Published in final edited form as:

Qual Health Res. 2018 June ; 28(7): 1065–1076. doi:10.1177/1049732318759528.

Group Medical Visits as Participatory Care in Community Health Centers

Ariana Thompson-Lastad, PhD(c)

UC San Francisco Dept. of Social and Behavioral Sciences.

Abstract

In this article, I examine group medical visits, a clinic-based intervention that aims to improve patient health by combining clinical care, health education and peer support. Research shows that health care inequalities are reproduced through the interplay of interpersonal, institutional, and structural factors. I examine changing social relations made possible by group visits, including peer support and an expanded role for patient knowledge. The qualitative data presented here are part of a mixed-methods study of how group medical visits and integrative medicine are combined and implemented for low-income people with chronic conditions. I find that patients take active roles in each other's care, supporting, challenging, and advocating in ways that shift patient-provider relationships. Such shifts demand reflection about what kinds of knowledge matter for health. Health care encounters can reproduce inequality for marginalized patients; this study suggests group visits can restructure patient-provider encounters to interrupt healthcare inequalities.

Introduction and Background

Existing research shows that health care inequalities are reproduced through the interplay of interpersonal, institutional, and structural factors in care delivery. At the interpersonal level, recent research shows that clinician racial bias, whether implicit or explicit, is associated with poor treatment for African-American patients (Hoffman, Trawalter, Axt, & Oliver, 2016; James, 2017). At the institutional level, literature describes how the typical structure of medical encounters plays a substantial role in the production of health care inequalities (Cooper & Roter, 2003; Waitzkin, 1993). Despite efforts towards increased clinician empathy (Kelm, Womer, Walter, & Feudtner, 2014) and patient-centered care (Constand, MacDermid, Bello-Haas, & Law, 2014; Dubbin, Chang, & Shim, 2013), clinicians are faced with ever-shorter visits with their patients (Fiscella & Epstein, 2008; Konrad et al., 2010). Reflecting reimbursement pressures, the trend towards short visits has been found to “exacerbate disparities in health care due to competing demands, miscommunications and activation of unconscious physician stereotypes” about low-income people, people of color, and those with limited English proficiency (Fiscella and Epstein 2008: 1843), and clinicians

Corresponding Author: Ariana Thompson-Lastad, UC San Francisco Dept. of Social and Behavioral Sciences, 3333 California St., Suite 455, San Francisco, CA 94118, USA, Ariana.thompson-lastad@ucsf.edu.

Declaration of Conflicting Interests:

The author declares that there is no conflict of interest.

have argued that patient-centered care cannot be implemented in brief visits (Maldonado, 2013). Among other structural concerns, low public insurance reimbursement rates create disincentives for clinicians from caring for low-income patients (Polsky et al., 2015).

Group medical visits, a clinic-based intervention, aim to improve patient health and interrupt the reproduction of health care inequalities through a combination of medical care, education, and peer support. This article is part of a larger study of integrative group medical visits, which add complementary health approaches such as acupuncture or yoga to existing group visit models. Where medical visits have traditionally been structured as one-on-one interactions between patient and clinician, the emerging phenomenon of group medical visits allows clinicians to conduct visits with multiple patients at once. These new routines and processes enable patients to receive care together, a rare form of intervention into the structure of clinical interaction. Group medical visits, also known as shared medical appointments (Noffsinger, 2012), are now widespread in U.S. primary care and are growing across medical specialties as well as internationally (Andersson, Christensson, & Hildingsson, 2012; Kaidar-Person et al., 2006; Klima et al., 2016). Commonly used for prenatal care (Lathrop, 2013), diabetes (Burke & O'Grady, 2012), and chronic pain (Geller, Kulla, & Shoemaker, 2015), among other conditions, these visits typically bring five to twenty patients to the same space for medical care, health education, and peer support. Depending on the group visit model, the same patients may be present at every session or patients may drop in; regardless, sessions typically last one to two hours and include group conversation as well as individual medical care. The clinician(s) may conduct medical visits semi-privately and one at a time or in a circle with other group members listening and even participating (Barud, Marcy, Armor, Chonlahan, & Beach, 2006; Rising, 1998), and typically bill insurance companies as they would for an individual visit. Group visits are designed to improve health outcomes, increase access to care, and give patients opportunities to support each other; this peer interaction is an essential part of most models (Geller et al., 2015; Noffsinger, 2012; Rising, 1998). Integrative group medical visits share most elements of these other programs, with the addition of complementary health approaches provided alongside allopathic medical care.

Many observational studies and a small number of intervention trials have found that patients participating in group visits have comparable if not better health outcomes than standard care for a variety of health conditions, including prenatal care and diabetes (Edelman, McDuffie, Oddone, Gierisch, & Williams, 2012; Lathrop, 2013; Novick et al., 2011). Existing qualitative literature on group medical visits has typically used interviews with patients and/or clinicians, and suggests that the group setting can result in a relationship between patients and clinicians that are distinct from the typical power dynamic relationship in standard care, and increase both groups' satisfaction with care. For example, Lavoie and colleagues (2013) argue that group visits create contexts in which patients and providers "co-produce" a clinical encounter that is distinct from individual care. This co-production allows providers to understand the social context of patients' health, and allows patients (in their study, primarily low-income Canadian adults), to feel safer and more trusting of clinicians. They conclude that "[w]hile power relations between providers and patients remain in [group visits], the group process appears better able to mitigate the impact of power differentials" (Lavoie et al., 2013). In a review of research on the Centering

Pregnancy model, Massey and colleagues claim that group prenatal care “reduces the paternalism so ingrained in our health care system and strengthens the provider-patient relationship by making them partners in care. The group [dynamic] reduces the power differential between a woman and her health care providers” (2006: 288). They argue that both providers and patients bring relevant knowledge and experience into the group visit setting. In a review of qualitative and mixed-methods literature on group visits, Kirsh and colleagues (2017) found that group visits can lead to more equitable patient-provider relationships than standard care, suggesting the presence of multiple patients and the extended amount of time patients and providers spend together allow for more informal and trusting relationships and even friendships. These studies did not include observation of group visits, which allows for further understanding of the processes by which patients participate in their own and each other’s care; in addition, Lavoie and colleagues examine the Canadian context, in which health care is more accessible to marginalised populations than in the United States.

