants feared that general practitioners would be pushed more into the purchasing role and this would result in the loss of the essence of British general practice:

> "You could actually find all the special things about general practice slipping away . . . and end with a major policy to re-introduce general practice"

It is unlikely that the views expressed by the key informants are representative of those of other members of the medical profession but comparison will be made with information obtained from in-depth interviews and a survey of a wider sample of practising clinicians working in the Region. It is possible that the informants would be more likely to express public 'politically acceptable' views than people who are not in a position of responsibility or leadership. Nevertheless, the application of the key informant technique to the study is justified by the significant insight into the relationship gained in a relatively short period of time. The results will be used to introduce and develop themes in later stages of the study.

Conclusion

The key informant technique is a qualitative research method which has been used extensively and successfully in several branches of social science investigation and could make a useful contribution to health care research. The principle advantages relate to the quality of data than can be collected in a limited period of time and the approach is potentially useful as an isolated research technique or in conjunction with other qualitative methods.

Acknowledgements

I would like to thank the key informants who participated in the study of the professional relationship between specialists and general practitioners, both for agreeing to be interviewed and for their comments on this article. I am also grateful for the guidance of my project supervisors, Professor Denis Pereira Gray, Professor David Phillips and Professor Roger Jones. The study was funded by a Research Training Fellowship from the Research and Development Directorate of the South and West Regional Health Authority.

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