Abstract

The experiences of men and women receiving primary care by attending Group Medical Visits are poorly understood. The purpose of this secondary analysis of nine in-depth interviews was to seek understanding of their experiences. The men and women in this analysis sought treatment for their chronic conditions by attending heterogeneous Group Medical Visits. A gender lens provided the necessary framework to move forward in seeking further understanding of why the men and women's experiences in this study were similar, rather than different. This study revealed six themes common to both the men and women: overcoming vulnerability and emotional isolation, connecting and creating community, reciprocal learning, increased feelings of safety, building relationship with the physician, and efficiency of time. It appears irrelevant that the audience was of mixed sex; what seemed to matter was the common link of living with a chronic condition and having someone truly understand the experience. Gender does not seem to make a distinction regarding the basic experiences shared by men and women of this age group, living with chronic conditions: the need to tell their story, and the satisfaction in and support received from telling one's illness story. A second finding was the leveling of the power structure between patients and providers, which is often inherent in traditional one-on-one physician-office appointments. The leveling of power created an increased trust between the client and physician leading to improved relationships and the creation of a safe environment to receive primary care. The men and women found the ability to express their illness story, especially to their physician and to an understanding audience of like individuals, to be very beneficial.
Preface

This is a secondary analysis of some of the patient interview data based on a larger project led by Drs. Sabrina Wong and Josée Lavoie and, the now CEO of Northern Health, Cathy Ulrich, examining the access and effectiveness of Group Medical Visits in the Northern Health Authority located in Northern British Columbia. The larger study is ongoing, jointly funded by Northern Health Authority and the Canadian Institutes for Health Research.

The UBC Research Ethics Board approval was received February 28, 2008. The certificate number is H08-00001.

No parts of this project have been published or are in the process of publication. All work in this document is the sole responsibility of the author.
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The Northern Health Authority, for their innovative and determined enthusiasm to improve the delivery of primary care to our residents, I thank you.
Chapter 1 Framing the Problem

Chronic conditions are a national concern and are now the leading cause of death in developed countries (Lindsay, 2009). Magnifying the impact of chronic conditions is the occurrence of chronic conditions as co-morbidities (CIHI, January 27, 2011, Gately, Rogers, & Sanders, 2007). The occurrence of two or more chronic conditions is associated with an increase in the use of healthcare services (CIHI, January 27, 2011), a decrease in quality of life (Gately et al.; Ohman, Soderbery, & Lundman, 2003), and a decrease in the client’s ability to self-manage his or her health (Gately et al.) For the purpose of this paper, the definition of chronic condition is an illness that is progressive, often permanent, long-standing, and usually without a cure (Ohman et al.). Examples of chronic conditions include diabetes, heart disease, arthritis, chronic pain, chronic depression, and asthma.

Chronic conditions are the result of an intricately woven web of determinants of health and risk factors. The management and prevention of chronic conditions lie in the principles of primary healthcare, which need to be woven into both the micro- and macro-levels of healthcare delivery. There is strong support in the literature suggesting that the only solution to both managing and preventing chronic conditions is to work in a collaborative, multi-disciplinary, inter-sectoral climate that promotes information sharing, uses available resources more effectively, and is patient and family-centered (Rich, 2005).

At the micro-level, there is a growing consensus in literature that family physicians, nurses, and other health professionals working as effective teams lead clients to experience improved health, improved access to services, improved use of resources, and improved satisfaction for both patients and providers. Effective, inter-collaborative teams are able to focus on health promotion to improve the management of chronic conditions (Kawasaki, Munter, Hyre, Hampton, DeSalvo, 2007; Rich, 2005; Safran, 2003). Patients perceive a
lack of material and human resources in the delivery of primary care, a main component of primary healthcare, as a barrier that often results in long waits for service, quantity of service, types of service, and a lack of community-based services and supports, resulting in dissatisfaction of the primary healthcare received. System reorganization toward service centralization would create an asymmetry with the patient’s need to have geographically accessible services provided by familiar, local providers (Gleason & Kneipp, 2004).

Past studies suggest less than half the population receives appropriate treatment for their chronic conditions (Wagner, Davis, Schaefer, Von Korff, & Austin, 1999) or has access to comprehensive primary healthcare services. Comprehensive primary healthcare is a “developmental process that emphasizes social justice, equity, community control and working for social changes that impact on health and wellbeing. In comprehensive primary healthcare, emphasis is placed on the conditions that generate health and ill health” (Wass, p. 12). A lack of access to these services makes it difficult for people with chronic conditions to maintain and or promote their health, despite advances in medical knowledge and improved treatments for major chronic conditions (Renders, et al., 2001). Literature suggests that most patients do not adhere to treatment plans and therefore have poorer health outcomes. Adherence by definition is the extent to which a person’s behavior is consistent with healthcare recommendations (Dunbar-Jacob & Mortimer-Stephens, 2001). In developed countries, approximately only fifty percent of persons follow prescribed treatment plans for managing chronic conditions (Dunbar-Jacob & Mortimer-Stephens; Todd & Ladon 1998). Dunbar-Jacob and Mortimer-Stephens suggest the cost of managing the consequences of poor medication adherence alone is close to $100 billion U.S annually.
The World Health Organization (WHO) suggests that one of the first steps healthcare providers can make to meet the needs of populations living with chronic conditions is to make better use of the resources already available. Utilizing available resources more effectively is a defining pillar of primary healthcare. Adopting a primary healthcare approach would place an emphasis on comprehensiveness of care and whole person health (Bodenheimer, Wagner, & Grumbach, 2002; Wagner, Austin, & Von Korff, 1996), which aims to inform and activate patients to become engaged participants versus passive recipients in their healthcare (Holman & Lorig, 2000). The Health Council of Canada (2009) states: “a team-based, multidisciplinary approach is the future look of healthcare delivery in this country” (p. 34). At present, the delivery of chronic disease management is in an episodic form of primary care, often through disease specific models.

Disease-specific models are frequently narrow in focus and fail to meet the broader needs of the population. Moreover, disease specific models, which are generally population focused, often remove the patient from the care of an individual primary care clinician (Moore & Showstack, 2003) and often focus on a single condition (Bromeling, 2005), rather than addressing all of the patient’s health issues. Consequently, many disease management interventions fail to incorporate effective behavior-change interventions, which would lead to improved self-efficacy and self-management (Todd & Ladon, 1998).

Examples of disease-specific models, such as “chronic illness management,” include systematic programs to manage diabetes, asthma, congestive heart failure, and depression. Bromeling (2005) suggests the importance of recognizing co-morbidity when planning and delivering chronic care services. Bromeling believes a model of care that addresses the whole person and integrates care for the person’s entire constellation of co-
morbidity is necessary for healthcare reform. Rothman and Wagner (2003) concur, suggesting

[a] Primary care practice team that organizes and coordinates patient care through a series of interactions during which they extract and review data concerning patient perspectives and other critical information about the course and management of the condition or conditions help patients set goals and solve problems for improved self-management, adjust therapy to optimize disease control, patient well-being, and ensure follow-up (p. 258).

System changes that lead to improvements in the process and outcomes of chronic disease care are similar for most conditions. To illustrate, consider care for diabetes and depression, two seemingly different conditions, which have been the subject of the largest volume of quality improvements research in primary care. A recent Cochrane Collaboration review (Renders, et al., 2001) examined 41 studies of interventions to improve diabetes performance in primary care. Most studies demonstrated some degree of hemoglobin A1C testing or the performance of retinal or foot examinations. A few studies showed significant improvements in disease control as reduced hemoglobin A1C levels, blood pressure, or lipid levels. The intervention that resulted in the largest positive changes tended to be complex and involved four areas: activities directed at changing clinician behavior, changes to the organization of practice, information systems enhancements, and educational or supportive programs aimed at patients (Rothman & Wagner, 2003). The most successful intervention addressed all four of these areas. The most improved patient clinical outcomes came with interventions that had a strong patient-oriented component. Interestingly, no one intervention on its own led to improvements in chronic disease care.
Callahan et al. (2006), studying the chronic condition of depression, conclude that effective guideline therapy requires an informed, motivated client, a healthcare team, and a redesign of the healthcare system by focusing attention on chronic conditions. The importance of patient educational and supportive interventions found in the Cochrane diabetes review is consistent with the growing body of literature demonstrating the positive effect of systematic efforts to increase patient knowledge, skills, and confidence in managing their personal experience of living with a condition (De Vries, 2008; Rothman & Wagner, 2003). For this process to occur, the need for multifaceted, interconnected changes to the organizations that provide primary care is required. At the primary care level, the delivery of care must include routine performance of the tasks that are critical to chronic disease management (Rothman & Wagner, 2003).

Rural Delivery of Healthcare

Utilization of primary healthcare services is an important determinant of health (Field & Briggs, 2001; Strasser, 2003). Unfortunately, persons living in rural areas have more barriers to access healthcare in comparison to persons living in urban centers. Approximately 20 percent of Canadians live in rural or remote Canada (Statistics Canada, 2009). Persons living in rural and remote Canada are often geographically isolated from urban healthcare services and within their own community experience the effects of limited healthcare infrastructure and professional healthcare providers (Public Health Agency, 2006; Harris, Wathen & Fear, 2006). Limited human health resources include all healthcare providers including, but not limited to, nurses, physiotherapists, physicians, and pharmacists. Interestingly, most research conducted on this broad topic has focused on the effect of the physician-patient ratio on clients’ health. In the report Geographic Distribution of Physicians in Canada: Beyond How Many and Where, the authors conclude
that rural Canadian communities, per capita, have fewer family physicians and even fewer specialists in comparison to their urban counterparts. Aside from geographic and physician ratios, other barriers are present that limit accessibility of healthcare to persons living in rural Canada.