Many advocates of group visits view them as a way to reduce health disparities and address injustice within health care by improving access to care and empowering patients (Geller, Dube, & Kowaleski, 2010; Rising, 1998). Group visits have been implemented in a variety of settings including private practice and large health care systems, and community health centers. The four organizations in this project are community health centers (also known as Federally Qualified Health Centers), which provide some care in group visits but the majority of care in individual visits that last 15 minutes or less. Community health centers developed out of the Civil Rights Movement, with a focus on addressing social determinants of health in addition to providing primary care. These organizations receive federal funding to support their mandate of caring for low-income people, including the uninsured, many people of color, people with disabilities, undocumented or recent immigrants, and others who live with ongoing trauma or social isolation. They retain some of their original emphasis on community participation; many are at the forefront of innovations such as patient-centered care models, and offer services not traditionally part of medical care such as free exercise classes or access to healthy food (Lefkowitz, 2007).

Social marginalization and other forms of chronic stress are strongly associated with morbidity and mortality from chronic conditions (Hilliard et al. 2016; Lee, Tsenkova, and Carr 2014; Sinnott et al. 2015), including conditions such as diabetes and chronic pain that are commonly addressed in group visits. Researchers and policy advocates aligned with the Black Lives Matter movement have called for universal access to health care and “reparations focused on healing ongoing physical and mental trauma” (Movement for Black Lives, 2016). They demand increased investment in health care for all, urging organizations to work towards community control of health services by those who have suffered most from poor quality and discriminatory care, including Black Americans, undocumented immigrants, and transgender people. Their call echoes patients and clinicians who participated in this research, who spoke clearly to the effects of physical and mental trauma on the health of individuals and communities, and the potential for truly therapeutic care—including group visits—to help people move from suffering and isolation towards individual healing and community participation. Some of the programs in my research normalize

inclusion of people with physical disabilities and mental illness, as well as integration of undocumented immigrants and people across racial and ethnic backgrounds.

This article draws on social science theories of multiple knowledges to help explain patterns of interaction between patients, their peers, clinicians, and other health care staff. Medical care has typically been structured with doctor/expert and patient/layperson as the two central roles and forms of knowledge, and a general assumption that the clinician is the expert in any interaction. Davis-Floyd and St. John (1998) argue that this is a necessary element of the dominant technocratic approach to medicine, but results in a loss of authority and responsibility for the patient. Social scientists have disagreed about whether and how lay/patient knowledge about health reflects a form of expertise. Popay and Williams argue that “...experience is checked against life events, circumstances, and history, [and] lay people acquire an ‘expert’ body of knowledge, different from but equal to that of professionals” (1996). Prior (2003) counters that the rise of “patient-centered care” and attention to patients’ perspectives on health have eroded the dominance of professional knowledge, and that lay knowledge is overvalued in medical sociology. Related research on authoritative knowledge has focused on health-related experiences outside of clinical settings. Social scientists have found that some people develop “syntheses of biomedical, lay, and bodily knowledge” in an attempt to reconcile medical advice with lived experience (Millard & Kingfisher, 1998), and that these syntheses of knowledge have substantial effects on eating and other health-related practices (Potter et al., 2016). Writing about ethics of care among people struggling with addiction and their families, Garcia describes how laypeople’s medical and technical knowledge changes their experience of health and illness, and argues that care from peers and families is essential when medical and other institutions neglect to provide needed care (Garcia, 2010).

Though group medical visits are being implemented in community health centers across the U.S., research has rarely examined the experiences and relationships of patients and clinicians participating in this form of care across multiple sites and health conditions (Kirsh et al., 2017). This article highlights how receiving care together can shift the traditional patient-provider power dynamic and create relationships of care between patients, potentially interrupting the reproduction of inequalities in health care. Using observation and interview methods, I focus on low-income adults, primarily people of color, receiving care in four U.S. community health centers. I examine the changing social relations that accompany these new forms of care, including greater patient participation and mutual support, and an expansion of the role of patient knowledge in the clinical setting. In many group visits, health care providers and patients act to refute hierarchical relationships and unequal care practices that are common in standard medical care. As I show below, the structure of group medical visits allows providers to utilise extended time with patients and the presence of peers to make patient knowledge central to the care process. In the course of conducting group visits, many providers come to view patient knowledge as a form of expertise that can be leveraged and shared as a form of care that benefits other patients in the room (Kennedy et al., 2009; Lavoie et al., 2013).

Methods

This article is part of a larger, mixed-methods study that examines how group medical visits and integrative health care (also known as complementary and alternative medicine) are being combined and implemented for low-income people with chronic conditions in the U.S. Data was collected at four community health centers in the San Francisco and Boston metropolitan areas between March and August 2016¹. These organizations include county-run health clinics as well as non-profit community health organizations. All offer primary care at multiple sites, and serve low-income families, including uninsured people and recent immigrants. These organizations were chosen for their robust group medical visit programs; all have offered group visits for at least 10 years. Most began by offering the Centering Pregnancy model of group prenatal care and/or group visits for diabetes care, and have since expanded to offer a variety of group visits including some that incorporate complementary health approaches such as yoga, acupuncture or meditation. None of the organizations has a specific focus on integrative health care; rather it is one of several innovative approaches to care such as integrated behavioral health care, food access programs, and exercise classes that are offered at some clinic sites. Though integrative health care is not the explicit focus of this article, it will be further explored in future publications.

Data for the project include ethnographic observations of group visits, as well as qualitative interviews of both patients and staff. Interviews and participant observation were conducted in English and Spanish. In conversation with clinicians involved in directing or coordinating group visit programs at each organization, I identified clinicians and other staff of integrative group visit programs as potential participants. All staff involved in integrative group visits were invited to take part in a one-on-one semi-structured interview and be observed providing care in a group visit. The content and scope of staff interviews was iteratively adjusted to explore themes that emerged in ethnographic observation of group visits and in ongoing patient interviews. A total of 28 staff interviews were completed by phone or in person; staff members included physicians, health educators, and other clinicians and support staff. Participants provided written consent and received a \$25 gift card. Interviews were audio-recorded and transcribed verbatim.

I conducted participant observation of 20 different integrative group medical visits at eight clinic sites across four organizations; observations were intended to collect data on patient-provider and peer relationships and serve as an opportunity to recruit patient participants in this study. Observation focused on interactions among patients and between patients and providers; in addition, I was sometimes invited to participate in group activities such as yoga or discussion. Eight groups focused on chronic pain; the remainder included groups focused on treatment modalities, including yoga and acupuncture, as well as groups focused on population or health condition, including men's health and opioid addiction. Programs varied tremendously in duration, frequency of meetings, and stability of membership; some accepted new patients at each session, others served the same patients over time. Group visits in this study generally included multiple staff, including a licensed clinician (typically

¹From 2009–2015, I developed and facilitated group medical visit programs at one of these organizations, but was no longer employed there at the time of data collection.

physician or nurse-practitioner), as well as one or more support staff such as a health educator or medical assistant. Throughout the article, I use the term “clinician” to refer to licensed providers, and “staff” to refer to health care workers more broadly, including clinicians. All patients and staff provided verbal consent at the time of observation; observations were recorded in detailed field notes.

