Institutional and Logistical Challenges to Clinician Recruitment for Research

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ABSTRACT

Background: Primary care clinicians are uniquely situated to discuss, educate, triage, and clinically manage sexual health concerns, and their insights are important when developing sexual health interventions. However, competing priorities make recruitment of clinicians for such types of research challenging.

Methods: We intended to conduct formative focus groups with primary care physicians (n = 6–8) and primary care advanced practice providers (n = 6–8) to gain insight into: (1) factors impacting sexual health history collection and (2) clinician STI management practices. Several institutional barriers limited successful recruitment of the proposed sample size.

Results: Insufficient recruitment of clinicians prevented completion of the focus-groups. Clinician access is first step to successful recruitment and was limited due to complex internal research approval protocols, limited email communication related to clinician email overload, and clinician privacy concerns. To mitigate these issues, we devised a multi-part strategy for future research that included: (1) prioritize need to build relationships early and validate the relationships often, (2) understand details of communication strategies used and preferred by sites (e.g., newsletters, emails), and (3) develop effective marketing/recruitment approaches tailored to clinician priorities, and (4) frequently assess organization's policies that could impact study success.

Conclusions: Engaging clinicians as research participants is essential to understanding their perspectives and approaches impact the clinical processes of sexual health concerns in primary care settings. It is imperative that we identify and reduce institutional barriers to clinicians' participation in research. Investigators must be prepared to start over if personnel loss or lack of involvement is an issue negatively impacting recruitment or ongoing participation.

Submitted 11 June 2025; accepted 11 June 2025

Keywords: recruitment, clinician, enrollment, participant recruitment, implementation

BACKGROUND

Sexual health is a fundamental component of the whole health model and contributes to overall well-being (Ramlachan & Naido, 2024). The Centers for Disease Control (CDC, 2025) recommends that clinicians should take sexual histories as part of routine care. Primary care clinicians are uniquely situated to discuss, educate, triage, and clinically manage sexual health concerns. However, rates of sexual history taking tend to be low in primary care (Palaiodimos et al., 2020) and understanding the various processes and approaches to sexual health (i.e., discussion, education, clinical management) is important when developing future interventions to improve sexual health care in the primary care setting.

The ongoing STI/HIV epidemic has highlighted a critical need for innovative methods to better understand factors driving these escalating public health threats. Qualitative focus groups with primary care clinicians could aid in gaining insights into current sexual health practices, clinician knowledge and attitudes, and how clinicians are engaging with emerging trends in sexual health care. Further, understanding the "clinician experience" could provide valuable insight into why and how sexual health discussions take place including barriers and facilitators to those discussions. Yet, there are increasing competing priorities in healthcare workplaces that make it challenging to recruit clinicians to participate in research, particularly within busy primary care settings.

Barriers to Clinician Research Participation

Several studies that describe barriers to clinician participation in research have been identified. Paget et al. (2017) conducted focus groups with a sample of 17 doctors, 12 nurses, and 11 allied health professionals working in a children's hospital to identify major barriers to research participation by clinicians. This investigation followed recruitment challenges in which all hospital clinicians (N= 1936) were invited to participate in a low-effort study, yet ultimately, only 40 clinicians consented to participate. The themes derived from the focus group interviews indicated that clinician participants felt that their health systems did not create cultures conducive to research participation: research participation was discouraged by leadership, undervalued, and not supported through protected time or financial support. As part of a quality improvement project to better optimize how Veterans Affairs' research units engage with frontline clinicians, Boucher et al. (2023) interviewed 21 multidisciplinary clinicians (e.g., nurse practitioners, nurses, physicians, allied health professionals) from one health system. Like the study participants from Paget et al. (2017), Boucher et al. (2023) clinician participants also expressed concern with a lack of time and compensation, but also added that there was an overall lack of awareness of what research projects were being conducted at their facility and it was unclear to the clinicians as to how to contact researchers whose work might focus on areas of interest to the clinicians.

Similarly, a focus group with 18 participants (allied health professionals, nurses, and dual clinician/researchers) highlighted lack of time and organizational support as barriers to clinician participation in research as well as a lack of personal involvement with the initial stages of the research (Williams et al., 2020). Clinicians wanted to be involved in the front-end planning of the research to ensure that what was being studied held clinical significance to them. Indeed, the common trends with barriers to research participation by clinicians appear to be compensation, time constraints, organizational culture support, communication regarding types of studies available, and clinical significance of those studies currently underway.