In a systematic review of the literature, Spenceley (2005) identified tangible barriers to accessibility experienced by persons living in Canada with chronic conditions. An important finding was the relationship between the provider and the client, and the correlation on access to healthcare services. Spenceley established that when there is an imbalance in power, status, or knowledge between care provider and patient, it often results in the patient experiencing feelings of fear, helplessness, vulnerability, uncertainty, decreased confidence, and a perception that his or her own knowledge is not valued, relevant, or in any way sufficient (p. 476). These feelings of intimidation negatively affect the patient’s perceived ability to access primary care.

The present design of primary care delivery, including office hours, long waits, missed appointments, and the detachment between healthcare providers, is an inherent barrier to access care (Kawasaki et al., 2007; Sadur, 1999). A reorganization of the delivery of primary care is essential in order to provide an efficient, cost-effective system that can deliver the highest quality healthcare within available resources and to do so in a manner that serves clients attentively and respectfully, supports their participation, and gains their trust. Furthermore, patients with chronic conditions expect the primary care physician to be attentive not only to the medical needs of the patients, but also to the social and psychological needs specific to persons living with a chronic condition (Infante et al., 2004).
As the Canadian population continues to age, the healthcare system will likely continue to be plagued with multi-level problems in providing accessible, affordable, and acceptable healthcare to all Canadians. The accessibility to healthcare for persons with chronic conditions living in rural and remote areas of Canada, specifically persons living in Northern British Columbia, is of particular concern. Those living with one or multiple chronic conditions in rural and remote areas may have fewer options for accessing appropriate healthcare, particularly given documented health human resource shortages, lack of transportation, and geographic conditions (Harris, et al., 2006; Wong & Regan, 2009).

The WHO has listed several strategies, based on a review of best practice and affordable healthcare models. These strategies mirror the elements of the Chronic Care Model (CCM), which are integral components of the Group Medical Visit (GMV). The WHO suggests that strategies should include developing health policies and legislation to support comprehensive care; reorganizing healthcare finance to facilitate and support evidence-based care; coordinating care across conditions, healthcare providers, and settings; enhancing the flow of knowledge and information between patients and providers; developing evidence-based treatment plans and supporting their provision in various settings; educating and supporting patients to manage their own conditions as much as possible; helping patients to adhere to treatment through effective and widely available interventions; creating links across healthcare to other resources in the community; and monitoring and evaluating the quality of services and outcomes. These principles are similar to core principles which Showstack et al. (2003) outline in their discussion of primary care.
Statement of Problem

Part of the funding the Northern Health Authority (NHA) received from the Primary Health Care Transition Fund (PHCTF) allowed for several innovative initiatives. These include using chronic disease management toolkits, increasing capacity for using electronic medical records, and implementing 17 registered nurse primary healthcare coordinators throughout the NHA. These initiatives have laid the foundation for an increased focus on the delivery of quality primary healthcare. Although funding through the PHCTF is now complete, NHA continues to move forward in strengthening primary healthcare (PHC). One way in which NHA is trying to strengthen PHC is to increase access to primary care using the model of GMVs for persons with chronic conditions.

Conceptually, GMVs can be effective in diverse healthcare settings, including acute care, primary care, and community care (Noffsinger, 1999). Theoretically, group medical visits are promising. Conceptually, properly run GMVs should increase effective utilization of available resources, improve obtainment of clinical practice guidelines, and incorporate preventative screening. Data supporting the outcomes of increasing patient satisfaction and comprehensiveness of care and access have been main themes throughout the small body of international literature, but there is an absence of Canadian literature studying GMVs.

Furthermore, there is an absence exploring the patient's experience of receiving primary care in a group format in the literature. There is no understanding of why patients enjoy the delivery of primary care in a group format, of whether there are differences or similarities according to gender, or of what changes could be made to improve GMVs according to the patient's perspective. Consequently, there is no knowledge regarding gender preferences pertaining to GMVs. Building knowledge around the questions of why
clients attend GMVs and whether there is a difference between how male and female clients perceive GMVs is unexplored.

In this secondary analysis, I am interested in exploring clients’ experiences, from a gendered perspective, of receiving primary care within a GMV model. This secondary analysis is based on data collected as part of a larger project examining the access and effectiveness of group medical visits led by Drs. Sabrina Wong and Josée Lavoie and, the now CEO of Northern Health, Cathy Ulrich. The larger study was jointly funded by Northern Health Authority and the Canadian Institutes for Health Research.

**Personal Experience with GMVs**

My personal experience as a primary healthcare coordinator (PHCC) in the Northern Health Authority (NHA) implementing GMVs is a motivating factor in this study. Accessibility was one impetus for the Northern Health Authority’s decision to implement GMVs. The theory behind GMVs is to bring healthcare to the population in an affordable and acceptable approach. Keys to the success of GMVs have been a collaborative team approach and the sharing of participant information as well as the support received from all levels of management within the Northern Health Authority. The core team is composed of a variety of health and healthcare related professionals with the understanding that the entire team would never be present at one GMV. To ensure efficient utilization of human resources, appropriate team members are designated specific roles that compliment their expertise. Team members also take on a more expanded role, relieving some of the pressures from the primary care physician.

As the PHCC, my role was to orchestrate the GMV, spending long hours working with the physicians, medical office assistants (MOAs), diabetic nurse educator, and other allied health personnel. Each person’s role was defined. Preventative screening became
apart of the process. As a PHCC, I witnessed principles of primary healthcare being implemented, and I felt a part of an integral team that was working together to improve the health of our community. From exit questionnaires, it was evident that the clients also responded favorably to the concept of GMVs.

The idea of having 15 to 20 clients sitting in a semi-circle, facing their primary care physician and sharing their health history was a foreign concept to all involved. Yet, clients did not seem concerned to share and were keen to tell their stories of success or to provide words of encouragement to others when necessary. Upon arrival to the GMV each participant signed a confidentiality form and had the opportunity to anonymously write out a question, which was then written out on a whiteboard. Each participant chose where he or she wanted to sit.

A member of the PHC team would lead the first 30 minutes of the GMV. The specific member may have been the dietician, the physiotherapist, the pharmacist, the diabetic nurse educator, or someone from the community who had specific information regarding health and health promotion programs/activities in the community. Participants were free to ask questions of the presenter. This was followed by the medical component of the GMV.

The physician, the MOA, and the facilitator of the GMV sat at the front of the semi-circle facing the clients. The physician then began the medical visit with one client at a time. With consent, client laboratory results were explained and analyzed. Client-specific concerns were addressed and the other GMV participants sat and listened. It was not uncommon for one client to share a concern and other participants to express similar concerns. The physician then addressed these questions, and discussion among all
participants ensued. The physician prescribed the necessary prescriptions, referrals, or requisitions for each participant. Each client had "individual" one-on-one time with the physician within the context of the group.

Simultaneously, while the team member presented and during the medical visit, individuals would be asked to join the PHCC in a private room next to the group. Here, all clients had their blood pressure and weight taken at every GMV. Seasonal flu vaccinations were offered, and disease specific interventions were performed according to best practice guidelines, including the diabetic foot assessment and depression screening. Furthermore, client-specific interventions were also performed to prevent the client from having to make an individual physician's appointment for, for example, a monthly vitamin B12 injection.

The dedication, teamwork, and trust in the team's abilities are integral components of successful GMVs. From personal experience, I observed that all team members found the GMVs satisfying and efficient. After each GMV, and based on the GMV exit surveys, the team reflected on the strengths and areas of improvement. What the surveys failed to elicit was the deeper level of insight from the participant's perspective. This insight, was not only missing from the GMVs being implemented in the NHA, but also from the body of literature I was using as a resource to improving the delivery of GMVs.

**Purpose of Study**

The purpose of this study was to gain understanding and insight from the client’s perspective regarding primary care delivered in a group setting. Specifically the study examined why men and women attend GMVs and what their experience was in receiving primary healthcare within a group delivery model. The specific research questions were:

A) How do men and women feel in regards to receiving primary healthcare in a group medical visit (GMV)?
B) What are the experiences of men and women participating in-group medical visits?

Theoretical Framework

Guiding the framework that British Columbia is using for the renewal of primary healthcare in the province are over-arching goals of the provincial government that are inclusive of all aspects of the healthcare system. The goals of the provincial government’s healthcare restructuring include high quality patient-centered care, improved health and wellness, and the creation of a sustainable, affordable healthcare system.

The theoretical framework guiding chronic disease management in British Columbia has roots dating back to the early 1990s. At this time, it did not incorporate the elements of health promotion or disease prevention. With the addition of these two elements, the “Expanded Chronic Care Model” was born. The literature on BC’s Expanded Chronic Care Model (ECCM) is sparse. An understanding of the Chronic Care Model is important to further the understanding of the system change that the Northern Health Authority is initiating in the implementation of Group Medical Visits.