While observing group visits, I typically invited all patients to participate in individual interviews. Eligibility criteria included age 18 or older, verbal fluency in English or Spanish, and willingness to participate in one semi-structured interview about their experience with integrative group visits. I interviewed 25 patients by phone or in person; participants provided written consent and received a \$25 gift card. Demographic data was collected through a brief questionnaire.

Interview transcripts were analyzed using grounded theory methods, including coding and memoing (Charmaz, 2006; Clarke, 2005). Field notes and interview transcripts were coded using the qualitative data management software Dedoose. I developed a list of codes and sub-codes in Dedoose, iteratively adjusting the code list as additional materials were coded, and refined the list of codes through ongoing memo writing and discussion with colleagues of emerging themes in the data. Emerging themes related to interaction, relationships, and how patients and providers participate in care were used for this article; additional themes will be further explored in future manuscripts. Constructivist grounded theory, as practiced by Charmaz and others, “sees both data and analysis as created from shared experiences and relationships with participants and other sources of data” (Charmaz 2006: 130), and allows for examination of the co-construction of this approach to care by the stakeholders involved. Alongside grounded theory methodology, the decision to incorporate both patient and provider perspectives is framed by a theoretical approach that values multiple forms of knowledge (Millard & Kingfisher, 1998; Prior, 2003). Studying the experiences of health care staff gives attention to those who shape how group visits happen and hold power over how medical care is delivered. Studying the perspectives of patients receiving care in safety-net settings brings attention to how they participate in, resist, and help shape the kinds of care that are offered to them. All study procedures including observation and interviewing were conducted with the approval of the UC San Francisco Internal Review Board (Study #15–18421). Informed consent was obtained from all participants.

Findings

Twenty-eight staff involved with group medical visits participated in interviews (Table 1), as did twenty-five patients (Table 2). In interviews and observations with patients and staff, I found that participating in group visits dramatically affected providers’ and patients’ experiences of giving and receiving care. In this section, I delineate specific practices that differentiate the process of care in group visits, allowing for participatory interactions for both patients and providers and thereby refuting some of the hierarchy typical in individual care. In the course of observations and interviews, I found that: 1) patients participate in the work of group visits in ways that were distinct from individual care, and group visit providers expressed confidence in patients’ ability to develop and act on medical knowledge; 2) providers participated in care in ways that were distinct from individual care and drew on

their own multiple forms of knowledge; 3) patients participated in each other's medical care by challenging, supporting, and advocating for one another. Building on existing literature about how group visit participants can co-create an alternate form of clinical care with the potential for more equitable relationships between patient and provider (Kirsh et al., 2017; Lavoie et al., 2013; Massey et al., 2006), this article provides detailed analysis of the processes and practices that allow for patients to meaningfully participate in their own and each other's health care.

“Twelve doctors in this group”: Work patients wouldn't do in standard care

In a men's health group that I observed, six men with pre-diabetes or hypertension met with their primary care doctor and a medical assistant, also men. When patients arrived, they appeared practiced and confident checking their weight and blood sugar and filling out paperwork about vital signs and medication refills. They chatted while helping each other with the blood pressure cuff, then joined the medical assistant in preparing vegetable egg muffins in the kitchen part of the group space. The doctor briefly checked in with individual patients at a desk in the room, as quiet music played.

Checking vital signs, including blood pressure, weight, and sometimes additional items such as blood sugar or pain levels, is a standard part of both individual care and most group medical visits. In group visits I observed, staff shared medical and technical knowledge with patients, and demonstrated their confidence in patients' ability to develop this knowledge and use basic medical technologies, such as those used for vital signs. In some programs, patients checked their own vital signs and helped each other when assistance was needed. As in the men's health group, patients would note their vital signs on a form that included data such as medication refill needs, pain scales, or questions for the provider. This information was later entered into the medical record by staff. When I asked a patient in the men's group if he had known how to check his vital signs before joining the group, he answered,

No, I didn't even know how to put on a sphygmomanometer cuff... [a staff member] showed me...I can't put it on by myself...there's always somebody there to help with the cuff...it took, you know, six months of doing it once a month to figure out how to work the blood sugar things...now I know how.

I mentioned that the patients looked comfortable checking their vital signs and he answered, “It's because of the group. I didn't know how to do any of this...this is a very cool thing.” It is notable that this patient not only felt comfortable checking his vital signs with assistance from peers, but had learned the technical term for a blood pressure cuff. The practice of patients checking and documenting their own vital signs is also a core part of Centering Pregnancy, a group prenatal care model that had been implemented at all four of my research sites and influences other group visit programs. At other sites where staff checked patients' vital signs, results were sometimes shared publicly on a whiteboard for all to observe. At one organization, patients who attended weekly chronic pain groups were not required to check vital signs at every session. When I asked a patient about this, she said, “Sometimes we do, sometimes we don't...we decide.” At that organization, patients were asked to fill out paperwork about their pain and health goals, and a medical assistant was available to check vital signs if patients decided to. A clinician told me they did not need vital signs to bill

patients' insurance (and had determined they were not clinically necessary on a weekly basis), but would check them if the patient or clinician wished to.

Many staff noted that patients more readily absorbed health-related information when it came from their peers rather than from a clinician, and talked about patients' health-related interactions with each other as the most important part of what happened in group medical visits. In a group for Spanish-speaking people with diabetes, Sushil², a clinician, told the 12 patients, "no hay un medico en este grupo, hay 12 medicos!" [*there isn't just one doctor in this group, there are 12 doctors!*] making the case that they could provide valuable medical care to each other. His comment mirrored the words of a support staff person that "this [group visit] is part of a culture change where the provider learns to share the care." Patients in group visits frequently challenged and supported each other in ways that providers cannot or would not do effectively, taking on a kind of work that is the provider's role in an individual visit.

In the diabetes group, Sushil asked each patient to share a recent success. One patient said he hadn't had any successes, explaining that he could not eat healthy or take medications regularly because of his job selling ice cream out of a mobile cart. Another young woman shared that she had recently started taking better care of herself despite the challenges of being a single mother of four children. Looking at her fellow patient the ice cream seller, she said firmly, "you have to take care of yourself because of love for your family!" A working parent herself, she could relate to the competing demands of self-care and caring for a family that made it hard for him to treat his diabetes, but she was confident that he could find a way to take his medications because she had done so. This patient had experiential authority that allowed her to challenge another patient without negative repercussions. Such legitimacy comes from being a peer with similar experiences and challenges, something Sushil's professional expertise and medical authority may not have provided. He did not see this woman's experiential knowledge as secondary to what he was offering, but as a legitimate, even authoritative element of other patients' care. In an interview, he explained how he viewed the patients' role in group visits, saying they should "teach each other and coach each other," work typically seen as belonging to health care staff. Like many providers I spoke with, he challenged the hierarchy of typical patient-provider interaction, arguing that medical expertise is not the only authoritative or valuable form of knowledge.