Facilitators to Clinician Research Participation

Addressing these barriers to participation can greatly facilitate study enrollment and ongoing participation. There is a paucity of research exploring clinician participation in research and impact of financial incentives. However, a study investigating prepaid cash incentives for physician participation in surveys demonstrated that prepaid cash incentives (i.e., $2, $5, and $10) significantly increased responses rates to this survey as compared to no incentive at all (Noel et al., 2019); it should be noted that there were no significant differences in responses when comparing incentive amounts ($2 vs $5 and $5 vs $10) suggesting even a nominal incentive can drive participation.

Beyond financial incentives, organizational culture and research team communication strategies are key factors impacting successful clinician participant recruitment. Organizational cultures can facilitate research participation by instituting protected time for research participation and including in projects a dedicated leadership role (e.g., research liaison) or grassroots role (e.g., research champions) for communicating research initiatives and opportunities for participation (Boucher et al., 2023; Paget et al., 2017). These individuals can also communicate with clinical staff to identify projects that might hold the most clinical interest to particular clinicians. To improve sample size, research teams should also identify the appropriate recruitment pool through upfront collaboration and communication with key clinical leaders and department heads (Boucher et al., 2023; William's et al., 2020).

Purpose

While recruitment and retention pose challenges to successful research projects, our experience with clinician-focused studies has ultimately led to some lessons learned that we share in this paper. The purpose of this research brief is to help others improve clinician recruitment by presenting the challenges and planned and unplanned detours encountered during a qualitative study that aimed to understand the process and nature of sexual health discussions among primary care clinicians.

METHODS

The proposed research used formative focus groups of primary care clinicians (N = 16). The intended recruitment was a balanced group of both primary care physicians (n = 6–8) and primary care advanced practice providers (n = 6–8) (i.e., nurse practitioners or physician associates). A semi-structured interview guide was developed to guide the research, and focus groups were planned to occur in a safe and private environment for audio-taped /transcribed focus groups.

Recruitment

Following IRB approval from the large public R1 university, we then planned our recruitment activities at two unique clinical settings. These included : (1) clinicians recruited from a large academic health system of which the authors had academic affiliation and (2) clinicians were recruited from a large federally qualified health center (FQHC) of which an author had clinical affiliation.

The academic health system first required IRB approval for any research proposal, and all research inquiries were then routed to their director of research for coordination and required a brief meeting with this research team to field questions or concerns prior to proposal approval. Once review was complete and all questions were answered the director of research granted written permission and connect this research team to the appropriate channels to begin recruitment.

The FQHC had an internal research approval process which was initiated, and our proposal was presented in-person to the clinical management senior management team. This team could approve or deny the request based on institutional need and competing demands if approved, the proposal would be presented to the board of directors, which convened once monthly for final approval.

To protect the privacy of interested clinicians, all recruitment materials were planned to be disseminated electronically via internal email listserv. This recruitment method allowed interested participants to quickly enroll into the study while allowing the research team to collect only as much information as necessary. Although this limits the ability to build rapport, the direct contact via email listserv has proven effective in other qualitative recruitment strategies (Fleming, 2015).

Recruitment Barriers

Academic Health System

The academic health system serves approximately 3.2 million outpatient visits annually and employs approximately 400 clinicians within their primary care network. The academic health system is predominately based in urban and suburban settings. Ten primary care clinic locations were targeted for this proposal, these were a mixture of Internal Medicine and Family Medicine based clinics. After approval to proceed with the research process, the director of research placed our recruitment flyer into a monthly department-wide newsletter that was sent out electronically to all staff, including clinicians. The intention of this choice was to limit email overload to clinicians, but the placement of the recruitment materials was near the bottom of the newsletter and required the recipient to scroll to the 'research' section in order to be aware of, and read, the study information. If the clinician was interested, they then had to scan an embedded QR code or click on the link for the study enrollment screening survey to determine if they met enrollment criteria.