Chronic care model.

The Chronic Care Model (CCM) was born with the recognition that patients with complex chronic conditions were receiving episodic care from their primary care physicians. The CCM model is conceptually able to adapt to various chronic illnesses, healthcare delivery settings, and target populations. The goals of the model are to achieve better health outcomes for patients, increase work satisfaction for providers, and improve expenditure and utilization of resources. Accomplishment of these goals depends upon informing the patient, whereby they become an active player and part of the proactive team approach to primary patient care.
The CCM is tripartite collaboration between the community, healthcare resources, and the patient. It is an intelligent and pragmatic approach to restructuring the healthcare delivery system (Gask, 2004). Part of the success has been the support and leadership from both managers of the institutions and the deliverers of care, where both were committed to change. However, a real barrier to the implementation of the CCM is the organizations where healthcare is delivered (Renders et al., 2001).

The CCM has been pivotal in the United States in the management of various chronic conditions including diabetes, asthma, depression, and heart disease (Gask, 2004). In a meta-analysis of interventions to improve chronic illness care, Tsai (2005) concludes that interventions containing at least one element from the CCM improve patient clinical outcomes and care delivery (p. 478).

The CCM addresses changing healthcare systems to respond to the client over the disease trajectory as opposed to a reactive response to an acute episode. The client becomes an active, informed, and empowered participant in his or her health. The strength of the CCM is the focus on the communication, education, building confidence, and self-efficacy of the client, family, and practice team. The authors of the CCM suggest that, by giving patients a central role in determining their own care, providers and clients work together to solve problems and establish goals that foster the clients’ sense of responsibility for their own health.

The principle of self-efficacy, a central concept suggested in the CCM, recognizes the transformation of power to others by allowing clients to plan and set achievable, meaningful goals. The CCM identifies six essential elements required for the success of a system change. These elements include the healthcare organization, community resources,
policies, self-management support, decision support, delivery system design, and clinical information systems. A more detailed description of each of the elements is contained in Appendix A.

Research pertaining to the CCM supports the effectiveness of the pragmatic approach to health management. Siminerio, Piatt, and Zgibor (2005) conclude that the integrated multi-faceted approach, which the CCM offers, is effective in the management and improvement of diabetes care. Siminerio, Zgibor and Solano (2004), in their research on the implementation of the CCM, found significant improvement not only in provider practices, such as ordering patient A1Cs, but also in patient clinical outcomes, such as A1Cs, lipid management, and blood pressure.

**Linking GMVs and the Chronic Care Model**

The six elements that create the foundation of the chronic care model, which guide the GMVs, closely parallel the pillars of primary healthcare. A reflection of the mirroring of the elements of the chronic care model and the pillars of primary healthcare is visible in the group medical appointments (GMV). The GMVs operate at a micro-level of primary healthcare within the Chronic Care Model (CCM). Following is a simple overview of how the threads of GMVs, CCM, and PHC are woven together to improve affordability, acceptability, and accessibility of primary healthcare in the Northern Health Authority.

Emerging in the literature is the importance of evidence-informed decisions. The electronic medical record system allows for the tracking of improvements, recalls, and population trends. Integral to the GMVs is the inputting of data into the chronic disease management toolkit (CDMT). The CDMT is an electronic medical record system that the Province of British Columbia developed for family physicians to assist in the management of patients with chronic conditions. Primary healthcare’s principle of effective utilization of
available technology is parallel with CCM’s element of implementation of a clinical information system. Though the principles of primary healthcare are targeted at large populations, the CCM breaks this large principle down into a tangible and manageable concept. The GMVs are a physical representation of utilization of available technology. The physicians using GMVs in the Northern Health Authority have input their patient data into the CDM Toolkit. This electronic data system allows them to identify disease-specific populations within their individual practices, recall patients based on best practice guidelines, and monitor clinical outcomes. Furthermore, GMVs have allowed physicians the opportunity to assess the whole patient and make referrals to specialists for complex cases.

**Linking GMVs and the Principles of Primary Healthcare**

**Acceptable and appropriate use of technology.**

Threads of the principles of primary healthcare are woven throughout group medical visits. Primary healthcare is operationalized by five principles that arise from the definition. The first principle is acceptable and appropriate use of technology. This primary healthcare principle demonstrates the effectiveness of appropriate methods and technologies in addressing known health challenges in a manner that is acceptable to clients (Alma-Ata, 1978). Presently, the implementation of the group medical visits in the Northern Health Authority ensures this principle by practicing best practice guidelines during the visits and by inputting data into the Chronic Disease Management Toolkit, an electronic record of physicians, patients, and their primary care interventions, laboratory results, medications, and goals. Other technologies can support information sharing among providers so that Canadians need not repeat their health histories or undergo the same tests for every healthcare professional they see. Communication through technology is able to
reconfigure the barriers of distance and time for both providers and consumers of healthcare.

**Essential healthcare.**

Essential healthcare, the second principle of primary healthcare, encompasses promotion, prevention, and curative, supportive, and rehabilitative concepts (Alma-Ata, 1978). Group medical visits have the potential to address each concept depending on the mix of the participants attending a specific group visit. For example, a GMV focused on patients with diabetes, would have multiple dimensions of health promotion, prevention of complications from diabetes, a supportive group environment, and potentially rehabilitative components depending on participant needs. These concepts are an important component of both primary healthcare and the collaborative group visits. Keeping persons at their optimal level of health with their condition and preventing further complications and new disease processes is important for both the individual and his or her community. Healthy community members are productive community members.

**Universal accessibility.**

Universal accessibility is the third principle of primary healthcare. This implies that healthcare be geographically, financially, and culturally accessible to all citizens for this proposed study, specifically residents in the Northern Health Authority. Accessibility to healthcare is a concern for residents who live in Northern rural communities. Geography is often cited as a barrier to physical healthcare resources and healthcare professionals (Spenceley, 2005).

Persons living in Northern communities often have to drive long distances, often in poor weather conditions, to seek healthcare. In the present system of non-collaborative delivery, some patients have to make frequent trips for complete healthcare. The maze
through which patients are required to seek healthcare is both complicated and system centered, rather than patient centered. For example, a patient may visit the doctor and be asked to return the following day for laboratory work requiring the patient to fast. The patient then returns to the doctor’s office a second time to discuss the results. If a specialist visit is required, the patient living in a Northern BC community will have to wait weeks or months. A return trip is always required to see the specialists, dieticians, possibly a disease-specific nurse educator, and then eventually the doctor for follow-up assessment.

The GMV model decreases the number of trips to the primary care physician’s office. Required laboratory requisitions are sent to the patient in the mail with instructions; the results are sent to the physician’s office where he or she assesses them before the group medical visit; the patient then attends the GMV, where a team of healthcare providers are there to meet the needs of the participants.

For example, if the GMV focuses on diabetes care, the team may well consist of the diabetes nurse educator, a dietician, a pharmacist, and the physician. The patient has the opportunity to have personal health questions answered and to listen to other participants’ questions and the corresponding answers. Furthermore, care plans are updated according to need, lab results are explained, and education is provided, which leads to an informed and activated patient. Prevention and promotion are integrated with Two Question Screening for depression and diabetic foot analysis; and, if required, pap smears are requisitioned.

**Inter-sectoral collaboration.**

Inter-sectoral collaboration is the last pillar principle of primary healthcare. Directly within the group visit model, inter-sectoral collaboration is evident. The primary healthcare delivery team is composed of dieticians, mental health workers, public health
nurses, physiotherapists, laboratory technicians, medical office assistants, pharmacists, nurses, and physicians. The participants’ support persons are encouraged to attend the group medical appointments and to learn about the disease process and how best to provide support to their family members. The key feature of primary healthcare reform is a shift to teams of providers who are accountable for providing comprehensive services to their clients. Team goals should include working towards improved health outcomes for the patient and a more cohesive and comprehensive level of primary care.

**Significance of Research**

Comprehensiveness of care and provider satisfaction are important outcomes of group visits. It is well documented that an informed, activated patient is much more successful in obtaining positive clinical outcomes and quality of life. This study will explore the patient experiences of receiving primary care within the GMV model. A large pillar of primary healthcare is disease prevention and health promotion. In the present medical model of primary care, there is limited time available to discuss either disease prevention or health promotion.

Possibly the most important contribution this study will make is in understanding the GMV model from the perspective of men and women living in rural British Columbia. It is important to determine whether the GMV model of primary care delivery is preferred by the men and women who chose to attend GMVs for their primary health care and to assess their feelings towards receiving care in the GMV model before further time and money are invested. This knowledge is invaluable to primary care providers and the NHA in making gender-sensitive decisions regarding the continued use of GMVs to manage chronic disease, improve health outcomes, and address health promotion and disease prevention.
Chapter 2 Review of the Literature

For the purpose of this chapter, I selected literature that focused on the delivery of primary care in a group setting. Due to the small body of knowledge regarding GMVs, there were no age, gender, ethnic, or timelines excluded from the search. Group visits that did not have a medical component, however, were excluded from the literature review. The history and structure of the GMV will first be presented, followed by an overview of the four models of GMVs found in the current literature. Next, the themes that emerged in the literature supporting the concept of GMVs will be addressed. Lastly, gaps in the literature and implications on this research will conclude this chapter.