Because group visits take place within clinical spaces, they must align with certain hierarchical standards of medical organizations and insurance companies. For example, before the use of electronic health records, many group visit programs would give patients their medical charts to note vital signs and other information that would become an official part of the chart. However, patients in the clinics I observed were not permitted to access their electronic medical records; instead, they typically wrote on paper and staff later entered the information into the electronic record. Small shifts, like inviting patients to make decisions about whether and how vital signs are taken—a routine rarely questioned in medical practice—were one of the ways that patients and staff refuted hierarchical practices by changing the process of care. In some cases, patients described making decisions

²All names are pseudonyms.

themselves about when to check vital signs. In other cases, patients willingly helped to provide each other's medical care by assisting each other with vital signs. As evident in these examples, staff assumed patients were capable of taking on specific elements of medical knowledge and practice, doing so accurately with staff members available to provide interpretation of results or negotiate conflicts that might arise between patients.

Serving patients water: work providers wouldn't do in standard care

Later in the men's health group, a female health educator arrived to lead a dance lesson. The patients and doctor stood in a circle, and the health educator led gentle stretches. Patients were smiling as the health educator taught them a routine to upbeat music playing on her phone. "Just move, it doesn't matter!" one patient told his confused neighbor. One man said, "next month they're gonna hire us!" and another, "we're gonna live 15 years longer!" When the lesson ended, everyone clapped. The doctor had been dancing too and asked, "did anyone notice it was a little easier this time?" He poured water in cups and served each patient as they chatted about sports. This was one of many times that I observed providers in group visits undertaking activities that they would be unlikely to do in a standard office visit. In a typical clinic setting, there is an emphasis on clinicians doing work that only they can do, and only that work. In group visits, clinicians often participated in some of the same activities as patients, and engaged in activities that would elsewhere be seen as the domain of support staff. Though clinicians were there to share their medical knowledge, they used multiple forms of knowledge and experience.

In the group described above, the doctor provided individual medical care, danced with his patients, and served them water. In many group visits, providers shared information about their own lives that they said they would not be as open about in standard care. For example, in most groups I observed, providers included themselves in group "check-ins," discussing their own health goals alongside their patients. Badra, a clinician, explained that she started a chronic pain group in part because of her own experience:

I also have chronic back pain and I found as a provider...I could be sympathetic or empathetic to what's going on.... Do I bring in my history? Not too much, but sometimes I will...if I'm assessing how their pain scale is, I'll let them know how I am doing today too.

In addition to providing medical care, Badra at times provided her own vital signs as a point of reference for her patients.

In observations and interviews, it became clear that many patients and staff saw anyone in the group space as a participant. Staff involved in group visits acknowledged that they held expert *and* experiential knowledge, and used both in the group setting. Clarissa, a group facilitator, said, "Everybody in the group is a participant...The [medical] residents who come in participate... Nobody is just sitting there watching and listening." My own attendance at group visits was ostensibly to introduce my research, observe and collect data. However, I often was also invited to participate in group activities, whether "checking in" at the beginning of group, sharing food patients had cooked, or doing yoga. Patients in some groups described support staff (such as medical assistants or health educators) as "group

members.” These support staff were more often people of color than clinicians, as were the majority of patients. One patient said about a support staff member:

He’s also one of us, because...he has the same issues that we do. [He asks] “How do I keep the weight off, having trouble getting to the gym, you know, what kind of food do I eat?”...Having him just be one of us, it makes a big difference.... He’s part of the group.

A patient named David extended this insight, explaining that in group, “You feel like you’re a community and not just a patient and a doctor...It’s essential to our health to have that ability to come and be social...and get to know each other.” David was not alone in making the case that such collective experiences of health improve his health and that of the other patients, in ways that are drastically different from many individual health care encounters. Patients described group visits as reducing the power differential between medical staff and patients but did not describe friendships with providers, which Kirsh and colleagues (2017) report as one result of more equitable patient-provider relationships in group visits.

Many providers spoke extensively about the benefits of minimizing their ‘expert’ voice or presence in group, while seeing themselves as holding particular kinds of knowledge that were different from patients’ knowledge. ‘Stepping back’ and ‘getting out of the picture’ were terms used to describe a facilitation technique that some clinicians emphasized as a key part of their role and experience in group visits. This technique was exemplified in different ways. One clinician said, “. . . if I can get myself out of the picture I think that’s really important just because of what I represent as a provider,” later indicating that as a provider her presence could be intimidating to patients. Other clinicians mentioned reducing how much they speak. One said in an interview, “My goal is to talk as little as possible” and another explained, “. . . It’s really good practice for me to keep my mouth shut!...just to listen to people and not jump in.” For these clinicians, stepping back is about speaking less, leaving space for patients to participate and take part in shaping discussion. Clinicians who reported that they practiced stepping back sought to remain attentive and provide input when patients requested it or when they perceived their specialized knowledge was needed, but also saw patients as having different kinds of knowledge that are a valuable part of the care provided. A clinician named Diane described how she intervened if patients are sharing information she saw as medically incorrect:

If it comes to a standstill, people are just scratching their heads, or people are just saying things that really are not correct, like, ‘yeah you can drink all the juice you want, it’s really good for you when you’re pregnant!’ then I do step in, and I go ‘well, actually. . .’ but it’s in that kind of mode of almost, not peer exactly, but kind of a sharing.

She affirmed that providing clinical information is an important piece of the provider’s role in group visits, just as in individual care, even as she described herself as playing a more peer-like role than in individual practice.

Practicing this way required a kind of re-training. When asked where they learned to step back while providing care in group visits, clinicians mentioned observing peers who practiced in groups visits or attending trainings with the Centering Healthcare Institute, one

of few organizations that provide formal training in group visits. Diane was perhaps most explicit in explaining how formal training in group facilitation shaped the way she practiced, saying the Centering Institute trainers “kinda gave me permission” to “just shut your mouth and let [the patients] talk.” Multiple clinicians described group visits as being the only place where they could practice the kind of medicine they found most helpful: an approach in which patients had time to share their experiences and there was adequate space for patients and providers to develop therapeutic relationships.