FQHC

In contrast, the FQHC serves an estimated patient population of 41,000 patients and employs approximately 50 clinicians across their care network. The FQHC has a diversity of locations with clinics in densely populated urban areas as well as resource limited rural areas. After presenting the proposal in-person to the clinical management senior management team, further communication with the FQHC was complicated by internal turnover of a majority of the senior leadership team including the chief medical, financial, and executive officers following this initial meeting. An additional challenge to successful recruitment we faced at the FQHC was that internal policies did not allow compensation for participation in research by staff during business hours.

Mitigation Attempts

Academic Health System

To increase visibility of the research, recruitment flyers were printed and distributed in person to the clinic manager at each site with brief instructions of appropriate placement (e.g., clinician facing areas). After confirming with the various clinic managers that delivery of materials was possible, we personally delivered the materials to each of the ten clinic sites and answered any questions that the staff may have had at that time as well as provided contact for questions as they arise.

FQHC

After communication was severed following all the personnel changes ta this site, the author attempted email communication to reconnect and reinitiate the research process with new staff members; however, given the internal turnover, the staff informed us that there was no documentation of the initial proposal. Attempts were made to present the initial proposal to the new interim clinical management senior management team, but the team declined given competing internal demands on staff time connected to the turnover.

RESULTS

Despite our various attempts to mitigate the challenges, these logistical tests to recruitment at both sites ultimately yielded one clinician who was eager to participate in the research.

Alternative Strategies

The unsuccessful recruitment of clinician participants prompted the research team to consider potential alternative strategies to complete the intended research. The potential alternative strategies included:

- Face-to-face recruitment (e.g., being present at a department wide meeting).
- Expanding number of recruitment sites.
- Change methodological approach to address issues such as clinician hesitancy to participate in time-intensive focus groups

The research team agreed that given time constraints, it made the most sense to transition the research approach to a quantitative survey that encompassed the various domains of interest. A survey was created using the Sexual Health Education for Professionals Scale (Ross et al., 2018). Following IRB approval, this survey was disseminated to the academic health system and data collection is currently underway.

DISCUSSION

Ultimately, it was decided to change the methodological approach to achieve the aims of the project within the timeframe required by the funding agency. Although the quantitative survey limits the richness of the data as compared to what we would expect from our originally planned focus groups, these data will still inform our understanding of the state of sexual health approaches in the primary care context. Institutional logistics inhibited the successful recruitment of clinicians for our proposed research, most specifically organizational culture and competing time demands of the intended recruitment pool. Clinicians, and the expert knowledge they possess, are invaluable when considering the clinical context and the various factors influencing health outcomes. However, unknown are the clinician-specific factors that prevented them from engaging with the proposed research which could inform future research approaches. Although clinician access and recruitment strategies were not the focus of this intended research project, it is apparent that there is much work to be done to more fully understand how to optimize clinician engagement in research particularly in primary care settings and those involving focus group methodology..

Future Considerations

The study team attempted recruitment approaches supported by the literature, such as financial incentives and communication with key leadership at study sites but were still unable to obtain the required number of participants

required for even one focus group. The challenges to recruitment were linked to organizational issues and procedures and structures that were mostly out of the control of the study team, i.e., leadership turnover, policies that limit use of incentives, and study information placement in site newsletter . Ultimately, a new study design was required to meet the study aims. We advise other researchers to consider, and truly understand, the impact of the partnering institution's research policies and structure prior to selecting them as a study site and jointly determine "work arounds" to any identified barriers. Certainly, some issues are beyond the investigator's control, such as loss of staff who were study advocates. As with all studies, methodological backup plans should be established at the start of the study if the required number of participants cannot be enrolled.

CONCLUSION

Understanding the process of sexual health discussions within the primary care context is foundational knowledge needed to understand public sexual health concerns. Clinicians play a key role in driving these health discussions in the clinical setting, but little is known about how these conversations unfold, what is discussed, when it is discussed, and if or why sexual health issues are brought up at all by providers or clients. Gaining an understanding of those factors from a clinician's perspective is essential and much investigation is still needed. This research brief details the complexity of, and responses to, some common barriers faced when trying to engage clinicians in a qualitative research sexual health communication study across various primary care settings.

Funding

This work was supported by the American Sexually Transmitted Diseases Association.

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