The electronic databases CINAHL, Academic Search Premier, Cochrane Systematic Reviews, Medline, Journals at Ovid, and PUBMED were searched using the key words *group visits*, *group medical appointments*, *DIGMA*, *cluster visits*, *patients/clients feelings attending group visits*, *patients/clients feelings attending group medical appointments*, *SMAs*, *patients/clients feelings attending DIGMAs and patient/clients feelings attending cluster visits*. Following is a review of the key literature.

History and Structure of the GMV

The GMV model has emerged as a potential solution for effective management of chronic conditions within the existing system of healthcare. Originally conceived in 1974 as a model for well-child consultations, group visits are recently emerging as new models of practicing family medicine (Jaber, Braksmajer, & Trilling, 2006; McLaren, 2008). Regarding the structure of the GMV, comprehensiveness of care provided to the client and collaboration among health care providers are frequent themes in the literature. Information sharing and team building are central components of effective GMVs. These workings of the GMV and their role in increasing accessibility correlate with the chronic care model of...
delivery system redesign, where the focus is on building care teams, expanding scopes of practice, building relationships, and expanding the focus of care to include pre-visit, visit, and post-visit follow up. Implementing systems to support decision support, self-management education, and delivery system redesign has a positive influence on practices and patient outcomes in outlying rural communities (Siminerio et al., 2005).

Current research supports the proponents of team-based care and suggests collaborative teams are critical to improving client health outcomes (Showstack et al. 2003; Siminerio et al., 2004). GMVs openly demonstrate team qualities, such as collaboration and cooperation between primary care providers. Rothman and Wagner (2003) reiterate the importance of the function of the team in the role of chronic condition management, stating the most successful chronic condition interventions include major roles for allied healthcare providers. Beck et al. (1997) suggest that when patients witness a collaborative working relationship between the primary care physician and the primary care team, patients will transfer their confidence from physician to team members. This transfer of confidence relieves physicians from tasks other team members are capable of performing and allows the physician more time focusing on the patient as a holistic person (De Vries, Darling-Fisher, Thomas, & Belanger-Shugart, 2008). This inter-collaborative approach has also been noted to improve the patient's perception of accessibility to primary care (Beck et al. 1997).

Group medical visits have the traditional one-on-one physician-client exchange, but within a group setting. The group may have as few as 6 clients or as many as 20, who usually have similar health care needs. Simultaneously, the group receives health care from a primary care provider and an inter collaborative team. GMVs are different from a
traditional one-on-one office visit, because health education, health promotion, self-management, and skill-building components are integrated into the session, which lasts from ninety minutes to 2 hours. The extended time allows for a greater number of questions and health concerns to be raised and thoroughly addressed (Campbell, 2009).

Though there is an educational component, GMVs differ from health classes or support groups because of the medical component. There are four models of GMVs in the literature. Depending on the condition or focus of the GMV, the medical component may take place at check-in, during the GMV, or with clients individually at the conclusion of the GMV. If a client requires a complete physical examination, this would occur privately, in a one-on-one encounter, usually while an allied health professional is presenting on health topics to the group. From the literature, GMVs have been used successfully to provide primary care in the following client populations: diabetes, hypertension, asthma, arthritis, bariatric surgery, women’s health care, oncology, chronic pain, fibromyalgia, cardiac care, and most recently, men’s health care. Following is a description of the four models of GMVs found in the current literature.

**Four Models of Group Medical Visits**

**The cooperative healthcare clinic model.**

The CHCC model is designed to provide adequate time to deliver the quality of care that all physicians know they should deliver. It was first developed to meet the needs of high healthcare using patients over the age of 65. The main objective of the CHCC model is to facilitate self-management of patients’ chronic condition(s) through enhanced education, encouragement of self-care, peer and professional support, and attention to the psychosocial aspects of living with chronic disease (Coleman et al., 2001). The therapeutic benefit of the group dynamic includes improved physician (Beck et al., 1997; Levine, Ross,
Balderson, & Phelan, 2010) and patient satisfaction (Beck et al.; Campbell & Gosselin, 2007; Coleman, Grothaus, Sandhu & Wagner, 1999; Jaber et al., 2006; Levine, et al., 2010; Scott, 2004), improved patient outcomes (Trento et al., 2001), reduced utilization of the emergency department (Colemann et al., 2001), improved patient education (Campbell & Gosselin), and sustained physiological benefits including glycemic and blood pressure control and overall quality of well being (Piatt et al. 2010).

In the CHCC model, the group medical visit is organized around a ninety-minute time slot. Group time is structured and includes set intervals of socializing, education, and the medical portion. The medical portion may include an overview of the patients’ medications, laboratory results, immunization, or any other primary care need the patients may have (Noffsinger & Scott, 2000). Specific to the CHCC model, is regular scheduled visits with the same group cohort over extended periods of time.

**Specialty cooperative healthcare clinic.**

The Specialty Cooperative Healthcare Clinic Model is similar to the regular CHCC model, but focuses on a specific disease. This disease-focused model is effective in assisting patients and care providers to follow clinical-based practice guidelines; however, recent literature suggests that delivering chronic disease management in a disease-specific framework is ineffective.

**Drop-in-group medical appointment.**

The drop-in group medical appointment model (DIGMA) was created in 1996 to improve access to care and enable physicians to better manage their large patient panels by seeing more patients in the same amount of time, while increasing patient and physicians’ professional satisfaction as well as improving access to care, level of service, and quality of care (Noffsinger & Scott, 2000). DIGMAs are customized to the needs, goals, practice
style, and patient panel constituency of the individual physician (Noffsinger & Scott). DIGMAs have demonstrated positive results in a variety of specialties, especially oncology, rheumatology, and neurology (Noffsinger, 1999). DIGMAs can be designed as heterogeneous, mixed, or homogeneous; typically, they are heterogeneous in terms of age, sex, diagnosis, marital status, race, and utilization behavior.

In a heterogeneous DIGMA, patients with any diagnosis can attend the group session, and patients may vary by age and sex. In the mixed DIGMA model, the physician will choose a different health concern or disease each week, and the clients attending will vary according to the topic. As an example, the physician may choose to hold a DIGMA around chronic pain one week, and the following week focus on hypertension and diet. Different patients may attend their physician’s DIGMA depending on their questions, needs, or diagnosis (Noffsinger, 1999). DIGMAs combine an extended medical appointment with the patient’s own physician and an effective support group consisting of the physician, a behavioral health professional, and other patients from the physician’s panel (Noffsinger, 1999). Noffsinger (1999) states, “DIGMAs provide better access, high-quality healthcare in which both mind and body needs [of patients] are addressed,” leading to highly satisfied clients and physicians.

**Physicals shared medical appointment.**

The fourth model of the GMV is the Physicals Shared Medical Appointment (PSMA). The PSMA was conceived by Noffsinger in 2003 as an effective and efficient method for physicians and specialists to increase their efficiency at providing physical examinations. Noffsinger felt the majority of time spent performing a physical examination was devoted to answering questions and exchanging information. In the PSMA, physical examinations are provided privately, but have a group component whereby an interactive
group discussion answers patient questions and provides patients with information. The most popular PSMAs are regularly scheduled and last ninety minutes. Two weeks prior to the session, patients receive an information package that includes history forms, laboratory requisitions, screening tests, and handouts. Patients complete the required procedures before the PSMA. Individual examinations occur during the first thirty to forty-five minutes of the session, with the remaining time reserved for group discussion. Questions that do not lend themselves to group discussion can be addressed during a private examination. Most PSMA are homogenous regarding age and sex.

Research Supporting GMVs

**Improved patient satisfaction.**

Slowly, research focusing on GMV models is emerging in the literature. In a quantitative literature review of research from 1974 to 2005 on group visits, Jaber et al. (2006) found only 33 articles on this form of primary care delivery. Ten of the eighteen studies were conducted after 2000. However, even with the paucity of available literature regarding GMVs common themes emerge. One consistent theme threaded throughout the literature is improved patient satisfaction. Patient satisfaction scores are consistently higher in the research that has studied satisfaction as an outcome concerning patients attending GMVs in comparison to the control group of patients who attend regular physician-patient visits (Beck et al., 1997; Coleman et al., 1999; Jaber et al., 2006; Scott, 2004; Trento et al., 2001). Scott (2004) found that patient satisfaction scores, 24 months post-study, continued to be significantly higher in comparison to the control group. The literature reports evidence of a correlation between patient satisfaction with primary care and patients’ improved perception of access to healthcare (Beck et al., 1997; Fitzpatrick, 2004) and clinical outcomes (Alazri, 2003; Harris, Lufe, Rudy & Tierney, 1995; Meng, 2004).
Furthermore, in a five-year follow-up of GMV participants, Trento et al. (2004) found patients who were in the group cohort had markedly increased problem-solving abilities and were able to identify potential problems and possible solutions. Interestingly, literature suggests that patients who experience high satisfaction with the level of primary care they receive are also more motivated in self-managing and following their treatment plan (Glasgow et al., 2001). Adherence to health treatment plans translates into improving patient outcomes and patient well-being (Franciosi, 2004; Ho et al., 2006, Todd & Ladon, 1998). Of the two studies that looked at provider satisfaction with delivering primary care in a GMV, both stated that an improved satisfaction among the primary care providers was noted (De Vries et al., 2008).