“Call you in the morning, call you at night:” peer relationships as medical care

The primary difference between group medical visits and standard care is that there are multiple patients present. Group visits include interaction between patients, and their interactions are often part of each other’s medical care. I argue that patients in many group visits actively participate in each other’s care by challenging and supporting each other with adhering to self-care practices, and advocating for each other in interactions with clinicians.

Dannie’lle, a patient in a group visit for chronic pain, lived with pain from a congenital disease, as well as mental health issues she described as “manic depressive schizophrenic bipolar.” When we met, she had participated in the group co-facilitated by a clinician and a mental health provider for over a year. A regular participant in their weekly sessions, Dannie’lle told me about plans to sell a book of poetry she had written and use the proceeds to buy a laptop that group members could share for things like job applications. She described how months earlier, she had unintentionally begun speaking in the group about a current mental health crisis:

I’d found some friends [in group] and then I kinda started opening up. When I had the--I call it my break when I was really mad at my mom, I wanted to kill her and everything...I had to apologise to group because I was like, I don’t want you guys to see this side of me.... It surprised me that most of them actually understood and they had similar maybe child trauma or abuse...that happened in their past with their parents.... They were texting me their most inner secretive things you wouldn’t share with people...It got them to open up about things really bad that happened to them.

I asked Dannie’lle whether other patients shared their traumatic experiences with the whole group, and she clarified, “They didn’t actually come to group and tell but they shared it with me,” allowing her to give as well as receive support. When I asked if the experience changed her ideas about what she might share with the group in the future, she answered:

...That was something initially I wouldn’t have shared but after I did, the response that I got--in that it helped other people--made me think maybe I could open up more about my mental problems and anger issues with the group, because they were more understanding then I thought they would have been...I thought [group] was just for the physical pains that you are having because that’s what pain and wellness--But [the staff said], “No, the wellness is to make you well, to help heal you in whatever way.”.... It helped [the other patients] when I was going through it and venting it. I didn’t think it was actually to help them, but it was helping me to let it go. [But] in hindsight, it did help them. In the future if I was having another

break, yes, I would probably share it again because it might reach someone who I didn't reach the first time.

Dannie'Ile's story shows how group visit staff created conditions that connected pain treatment, wellness, and the work of healing. Providers acknowledged that peer support alongside expert intervention could produce all of these, and encouraged patients to support each other as part of accessing care. This case exemplifies how patients participated in their own and each other's care in group visits, in this case disclosing traumatic experiences and receiving emotional support from peers instead of or alongside medical providers. Garcia (2010) writes about peer relationships among people struggling with addiction, "Within the clinic the idea that the other's suffering is our own is not abstract; it is visceral. How might those in the throes of pain help to heal each other? How might the suffering of others and the painful forms of recognition it evokes be a force for care and not a crippling force?" (67–8). In presenting her vulnerability, Dannie'Ile did not feel stigmatized, and indeed her experience in the group resulted in seeing herself as a force for care for others with chronic pain and trauma. She did not initially intend to share the details of her mental health crisis but was glad she did. Her unplanned disclosures resulted in a referral to ongoing mental health care, closer connections to peers, and mutual support. Garcia (2010) shows how in the context of drastically inadequate access to medical care for addiction, peers and family members provided tremendous support with limited positive results. In contrast, Dannie'Ile developed relationships of care with peers because she had access to frequent health care with peers present. In turn, she accessed additional mental health care because she shared her story with her peers. Where Garcia observed people who were a force for care in the absence of needed health care, Dannie'Ile acted as a force for care alongside health care staff, within an innovative and accessible clinical setting where she simultaneously experienced medical and mental health care and mutual peer support.

Many staff noted that patients more readily absorbed new information when it came from their peers rather than from a clinician, and talked about patients' health-related interactions with each other as the most important part of the group visit. Marie, the facilitator of a group for patients with mental illness, described how group members supported one woman who struggled to give herself the daily insulin injections she needed. Marie explained the strategies that the group developed to support her:

[She] goes through these periods where she just will not take her [insulin]...she's got this kind of like, 'I don't know, it's just hard to remember. I just didn't take it.' We've tried everything. Can you line it up with your favorite TV show? Can you set an alarm on your phone? And the group members are like, "Okay I'm going to call you. I'm going to call you in the morning, I'm going to call you at night." They're like that. They're not in denial about each other's medical issues... they feel empowered in the group, like 'this is our group...' She needs that call every morning and night to take her meds, but it needs to be from another patient. It can't be from me.

Marie noted that, after the reminder phone calls from the group members and her subsequent more consistent use of insulin, this woman's blood sugar levels went from being dangerously high to stabilizing within the range considered "good control." Other patients

supported her through frequent contact and accountability that began within a clinical space, and continued outside of it. The patients' willingness to call their peer twice a day exceeded the parameters of Marie's job, and she was confident this care was more effective coming from patients. Like Dannie'llie in the story above, these patients became a force for care; they and Marie challenged the hierarchy of typical patient-provider interaction. She argued that medical expertise is not the only authoritative or valuable form of knowledge that can improve patients' health, and that patients' expertise has value for their peers.

In some group visits, I observed patients advocate for each other with clinicians. In a chronic pain group, a clinician named Izumi provided brief medical consultations in a circle, making referrals and refilling medication with patients listening to each other's visits. A patient named Berla asked if she could see a podiatrist, and Izumi questioned why she needed the podiatry visit. Berla seemed confused and another patient offered to clarify, explaining to Berla that "Izumi needs to refer you, and wants to know what the referral would be for!" Berla explained she wanted a podiatrist to check her orthotics; after 19 years wearing the same ones, she felt they were worsening her chronic pain. Izumi quickly agreed to the referral and they moved on. Here, patient and provider were operating within the confines of a healthcare landscape where insurance would not pay for a specialist visit without a referral from a primary care provider. The patient and clinician seemed confused, and another patient briefly intervened to make sure they understood each other. This advocacy allowed the visit to move forward without conflict, and the patient's medical need was met. In an individual visit this interaction might have become adversarial, or the patient might have dropped the question rather than risk a tense interaction. Instead a misunderstanding was quickly resolved, allowing the clinician to make the appropriate referral, the patient to see the podiatrist, and the group to move on to another person's care, all aided by the momentary intervention of another patient.

These examples and others demonstrate how low-income patients can participate meaningfully in each other's medical care, even within the constraints of clinical settings. The presence of peers makes space for patients to informally share knowledge of how to navigate the healthcare system, and to model successful communication with clinicians in ways that allow others see how to get what they need. These interactions took place in sessions where patients with chronic conditions received medical care, shared snacks, asked and answered each other's health questions, and participated in meditation, acupuncture or other complementary health approaches. While they depended on their health care providers' professional expertise, they benefitted also from their peers' willingness to challenge, support and advocate for each other. As a patient named Ruth succinctly described the women in her group visit: "We're encouraging each other.... Let me see if you can do it, and we do it together, and we watch each other...We amplify each other, we lift each other up."