**Comprehensive care.**

A second theme to emerge from the literature was the level of comprehensive care physicians’ felt they were able to provide. Comprehensive care of patients was discussed in several of the articles (Campbell & Gosselin, 2007; Clancy, 2007; Clancy, Brown et al., 2003; Scott, 2004; Trento et al., 2001; Wagner, 2001). Examples of comprehensive care mentioned in the studies include preventative maneuvers, increased ability to review medication, testing and recording of micro albumin, and increased patient knowledge concerning diabetes. Clancy, Cope, et al. (2003) in their study saw an improvement in 10 American Diabetes Association indicators of care. Clancy (2007), in a randomized control trial of GMVs, concluded there was a greater level of patient adherence to the American Diabetes Association guidelines among patients in the GMVs in comparison to the control group. Renders et al. (2001) and colleagues suggest that compliance with diabetes clinical practice recommendations is inadequate in primary care, and that a large number of persons with diabetes remain at high risk. Clancy (2007) also reported that women who attended
GMVs were more likely to meet practice guidelines for PAP smears and screening mammograms.

**Efficient and effective.**

The theme of GMVs having the potential to be efficient, clinically effective, and cost effective is another threaded theme throughout the literature. Researchers have found improved outcomes for group visit participants, including reduced use of nursing facilities, shorter inpatient stays, reduced ambulance use, fewer emergency department visits, fewer visits to sub-specialists, and fewer repeat hospital admissions. Compared to patients receiving traditional primary care, group medical visit patients were also more likely to receive influenza and pneumonia vaccinations. In addition, GMVs can help improve physician and clinic productivity, aid with patient compliance, and help physicians with diagnoses and treatment. The efficiency of the group process in conveying information while avoiding repetition leaves the patients and the physicians feeling that the time was well spent, which may contribute to the increased patient and physician satisfaction (Beck et al, 1997). Physicians, in a study conducted by Abram (2007), expressed the increased efficiency of the GMV. Because patients arrived at the same time for a group appointment, there was less impact on their clinic due to late arrivals and no shows, allowing for scheduling to be more efficient and streamlined. In this same study, physicians saved on average four minutes per patient in comparison to the regular physician-client appointment. In the course of a day, four minutes per client can amount to freeing up an hour in clinic time per day, or five hours in one week. Physicians also noted the favourable aspect of teachings given only once to the group, which reduces redundancy and allows patient-specific information to be given to the individual. Furthermore, some studies report improved clinical outcomes, including improved A1C and high-density lipoprotein
cholesterol levels (Siminerio et al., 2005; Trento et al., 2001) and sustained clinical improvements and quality of well being (Piatt et al., 2010).

GMVs can provide emotional support and reduce the stigma and stress of illness as patients share coping strategies and experiences and learn from others in the group. Peer learning can be an important tool for improving treatment compliance and clinical outcomes for patients (Scott, 2004). Patients report greater satisfaction with the quality of care and improved relationships with their providers; moreover, patients report feeling better able to cope. Research also suggests participants in GMVs show evidence of improved self-management skills and functionality as well as the perception of improved quality of life (Piatt et al. 2010; Trento, et al., 2001). GMVs may also improve quality of care by providing more frequent follow up and by allowing time during the visit to focus on psychosocial needs, that is aiding patients experiencing depression, anxiety, or distress related to their health, which is an important component of what patients desire from their primary care team (Infante, et al., 2004).

Campbell (2009) in a follow-up study of 241 men who attended a men's health focused GMV revealed that 95% of the participants stated they would choose the GMV for their next annual visit. Further findings revealed that satisfaction derived from the strong educational component, increased knowledge regarding men's health from other participant's questions, and increased knowledge regarding medical information that participants felt they would not have received in a traditional physician-patient appointment. In this same follow-up study, Campbell states the extended period of time the primary care provider spends with the client is an important factor in the GMV. He states that the men consistently reported the extended time with the primary care provider
allowed questions to be asked and addressed, leading to an increased knowledge of men's health issues.

**Relationship building.**

A fourth theme woven throughout the literature is the opportunity to build relationships with the primary care providers. The GMV provides a delivery of healthcare whereby the relationship between the primary care team and the patient is core to the success. Wellington (2001) states, “Group visits allow conversations, which compose the basis of any relationship” (p. 12). Building of trust-enhancing relationships, which lead to partnerships and shared decision making regarding healthcare treatment plans, is fundamental in effective chronic disease management (Moore & Showstack, 2003). The physician, in his role within the GMV, is able to engage with the group of clients from 90 minutes to 2 hours (Campbell & Gosselin, 2007) in comparison to a 15-20 minute one-on-one regular office visit. One reason cited for improved satisfaction with GMVs over the traditional one-on-one physician-client appointment is having more time with the primary care providers in a more relaxed environment (Beck et al, 1997).

In a study examining the relationship between physician practice style and patient satisfaction, Flocke, Miller and Crabtree (2002) found patients who had a physician who was ‘person focused’ had perceived higher levels of quality care. Person-focused physicians are described as those who are more focused on the person than on the disease, perceived as personable and friendly, open to the patient’s agenda, and who frequently negotiate options with the patient.
Limitations of Group Medical Visits

Conceptually, GMVs have a lot to offer in the management of chronic conditions. Due to the minimal amount of research completed to date, there may be some limitations due to insufficient qualitative and quantitative data supporting or not supporting this model of primary care delivery. In today’s evidence-based practice environment, and with the need for accountability, research into the effectiveness and sustainability of GMVs is essential.

Management at all levels must have an understanding and be supportive of the system change that is required for proper implementation of the chronic care model which umbrellas the GMVs. Appropriate policy development is required to assist and encourage multi-faceted interdisciplinary teams to work cooperatively and collaboratively. Policies would aid in removing the present silo structure delivery of primary care. Removing this system barrier to support effective delivery of primary care will assist in promoting an integrated and collaborative primary care team with the patient as the focus.

Furthermore, many physicians have not worked as part of a team in the delivery of primary care (Health Council of Canada, 2005; Rothman & Wagner, 2003; Safran, 2003) and would require teaching and mentoring to feel comfortable with this new delivery of primary care. Medical school curriculum also requires components of the physician's role in interdisciplinary teams (Health Council of Canada).

Another limitation of the GMV model is the need for implementing patient self-management. This concept emerges as an integral component of effective chronic disease management, and there appears to be an association with effective delivery of GMVs. Nevertheless, there is inconsistent documentation in the research of the groups studied that had self-management education knowledge. This knowledge and ability to facilitate
change appears to be vital and an area that requires expansion, regarding teaching the providers of GMVs how to provide self-management education to clients.

Administrative limitations to implementing the GMVs are also apparent. The organization of a GMV model is time intensive and requires a point of contact in the office that will be advertising the program, registering the patients, keeping schedules, sending reminders, and pulling charts (Jaber, Braksmajer, & Trilling, 2006a). Moreover, policies and guidelines for physician reimbursement for those who practice GMVs in Canada are required, as well as provisions and incentives for preventive care, self-management counseling, and follow-up contacts.

**Gaps in the Literature**

The first identified gap is lack of structure and clearly defined characteristics of effective GMVs. Evidence supporting the concept of improved clinical outcomes correlating with patient satisfaction of GMVs is inconsistent in the available literature; however, several hypothetical explanations can account for the inconsistency. Weingarten et al. (2002) explain, “It is ironic that disease management programs are designed to reduce unexplained variations in care, yet there are large and unexplained variations in the design, development, and implementation of disease management programs” (p. 6). Factors may include the delivery of the GMV, which includes, but is not limited to, the expertise of the providers and follow-up care. In addition, the studies may not have measured patient satisfaction, or may have been misaligned with patient value systems. Disease-management program developers have limited qualitative or quantitative information about which interventions achieve the greatest benefits; therefore, programs vary greatly in design.

There is a clear difference between the DIGMA and the CHCC models; however, even when using the same model, providers deliver GMVs differently. For instance, in a
1997 study by Beck et al., in which the CHCC was evaluated, an individual physician appointment occurred only as needed. In comparison, Clancy, Brown et al. (2003), who used the CHCC model, included an individual physician appointment with every GMV. Inconsistencies in the delivery of the GMV make evaluation and comparison meaningless. Noffsinger, the originator of the DIGMA model, contends that if the GMVs are not implemented properly with the right people, in the right place, then the only thing being measured is the inconsistencies in the delivery of the GMVs (personal communication, October 3, 2006).

A second gap in the literature is a Canadian perspective. The majority of research on GMVs is based on work conducted in the United States. Both the healthcare systems and the philosophy, which the GMVs are being provided under in the United States, are different from the GMVs in Northern British Columbia, Canada. GMVs are being used in the United States to improve practice revenue, whereas in Canada, particularly Northern British Columbia, GMVs are being implemented to improve accessibility to healthcare with the overall goal of improving population health. Canadian content is necessary to assess the fit of GMVs with the paradigm of primary healthcare and the value system of the population being served.

Moreover, most of the studies on GMVs conducted in the United States have been in health maintenance organizational structures of healthcare delivery. Healthcare delivery in British Columbia is provided through 5 health authorities and 16 service delivery areas. The BC Ministry of Health works together with BC’s health authorities to provide quality, appropriate, and timely health services to British Columbians. The ministry sets province-
wide goals, standards, and performance agreements for health service delivery with the health authorities.

Data are limited in determining the long-term outcomes of group medical visits. More baseline data is required to quantify and evaluate the benefits of GMVs in relation to feasibility, efficiency, clinical effectiveness, and implementation, as well as to determine how patients perceive receiving care in a group medical setting. Additionally, in the present literature, there is inconclusive evidence that GMVs consistently improve patient clinical outcomes consistently. For example, in a randomized control study with type two diabetic patients, Trento et al. (2001) found that patients participating in group visits were able to achieve stable HbA1C and serum urea nitrogen levels, whereas, Clancy, Cope et al. (2003) in their randomized control trial on diabetic patients, found no differences between their study groups in either lipid profiles or HbA1C. Wagner et al. (2001) also reported no significant differences in HbA1C or cholesterol between their diabetic control group and their study group. These inconsistencies may reflect differences in the models used, variations in the quality of the GMV, and/or type of expertise of the providers of the GMV.

Cultural acceptability is another identified gap in the literature that is of critical importance to the implementation of GMVs. The population in the Northern Health Authority is almost 16% Aboriginal (BC Stats, 2005). Before generalizations from this study can be made to this population, it will be most important to understand their values and beliefs in general, but also specifically on health and disease. It will also be important to form relationships and to integrate their beliefs and health traditions into the group medical visit model of primary care delivery. The delivery of information must be
presented in a language-appropriate and culturally acceptable manner to build trusting relationships that will assist in facilitating access to healthcare.

A further gap in the existing research is the study of GMVs in rural Canada. Studies relating to chronic disease management have primarily been set in urban settings. It is reasonable to question the ethics and effectiveness of this juxtaposition of urban research onto rural Canadian communities. Clearly, a need for specific research into the development of rural health prevention and promotion programs is necessary (Public Health Agency of Canada, 2006).

Gender specific studies concerning GMVs are another identified gap in the literature. Within the available literature, there was one male-only study conducted using the GMV delivery of primary care and no female-only studies. The focus of the male-only study was the educational component of the GMV. The researcher's goal of the study was to identify whether the GMV was superior to the traditional one-on-one physician-client visit, regarding retention of health information, follow-through with recommended health screening practices, and overall improved health related decisions by the patient (Campbell & Gosselin, 2007). Gender norms are constructed differently according to the setting. This is important in trying to understand experiences of the men and women who attend heterogeneous GMVs.

Lastly, a gap exists in exploring patients’ experiences, perceptions, and feelings towards receiving primary care within a GMV model. Available literature does not answer the questions of why men and women chose to attend GMVs, what differences men and women experience when attending GMVs, what men and women feel about GMVs, and finally what makes GMVs effective for the men and women who attend. Filling this gap in
the literature is an important component of creating patient-centered healthcare delivery. Furthermore, to implement the chronic care model under the auspice of primary healthcare, the delivery of healthcare should be harmonious with the needs and values of the recipient population.

Theory development pertaining to the process of why GMVs are successful is absent from the literature. Theory is required to guide the implementation and to increase the understanding of the process by the providers. Theory is also necessary to allow for further development and refinement of the GMV model. Theory provides a framework for both implementation and evaluation. Moreover, evidence-based practice is an integral piece of healthcare delivery in today’s practice climate. This study will start to fill the void and provide necessary structure and supportive evidence for the implementation of GMVs.
Chapter 3 Methodology

A secondary analysis through a gender lens was used to assess clients’ experiences with receiving primary care delivered through a GMV model. Constant comparative analysis within the framework of Grounded Theory was used to process the data. A basic assumption of Grounded Theory is that there are similarities in the way people experience life. A thematic methodology was used to analyze the data gathered from nine interviews conducted with clients who had attended at least one GMV. Thematic methodology best answers the research questions as it allows for detailed exploration of the participants views and experiences with the phenomenon under study (Artinian, 1988; Sandelowski, 2000). Qualitative description argues that creating data categories after the data has been collected allows for a broader and deeper understanding. In the context of this analysis, it will allow for a deeper understanding of the men's and women's experience of receiving primary care within a GMV model. This is an important aspect of this methodology for this research study because there is an absence in the present literature of research exploring the client’s experience.

In this secondary analysis, I was interested in exploring both men's and women's experiences of receiving primary care within a GMV model. I was interested in examining whether there were differences and/or similarities between men’s and women’s experiences with GMVs. The goal of this research was to build on theory regarding the delivery of health services within the context of primary care. This is a secondary analysis because the data were collected as part of a larger project, led by Drs. Sabrina Wong and Josée Lavoie and, the now CEO of Northern Health, Cathy Ulrich, examining the access and effectiveness of GMVs. The larger study was jointly funded by Northern Health Authority
and the Canadian Institutes for Health Research. What follows below is a description of how the data were collected.

**Target Population**

The target population was adults over the age of 19 who resided in the Northern Health Authority and who have participated in at least one medical group visit in primary healthcare delivery within the past year. Further criteria for inclusion in the study were that participants were able to understand and speak English. Subjects could elect not to participate when asked.

**Sample Selection Procedure**

The sampling allowed for variability in such factors as age, education, medical diagnosis, and gender. Communities and primary care practices in the Northern Health Authority that offer GMVs were asked to identify possible patients to take part in the study. Once potential patients were identified and agreed to be contacted, the research team contacted the participants by phone, answered any questions they had regarding the research, and set up a telephone or face-to-face interview.

**Data Collection**

**Methods and instruments.**

Before commencing the interview, the researcher explained the purpose of the study and answered any questions the participants had. Signed consent was obtained from each participant prior to the in-depth interview. As part of the interview, a descriptive profile was also obtained from each of the participants. Open-ended questions were used in the interviews to stimulate discussion. The questions were aimed at eliciting responses about the access to and effectiveness of GMVs as a method of primary care delivery. Prior to data collection, ethical approval was obtained through the University of British
Columbia Behavioral Research Ethics Board, the Northern Health Authority (NHA), and the University of Northern British Columbia. All interviews were tape-recorded and transcribed verbatim. Data were cleaned so no personal identifying information was included in the transcripts. All data were stored according to standard UBC protocol in a locked filing cabinet in a locked office.

Data Analysis

For the purpose of this thesis, a thematic content analysis of nine interviews, five from women and four from men, was conducted. The interviews were randomly chosen from the patient interview data, excluding interviews conducted with GMV participants who are First Nations. This exclusion was intentional, as that set of interviews will be analyzed through a cultural lens in a different study. The interviews analyzed are from 4 different clinics offering the GMVs within the NHA.

The data were analyzed through a gender lens, which is compatible with this secondary analysis, because “[g]ender roles are the behavioral norms applied to males and females in societies, which influence individuals’ everyday actions, expectations, and experiences” (Johnson, Greaves, & Repta, 2007, p. 5). In regards to understanding the experience of receiving primary care in a GMV model, it is important to gain an understanding of the experience from the perspective of both men and women living with chronic conditions. Analyzing the data from these GMVs through a gender lens will be particularly interesting as all of the GMVs in the study were heterogeneous according to sex. What are the similarities and differences of men and women's experiences of receiving primary care in a GMV model? Is it beneficial to offer heterogeneous GMVs? What are the participants trying to tell me? What do their words have in common and what do they mean? These are the questions I asked myself while reading and probing the data.
to gain insight and understanding. The thematic content analysis followed the four principles described by Morse and Field (1995). Often in thematic analysis, the theme is hidden and requires the researcher to step back and reflect upon the data (Morse & Field).

**How this lens will add to the study and findings.**

Within this study, a gender lens will provide the necessary framework to move forward in identifying and clarifying the differences and/or similarities between men’s and women’s perceptions of receiving primary care in a heterogeneous GMV for their chronic condition. There is little understanding of the experiences of men and women receiving care in heterogeneous GMVs. Gaining an understanding of the experiences through a gender lens will guide and inform gender-sensitive policymaking and future development of GMVs in the NHA. The aim of using this lens is to increase the overall care of both men and women living in the NHA who seek their primary care through the utilization of GMVs.

**Active analysis.**

The art of analyzing qualitative data is an active process of continuous redesign (Morse & Field, 1995; Rubin & Rubin, 2005). The researcher is required to knead the data to create familiarity with the language and words of the interviewees. To be able to step back and question what and why something was said and how it was said is an important component of qualitative inquiry. Inductive reasoning and questioning must occur to allow the researcher to keep building on new findings while gathering evidence for testing and changing the emerging theory. As the theory emerges, the researcher modifies questions to test emerging ideas in new interviews and to get a sense of how far the emerging theory can be generalized. Rubin & Rubin (2005) suggest this approach to design to ensure that, when the data collection period is complete, the research questions are answered and there is
adequate data to produce a rich and distinct research report. This design also ensures that when the project is complete, the results will be on target, convincing, and important. Ideally, the results will be recontextualized to be generalizable to other populations (Rubin & Rubin). Morse and Field (1995) suggest that this process of working the data to the point of recontextualization follows four sequential processes.