Discussion and Conclusion

This article adds to the substantive literature on group medical visits as an innovation in health care delivery. Such research has focused primarily on health outcomes (see for example Edelman et al., 2012; Homer et al., 2012). In contrast, I have delineated some of the

key practices that allow for participatory care in group medical visits at four community health centers in the U.S., improving patient and provider satisfaction with care and representing a potential challenge to the hierarchy of typical patient-provider interaction. I find that the presence of multiple patients is a distinct element of the process of care which affects how both patients and providers act in the medical interaction, and thus changes relationships between them. In addition, I argue that patients participate in their own and each other's medical care while giving and receiving peer support.

The current standard for individual medical care includes extremely abbreviated visits that may be unavoidably rushed and transactional and exacerbate health care inequalities (Fiscella & Epstein, 2008; Sweet, 2012). In group visits, patients share the provider's time and attention for an hour or more. In addition, they have opportunities to offer and receive care, support, and advocacy alongside their peers (Lavoie et al., 2013). Previous research on group visits has included community health centers and other settings serving low-income or otherwise marginalized patients, and has also shown the benefits of group visits for patients in other settings including private practices and specialty care such as cancer survivorship programs and bariatric surgery follow-up (Kaidar-Person et al., 2006; Noffsinger, 2012; Reed, Partridge, & Nekhlyudov, 2015). Staff and patients in my research all agreed that some patients would never choose to receive care in group visits, either because of discomfort with sharing their medical history or discomfort in group settings for other reasons. However, it is clear that group visits are not a form of second-class care for patients with limited health care access, but have unique benefits that appeal to patients with a wide variety of health concerns and life circumstances.

It is notable that when asked about challenges and limitations of group visits, the patients and staff members I interviewed had overwhelmingly positive feedback about the programs, and this is both a strength and a limitation of this study. All agreed that group visits should not be mandatory in any setting, and some patients and staff thought that particular personal characteristics made clinicians more suitable for group visits. There were varied perspectives on how much group visits could or should replace individual primary care, and whether it was better for patients to participate in intensive short-term group visit cohorts or long-term programs with flexible drop-in membership. Future research could include the perspectives of patients and staff who had participated in group visit programs and then stopped participating, and should explore the strengths and weaknesses of programs with different durations of participation; this would likely provide more insight into the limitations of such programs.

Another limitation of this study is that over 60% of the patients in the interview sample had at least some college education, which is not typical for a safety-net clinical setting. Only 25% of patient interviewees had completed an associate's degree or higher, however, and the mean age of the sample was 58, indicating that interviewees would may be unlikely to complete a degree program if they have not already. It is possible that interviewees had higher levels of health literacy and health-related knowledge than other participants in group visits. It also seems likely that more educated patients self-selected for participation in this university-sponsored research study. Though this sample appeared to represent a cross-section of group visit patients at these clinics in terms of health and socioeconomic status,

future research should include targeted sampling to learn about the experiences of patients with lower levels of education who participate in group visit programs. Such sampling could provide more insight into the benefits of group visits for improving health literacy and technical/medical knowledge.

Care in group visits is provided in ways that align with insurance company requirements and clinical guidelines used in standard care. The programs I describe provide integrative health care, combining medical care with complementary health approaches such as acupuncture, yoga, or mindfulness. Yet the patients and staff in these programs also take part in the rushed, high-volume individual care that is standard in community health centers and other settings. A critique of group medical visits might suggest that they are a way of teaching patients to be more successfully socialized into medicine through increased self-surveillance (Armstrong, 1995). Because these programs operate within a hierarchical system, patients' knowledge claims are subject to constraints. In group visits, as in the rest of health care, clinicians are the dominant group, holding control over resources and treatment approaches that affect patients' lives. My analysis partially refutes this critique by demonstrating how multiple forms of knowledge can be made visible and actively challenged and legitimated in a clinical setting. These findings suggest that patients' embodied and experiential knowledge is synthesised with medical knowledge, and that while group visits do not entirely evade medical hierarchy, they may create spaces for patients to dissent or resist clinicians' authority or treatment recommendations.

Building on the literature of multiple knowledges and lay/expert knowledge divides, I detailed settings in which both patients (typically seen as laypeople) and providers (typically seen as experts) are assumed to have syntheses of multiple kinds of knowledge, including medical and experiential knowledge, and take on new activities and responsibilities (Potter et al., 2016). The presence of multiple patients in the same clinical encounter means patients, through their very participation, shape the group and the role it plays in their lives and in clinicians' practice. Where in individual visits the roles of patients and providers are taken for granted, group visits demonstrate that these roles can be flexible: patients can take vital signs and follow up with each other about medication adherence; providers can share about their own lives and act as facilitators or coaches, not purely experts (Gray, Ross, Prat-Sala, Kibble, & Harden, 2016; Massey et al., 2006). This is possible when clinicians have enough time to both provide needed care and act outside of their typical clinical role. This allows them to make space for and actively value patient knowledge as relevant to clinical care; they give up the assumption that their medical and technical knowledge is the only authoritative knowledge, and see patients' knowledge as beneficial to their peers. Such shifts demand critical reflection about to what extent hierarchy is necessary in medical care, and what kinds of knowledge are important to improve health. In group visits, staff and patients benefit not only from the knowledge of the health care provider(s) present, but from the syntheses of knowledge brought by all group attendees. Many clinicians in this viewed the knowledge that patients bring as not only valuable and even authoritative, but as constituting a form of care in itself. Patients, in turn, viewed clinicians as holding specialised knowledge that they need and benefit from, but also holding relevant experiential knowledge; in addition, some saw their peers as what Garcia (2010: 68) calls a "force for care." Patients and clinicians saw this care setting and the practices that are part of it—whether clinicians

sharing information about their lives or patients checking their own vital signs—as leading to mutually respectful relationships and improved health. These changes in how patients and clinicians view each other serve as a means of questioning power hierarchies by undoing the strong separation between these two groups.

It is important to note that the programs included in this research primarily serve communities of people who have been deeply affected by lack of access to medical care and by discriminatory care. Patients and staff spoke of the effects of past and ongoing trauma on the health of group members and local communities, and believed group visits could play an important role in addressing physical suffering and social isolation by providing healing relationships with clinicians and peers. Several staff described group visits as “mending” patients’ negative relationships with health care staff, not by erasing past experiences, but by demonstrating more horizontal and mutually respectful relationships within the group and supporting patients’ ability to advocate for themselves with clinicians outside of the group. Patients and staff spoke to the power of peer support to improve patients’ physical and mental health. Past research has shown that health care encounters reproduce inequality for marginalised patients (Dubbin et al., 2013; Waitzkin, 1993); group medical visits suggest that this need not be the case if the structure of the health care encounter is changed. Group visits expand on access to care, and create an ethic of ownership in which patients can become part of a community while receiving medical care. In the current political moment, group medical visits offer one approach with potential to reduce the vulnerability of those targeted by particular health and political policies. Providing peer support and community integration in a clinical setting can, formally or informally, provide a critical sanctuary.