The first step in the process is comprehending, which, according to Morse and Field (1995), occurs when the researcher begins to understand what is going on in the data. Morse and Field express the importance of keeping prior knowledge of the topic separate from the findings to prevent ‘contamination’ (p. 126). Comprehending commences with accurate transcription of data. It is fundamental that the data has been checked, corrected, and coded. Lincoln and Guba (1995) suggest that the first reading of the data should be no more than a thorough read to acquaint the researcher with the data and to make a brief notation of the initial reaction to what was read. Morse and Field’s principle of comprehending, which will be guiding my analysis, will commence with the second read of the data and the beginning of open coding.

Open coding consists of line-by-line notes written in the right margin of the transcript. Words lifted from the actual transcript are often the starting point to open coding (Morse, 2002). Upon completion of the open coding, the transcript will be read again and broad categories will be created. The creation of the broad categories assists in data management (Strauss & Corbin, 1990). Morse (2004) refers to these broad categories as *emic tagging*. She describes an emic tag as a label derived from the category that actually occurs in the data and that best describes the category as a whole. Once all the data has been emic tagged, the data will then be further divided into subcategories, or concepts.
The concepts that will be tagged are core ideas that can be summarized as nouns, noun phrases, or gerunds (Rubin & Rubin, 2005). At this stage the branches of subcategories will be created to provide a visual representation of the data and assist in the detection of themes, linkages, and identification of what the participants have not said, as part of synthesizing the data.

To keep the data manageable, no more than 10-15 broad topics, or categories, were used (Morse & Field, 1995). Given the small number of interviews all procedures related to managing and organizing the data took place manually. To differentiate between the interviews, each interview was photocopied onto a different colored paper. Pink paper, for instance, represented interviewee one, blue paper represented interviewee two, and so forth. Each transcript will be copied three times. One copy stayed completely intact and unmarked in a three ring binder. The second was used as the working copy, where all of my notations and comments are made. The third copy was used to cut and categorize into the respective files. All of the data will then be emic tagged. Each category was designated a specific colored file folder; subcategories had the same colored folder, with a black stripe to indicate ‘subcategory,’ and labeled with the appropriate subcategory title. Data were be hand cut and placed into the appropriate file folder. While sorting the data into categories and subcategories, paying close attention to what has not been said; I will simultaneously be making notes on potential relationships or linkages between categories, on questions that are occurring to me, and on patterns that are emerging. The process of comprehending was complete when the writer was able to write a complete, detailed, coherent, and rich description of the data. This process then led to the second stage of analysis, synthesizing.
Synthesizing begins when the researcher starts to get a feel for the data. The researcher is now able to tell stories of the combined experiences, describe norms amongst the participants, and provide individual narratives to support generalizations (Morse & Field, 1995). It is during this process of synthesis that the researcher starts to discover relationships and linkages between data and literature. During synthesis of the data, significant moments or significant factors that played an important role in the development of a person’s experience were revealed; these points of juncture must be allowed to emerge (Morse & Field). The third process of data analysis is theorizing.

The identification of commonalities as themes is an important step in the process of building theory (Morse, 2002). Rubin and Rubin (2005) suggest the researcher continually return to his or her research questions to choose the themes to be developed. The overall goal of the research study guides the themes to be chosen for further maturity. New questions around these themes are created and explored with new interviews. These themes were molded, developed, and shaped to eventually produce a definition or description of the theme. Once a definition was created, both scientific and lay literature were consulted to determine if the definitions of the concepts exist in the literature. If the concept definition does exist, the emic tag will be replaced. However, if the researcher is unable to locate a definition for the concept in the literature, the opportunity to introduce it to the body of knowledge as a new concept is presented. Thus, when gaps are discovered in the literature, new concepts can be identified, developed, published, and incorporated into education and practice (Morse, 2002). Theory development does not end at this stage, however. The final stage was recontextualizing the emerging theory to allow for
generalizability to other settings and other populations (Morse & Field, 1995; Rubin & Rubin, 2005).

Recontextualization is the real power behind qualitative inquiry (Morse & Field, 1995; Rubin & Rubin, 2005). Theory development is the most important product and should be the impetus for qualitative inquiry (Morse & Field; Rubin & Rubin). A theory is a set of statements that brings together concepts and themes to explain how things happen. A theory links concepts and themes into an overarching explanation that addresses the immediate research question(s) and creates broader understandings about important societal issues (Rubin & Rubin, 2005, p. 230). It is during this process of recontextualizing the theory that published literature is consulted to find linkages between the new findings and existing theory, whereby advances in theory development and knowledge are made.

Rigor.

According to Lincoln and Guba (1985), four general criteria are necessary to ensure trustworthiness in qualitative evaluation. These four criteria are truth-value (or credibility), applicability, consistency, and confirm ability. Truth-value is not defined prior to data gathering, as it is subject orientated. Credibility is obtained when the researcher meticulously reports the perspectives of all the informants. Applicability is the criterion used to determine whether the findings can be generalized to other groups or in other contexts or settings. Consistency in quantitative research refers to context: if the research were to be conducted again would the findings be similar in context? However, because it is widely acknowledged that, there are multiple realities amongst subjects; qualitative research expects variation in experiences and perspectives, rather than the repetition of findings. The fourth criterion is confirming ability. Using these four criteria as guidance will obtain trustworthiness in the proposed research study.
The second criterion to ensure trustworthiness (rigor) is applicability. According to Morse (2002), the only way to make research generalizable beyond the initial group is to develop theory. Theory development requires taking the findings beyond a superficial level of analysis to a deeper level of abstraction. Morse poignantly suggests qualitative researchers ask themselves this: if our findings are not generalizable beyond the initial group then why are we doing the research? To work toward the general, then, theory will be created in this proposed research study by constantly reworking and developing emerging themes (Morse & Field, 1995).

According to Lincoln and Guba (1985), consistency is the third criterion applied to assure rigor. Consistency in patients’ perspectives of group medical visits emerged as coding evolved into consistent themes emerging from the focus groups. Rather than looking for saturation of a theme, consistencies in themes were monitored. This was performed by keeping count of the number of entries in each of the subcategories and keeping track of the data that, in my opinion, did not belong to any of the subcategories. Confirm ability was achieved through extended time with the subjects, or by using long periods of observation with them. Lincoln and Guba (1985) suggest that the researcher should identify personal biases through memo writing and reflecting with other researchers to increase confirm ability in their research study. Throughout this process, I critically reflected on how I was analyzing data and made note of personal values, which could affect the interpretation of the data (Polit & Beck, 2008). Within this context, I explored my experiences with setting up and participating in delivering GMVs. I tried to ensure that I was not placing my own preconceived notions of what the theme may be, but am interpreting the data itself. I also needed to recognize my own position as a member of
society and as a nurse. To assist in the process of self-reflexivity, I journalled my thoughts, values, and beliefs throughout the analysis process and discussed this with my committee members.

**The Audit Trail and Field Notes**

Quality field notes are an important piece of data that helps to create rich thick descriptions of participants’ experiences and thoughts (Rodgers & Cowles, 1993). Field notes will detail what the audio recordings of the interviews are unable to capture, including body language, reactions to member comments, and signs of emotion. Quality field notes add to the establishment of trustworthiness in the research study (Rodgers & Cowles).

The audit trail created in qualitative research plays a significant role in establishing rigor in the study (Morse & Field, 1995; Rodgers & Cowles, 1993). According to Morse (2004), the audit trail consists of the following six forms of documentation: raw data; data reduction; analysis products; data reconstruction and synthesis products; process notes, which are materials relating to intentions and dispositions; and instrument development information.

**Contribution to Existing Knowledge**

The results from this study formed the basis for theory development regarding group medical visits as a model for primary care delivery to men and women. Presently, there is an absence of theory and empirical evidence to support the implementation of group medical visits as a model of primary care delivery. There also is an absence of literature on gender specific GMVs. The NHA has been offering heterogeneous GMVs to participants who have the same or similar chronic conditions. The results build support concerning the need for collaborative primary healthcare delivery and effective utilization...
of primary healthcare providers. The results provided direction for future development of GMVs. The role of the nurse, as a primary care coordinator, will also add to the already diverse role nurses play in the delivery of primary healthcare. The results suggest that nurses can be catalysts for innovative strategies to deliver improved, evidence-based, gender-appropriate healthcare to rural communities where both physical and human healthcare resources are limited.

Study Limitations

One limitation is that the findings may not be generalizable outside the communities within the Northern Health Authority. Further, I did not collect the data, which may have been gathered from a different perspective using a different frame of reference. The questions used in the original research may also have been intended to elicit different information. Lastly, I had a small sample of only nine interviews, five female and four male.

Future Directions

This secondary analysis brings attention to the similarities and/or differences that men and women feel regarding receiving primary care in a heterogeneous group medical visit. Secondly, this secondary analysis was intended to provide evidence to assist in policy development for further implementation of group medical visits in the Northern Health Authority. The results will also be used to create a standardized evaluation form to be used by all care providers of group medical visits within the Northern Health Authority. The results may also lead the researcher to conduct further studies of the providers’ perspective of delivering primary care within a group visit setting. These data could be triangulated with the present results to find commonalities and disparities that will advance the theory behind group medical visits.
Chapter 4 Results

This secondary analysis was performed on nine in-depth interviews. The nine interviewees self-identified as English-speaking Caucasian men and women who had attended at least one Group Medical Visit (GMV); they were all residents living in Northern Health Authority (NHA), British Columbia, and were at least 19 years of age. Four men and five women were interviewed (Table 1). The participants were patients from four primary care practices located within NHA. The physicians used GMVs as a part of their regular practice to deliver primary care to persons living with a chronic condition. All GMVs that participants attended were centered on chronic conditions, including diabetes, chronic pain, fibromyalgia, and heart disease and were heterogeneous according to sex. One man and one woman were interviewed as a couple in a joint interview.