Acknowledgements

My thanks go to the community health center patients and staff who participated in this study, for their time and interest. Thanks also to Howard Pinderhughes, Janet Shim, Maryani Rasidjan, Emily Treleaven and Lily Walkover for support developing and writing this article.

Funding:

This work was supported by the National Center for Complementary and Integrative Health of the National Institutes of Health, [grant number F31AT008747]. The content is solely the responsibility of the author and does not necessarily represent the official views of the National Institutes of Health.

REFERENCES

- Andersson E, Christensson K, & Hildingsson I (2012). Parents’ experiences and perceptions of group-based antenatal care in four clinics in Sweden. *Midwifery*, 28(4), pg. 502–508. 10.1016/j.midw.2011.07.006 [PubMed: 21925778]
- Armstrong D (1995). The rise of surveillance medicine. *Sociology of Health and Illness*, 17(3), pg. 393–404. 10.1111/1467-9566.ep10933329
- Barud S, Marcy T, Armor B, Chonlahan J, & Beach P (2006). Development and implementation of group medical visits at a family medicine center. *American Journal of Health-System Pharmacy: AJHP: Official Journal of the American Society of Health-System Pharmacists*, 63(15), pg. 1448–1452. 10.2146/ajhp050266 [PubMed: 16849711]
- Burke RE, & O’Grady ET (2012). Group Visits Hold Great Potential For Improving Diabetes Care And Outcomes, But Best Practices Must Be Developed. *Health Affairs*, 31(1), pg. 103–109. 10.1377/hlthaff.2011.0913 [PubMed: 22232100]

- Charmaz K (2006). *Constructing Grounded Theory: A Practical Guide through Qualitative Analysis* (1 edition). London; Thousand Oaks, Calif: SAGE Publications Ltd.
- Clarke A (2005). *Situational Analysis: Grounded Theory After the Postmodern Turn*. SAGE.
- Constand MK, MacDermid JC, Bello-Haas VD, & Law M (2014). Scoping review of patient-centered care approaches in healthcare. *BMC Health Services Research*, 14(1), 271. 10.1186/1472-6963-14-271 [PubMed: 24947822]
- Cooper L, & Roter AY (2003). Patient-provider communication: the effect of race and ethnicity on process and outcomes of healthcare In *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: National Academies Press Retrieved from <http://www.ncbi.nlm.nih.gov/books/NBK220354/>
- Davis-Floyd R, & St. John G (1998). *From doctor to healer: the transformative journey*. Rutgers University Press.
- Dubbin LA, Chang JS, & Shim JK (2013). Cultural health capital and the interactional dynamics of patient-centered care. *Social Science & Medicine* (1982), 93, pg. 113–120. 10.1016/j.socscimed.2013.06.014 [PubMed: 23906128]
- Edelman D, McDuffie J, Oddone E, Gierisch J, & Williams J (2012). *Shared Medical Appointments for Chronic Medical Conditions: A Systematic Review*. Washington, DC: Department of Veterans Affairs Retrieved from <http://www.hsrd.research.va.gov/publications/esp/shared-med-appt.pdf>
- Fiscella K, & Epstein RM (2008). So much to do, so little time: care for the socially disadvantaged and the 15-minute visit. *Archives of Internal Medicine*, 168(17), pg. 1843–1852. 10.1001/archinte.168.17.1843 [PubMed: 18809810]
- Garcia A (2010). *The Pastoral Clinic: Addiction and Dispossession Along the Rio Grande*. University of California Press.
- Geller J, Dube E, & Kowaleski J (2010). *Establishing and Maintaining Successful Chronic Pain Group Medical Visits Using an Empowerment Model*. Lawrence, MA: Greater Lawrence Family Health Center Retrieved from <http://glfhc.org/images/final%20pain%20manual%202011.pdf>
- Geller JS, Kulla J, & Shoemaker A (2015). Group Medical Visits Using an Empowerment-based Model as Treatment for Women With Chronic Pain in an Underserved Community. *Global Advances in Health and Medicine: Improving Healthcare Outcomes Worldwide*, 4(6), pg. 27–60. 10.7453/gahmj.2015.057
- Gray D, Ross K, Prat-Sala M, Kibble S, & Harden B (2016). Stepping Back and Listening: Staff Experiences of Using a Coaching Approach in an Acute Rehabilitation Ward for Older Adults. *Qualitative Health Research*, 26(10), pg. 1434–1443. 10.1177/1049732315604589 [PubMed: 26481943]
- Hoffman KM, Trawalter S, Axt JR, & Oliver MN (2016). Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *Proceedings of the National Academy of Sciences*, 113(16), pg. 4296–4301. 10.1073/pnas.1516047113
- Homer CSE, Ryan C, Leap N, Foureur M, Teate A, & Catling-Paull CJ (2012). Group versus conventional antenatal care for women. *The Cochrane Database of Systematic Reviews*, 11, CD007622 10.1002/14651858.CD007622.pub2 [PubMed: 23152247]
- James SA (2017). The strangest of all encounters: racial and ethnic discrimination in US health care. *Cadernos de Saúde Pública*, 33(suppl 1). 10.1590/0102-311x00104416
- Kaidar-Person O, Swartz EW, Lefkowitz M, Conigliaro K, Fritz N, Birne J, ... Rosenthal R (2006). Shared medical appointments: new concept for high-volume follow-up for bariatric patients. *Surgery for Obesity and Related Diseases: Official Journal of the American Society for Bariatric Surgery*, 2(5), pg. 509–512. 10.1016/j.soard.2006.05.010 [PubMed: 17015202]
- Kelm Z, Womer J, Walter JK, & Feudtner C (2014). Interventions to cultivate physician empathy: a systematic review. *BMC Medical Education*, 14(1). 10.1186/1472-6920-14-219
- Kennedy HP, Farrell T, Paden R, Hill S, Jolivet R, Willetts J, & Rising SS (2009). “I wasn’t alone”--a study of group prenatal care in the military. *Journal of Midwifery & Women’s Health*, 54(3), pg. 176–183. 10.1016/j.jmwh.2008.11.004

- Kirsh SR, Aron DC, Johnson KD, Santurri LE, Stevenson LD, Jones KR, & Jagosh J (2017). A realist review of shared medical appointments: How, for whom, and under what circumstances do they work? *BMC Health Services Research*, 17(1). 10.1186/s12913-017-2064-z
- Klima C, Patil C, Norr K, Leshabari S, Kaponda C, & Rising S (2016). Exporting Centering Pregnancy May Contribute to Improving Antenatal Care and Improving Maternal and Child Health in Sub-Saharan Africa. *Journal of Midwifery & Women's Health*, 61(5), pg. 660–660. 10.1111/jmwh.12560
- Konrad TR, Link CL, Shackelton RJ, Marceau LD, von dem Knesebeck O, Siegrist J, ... McKinlay JB (2010). It's about time: physicians' perceptions of time constraints in primary care medical practice in three national healthcare systems. *Medical Care*, 48(2), pg. 95–100. 10.1097/MLR.0b013e3181c12e6a [PubMed: 20057331]
- Lathrop B (2013). A systematic review comparing group prenatal care to traditional prenatal care. *Nursing for Women's Health*, 17(2), pg. 118–130. 10.1111/1751-486X.12020
- Lavoie JG, Wong ST, Chongo M, Browne AJ, MacLeod ML, & Ulrich C (2013). Group medical visits can deliver on patient-centred care objectives: results from a qualitative study. *BMC Health Services Research*, 13(1). 10.1186/1472-6963-13-155
- Lefkowitz B (2007). *Community Health Centers: A Movement and the People who Made it Happen*. Rutgers University Press.
- Maldonado M (2013). In The Safety Net: A Tale Of Ticking Clocks And Tricky Diagnoses. *Health Affairs*, 32(8), pg. 1501–1504. 10.1377/hlthaff.2013.0146 [PubMed: 23918493]
- Massey Z, Rising SS, & Ickovics J (2006). CenteringPregnancy group prenatal care: Promoting relationship-centered care. *Journal of Obstetric, Gynecologic, and Neonatal Nursing: JOGNN / NAACOG*, 35(2), pg. 286–294. 10.1111/j.1552-6909.2006.00040.x
- Millard AV, & Kingfisher CP (1998). "Milk Makes Me Sick but My Body Needs It": Conflict and Contradiction in the Establishment of Authoritative Knowledge. *Medical Anthropology Quarterly*, 12(4), pg. 447–466. 10.1525/maq.1998.12.4.447 [PubMed: 9884993]
- Movement for Black Lives. (2016). A Vision for Black Lives: Policy Demands for Black Power, Freedom, and Justice. Retrieved from <https://policy.m4bl.org>
- Noffsinger EB (2012). *The ABCs of Group Visits: An Implementation Manual For Your Practice* (2013 edition). New York: Springer.
- Novick G, Sadler LS, Kennedy HP, Cohen SS, Groce NE, & Knafl KA (2011). Women's Experience of Group Prenatal Care. *Qualitative Health Research*, 21(1), pg. 97–116. 10.1177/1049732310378655 [PubMed: 20693516]
- Polsky D, Richards M, Basseyn S, Wissoker D, Kenney GM, Zuckerman S, & Rhodes KV (2015). Appointment Availability after Increases in Medicaid Payments for Primary Care. *New England Journal of Medicine*, 372(6), pg. 537–545. 10.1056/NEJMsa1413299 [PubMed: 25607243]
- Popay J, & Williams G (1996). Public health research and lay knowledge. *Social Science & Medicine*, 42(5), pg. 759–768. [PubMed: 8685744]
- Potter DA, Markowitz LB, Smith SE, Rajack-Talley TA, D'Silva MU, Della LJ, ... Carthan Q (2016). Healthicization and Lay Knowledge About Eating Practices in Two African American Communities. *Qualitative Health Research*, 26(14), pg. 1961–1974. 10.1177/1049732315606683 [PubMed: 26443795]
- Prior L (2003). Belief, knowledge and expertise: the emergence of the lay expert in medical sociology. *Sociology of Health & Illness*, 25(3), pg. 41–57. 10.1111/1467-9566.00339 [PubMed: 14498929]
- Reed SC, Partridge AH, & Nekhlyudov L (2015). Shared Medical Appointments in Cancer Survivorship Care: A Review of the Literature. *Journal of Oncology Practice*, 11(1), pg. 6–11. 10.1200/JOP.2014.001411 [PubMed: 25424650]
- Rising SS (1998). Centering pregnancy. An interdisciplinary model of empowerment. *Journal of Nurse-Midwifery*, 43(1), pg. 46–54. [PubMed: 9489291]
- Sweet V (2012). *God's Hotel: A Doctor, a Hospital, and a Pilgrimage to the Heart of Medicine*. Penguin.
- Waitzkin H (1993). *The Politics of Medical Encounters: How Patients and Doctors Deal with Social Problems*. Yale University Press.

Table 1:

Demographics of Group Visit Staff Sample (N=28)

Characteristic	n (%)
Age, mean years (SD)	43 (SD 12)
Gender, n (%)	
Male	6 (22)
Female	22 (78)
Race/ethnicity, n (%)	
Asian	3 (11)
Black/African American/African	2 (7)
Hispanic/Latino	4 (14)
White/Caucasian	15 (54)
Multiracial or other	4 (14)
Primary role, n (%)	
MD	13 (46)
Manager or program coordinator	4 (14)
Health educator/group visit coordinator	4 (14)
Other licensed clinicians (nurse-practitioners, psychologists)	2 (7)
support staff (medical assistant, substance abuse counselor, promotora, AmeriCorps member)	5 (18)
Years of experience in Group Visits, n (%)	
<1 year	2 (7)
1–5Years	14 (50)
6–10 years	6 (21)
>10 years	6 (21)

Table 2:

Demographics of Group Visit Patient Sample (n=25)

Characteristic	n (%)
Age, mean years (SD)	58 (12)
Gender, n (%)	
Male	7 (28)
Female	18 (72)
Race/ethnicity, n (%)	
Black/African American	15 (60)
Hispanic/Latino	3 (12)
White/Caucasian	5 (20)
Other	2 (8)
Education, n (%)	
Less than high school	2 (8)
High school	7 (28)
Some college	9 (36)
Associate's or bachelor's degree	5 (25)
Self-reported chronic conditions, n (%)	
Diabetes	7 (28)
Chronic pain	18 (72)
Mental health condition (most common depression, PTSD)	10 (40)
Hypertension	7 (28)
3 or more chronic conditions (including conditions listed above)	12 (40)
Length of Participation in Group Visits, n (%)	
< 6 months	13 (52)
1–2 years	8 (32)
>2 years	4 (16)