Table 4.1 Interviewees by age and gender

<table>
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<tr>
<th>Interviewee (n=9)</th>
<th>Gender</th>
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Thematic analysis identified one main theme and several sub-themes interwoven across all the interviews. One important recurring theme was the therapeutic effect of being able to tell one’s story of living with chronic conditions. Having the opportunity to both tell their illness story and to listen to similar stories of others’ experiences of living with a chronic condition provided participants with a pathway to move from a place of isolation
and loneliness to feeling connected with others and creating community. The strength in sharing came not only from being a part of a group of like individuals, but also from feeling that they were truly being listened to when they spoke. Having an attentive audience summoned feelings of being cared about by other participants of the GMV as well as the physician. As one man summed up,

[anda]nd that sharing I think in itself is therapeutic to some degree really, you know, if you have a listener of all these people. I mean everybody isn’t talking at one time to everybody else. They’re listening to you when you speak and you’re listening to them when they speak. It’s really nice to have that kind of an audience

[GMV_116M624-630].

Six sub-themes arising from an analysis of the data included overcoming vulnerability and emotional isolation, connecting and creating community, reciprocal learning, increased feelings of safety, building relationship with the physician, and efficiency of time. The following is an exploration of these themes in detail.

**Overcoming Vulnerability and Emotional Isolation**

Although all participants indicated that they preferred group medical visits compared to one-on-one office visits with their usual doctor, often attending their first GMV created personal conflict. Participants voiced feelings of apprehension of the unknown, wondering what it would be like to speak about their health status in front of strangers and what it would be like to listen to others’ stories, fearing judgment by others, and feeling pressured to share their experiences of living with a chronic condition. These feelings originally created a sense of hesitancy about attending a GMV. One participant describes this initial hesitation:
I was a bit skeptical at first. I wasn’t sure I wanted to sit ensconced in a clinic and learn all about everybody’s problems. And then I wondered what it would be like to talk about, it’s like showing off your, you know. But he’s [doctor] he’s been very good because he, he makes sure each person gives permission for him to relate any information about them. You have to agree. So ‘do you mind if I talk about your disease or whatever’ and you can say yes or no. So it worked out very well but like I say we were a bit skeptical at first, just kind of reticent about it a bit. But after we got going it’s, it’s really, it’s educational actually [GMV_120Fp1].

Many of the interviewees stated that it only took attending one GMV before they became comfortable with the concept. Participants who have attended two or more GMVs could identify the vulnerability in “first timers” to GMVs: “The first one they come to they’re quite quiet and they don’t ask very many questions, they just listen. But you notice as they come to other DIGMAS afterwards that they are more relaxed all the time and it works, it’s working for them” [GMV_106F676-680].

Sharing openly increased the participants’ self-confidence in understanding their chronic condition, which leads to improved self-management. One man spoke of how he was able to see personal growth in individual participants that led to improved self-management.

Interviewer: You can see people grow really?

Interviewee: Yeah you see them definitely, you can see their growth because you see them willing to take more risk and chances and express more about themselves and be more open within the group. And if that isn’t growth, you know, of the individual then growing towards
self-management. That’s why the group is so great, I mean it’s just it gives you a great feeling. And these people are really taking this in and they’re helping themselves and they’re sharing with you because they feel it’s important to share with other people. And you don’t do that in isolation, you can’t, of course, because you’re the only one there. And on the other hand you don’t feel comfortable until you really get into a group and become part of it and then you can [GMV_116M610-623].

In addition to participant’s overcoming their feelings of vulnerability in participating in a GMV, they had to believe that there were others who knew what living with a chronic condition entailed. Prior to attending a GMV, participants spoke of loneliness in terms of feeling isolated from other people within their community, their physician, and their families. Loneliness was linked to the belief that they were the sole person living with a chronic condition. One interviewee described “knowing in her head” that other people have the same chronic condition as she does, but being in one room and hearing about their experiences made what she knew in her head tangible: Interviewee: “So I sort of feel, I’ve felt like I’m off in a, off by myself. This way it’s, there’s more, there’s more like me. [Laughter] I mean I knew that up in my head” [GMV_117F103-127]. Loneliness was also linked to the decreased socialization in relation to their poorer health: "It's social, …you get to see other people, which when you have a chronic disease, you don't get out as much" [GMV_106F15-20].

Participants spoke of their frustration when friends or family would ask, “How are you doing.” They found it frustrating to attempt to explain how they were feeling when
they believed that no one could understand what it was truly like unless one had lived with
the condition. The feeling of not being understood by significant others reinforced their
feelings of loneliness and emotional isolation. The following is an excerpt from one
woman’s description of feeling “alone” with a diagnosis of diabetes. She clearly describes
how she feels that neither her husband nor her doctor could fully understand or appreciate
what it is like to live with the condition:

Sometimes the doctor turns it all into medical where I, I don’t think it’s all medical:
a lot of it is mindset. And, you know, if you’re, it’s like football players, they like
to hang out with other football players, you know, so it’s the same idea and I think
then you don’t feel like you’re the only one that’s got this terrible thing happening.
You’ve got a group that can back you up and that you can say ‘gee I feel shitty
today’, and they are understanding what you’re going through, like, for example, if
I tell my husband oh my blood sugar is 2.4 today, he says and truly he’s been with
me through all of this for twenty years. Often if I say to him my blood sugar is 2.4
he’ll say, ‘well you better take some insulin,’ you know. So, you know, there’s,
um, and he hasn’t really bothered to even read about it or find out what it’s about or
like if, if I have a real low blood sugar he’ll get irritated with me. Well that’s the
last thing you need, so that’s what I mean you hang out with other people who
know what you’re dealing with and you can talk to and they know what you’re
talking about. Whereas the group medical appointment even though I think they’re
wonderful too, um, the doctor has never had diabetes and so really he can’t know
where you’re coming from [GMV_107F779-807].
The burden of sole responsibility and the feeling of not being able to count on anyone to “watch over” her, not even her husband of 20 years added to her feelings of emotional isolation and loneliness.

**Connecting and Creating Community**

When interviewees heard GMV participants’ stories of living with a chronic condition, they indicated that they experienced a sense of relief as they realized that symptoms and emotions they thought were unique to them were experienced by others living with the same or similar conditions. As one, participate expressed,

I found out that things that I’m going through are not as rare as I thought they were, medications problems and mobility problems. A lot of people, like there was a couple of the people that have chronic headaches, that were there on Monday and I found out some things that I thought were unique to me, and they’re not [GMV_108M121-129].

This realization provided comfort and a sense of understanding among the participants as expressed in the following passage:

The group brings a lot of comfort to patients because they understand they’re part of a group for a reason, that we have similar problems or concerns and that’s why we’re here. And so you don’t feel isolated, you don’t feel alone, you don’t feel that you’re kind of one with the doctor when you are one on one. With your disease, you feel you’re a community of disadvantaged people because of your disease [GMV_116 M 257-265].

Identifying common ground by sharing life experiences resonated with the GMV participants because it created connection and socialization. According to another interviewee, “So to me the DIGMA was getting out and doing things. And that’s a benefit
no matter how you look at it” [GMV_108M951-952]. Connecting to a community of similar individuals provided participants with a sense of purpose and meaning to their life, possibly a deeper sense of purpose and meaning to living with a chronic condition.

Interviewer: So here you are a part of the group?

Interviewee: I’m just a person, I’m just a diabetic in amongst all the others.

Interviewer: Is that nicer to kind of just?

Interviewee: Yes. You’re connected [GMV_117F103-127].

Participants provided encouragement and support, became advocates for one another, and learned skills both from others and by reflecting on their own journey living with a chronic condition. Expression of increased feelings of empathy, sympathy, and caring towards other participants were shared:

You gain; I think you gain a feeling of security, of understanding, of sharing with other people, of compassion, of support. I mean you just gain so many things that you wouldn’t gain if you were one on one because of the humanity of us as people. You know we try to support one another [GMV116M270-276].

Many participants spoke about the satisfaction of sharing their knowledge of living with a chronic illness. Sharing was important to the participants because it acknowledged their personal experience and it was hoped that they would be able to help others in managing their chronic condition: “You learn from other people and hopefully they learn something from me” [GMV_107F48-49]. One male participant spoke about learning to view his chronic pain from a perspective shared by a woman who lives with the pain of migraine headaches:

Her basic statement was, ' make the pain your friend.'
I've been thinking a lot about that and that might mean I just might put up with a little more of it [pain] and not complain even to myself in the future…it takes too much energy to fight it constantly sometimes so why not accept that you're gonna have some pain in your life, everybody does. And yet I guess I've always thought I don't know if I learned this yet or if I ever will, but I'm gonna have to accept that there's going to be a level of pain that's bigger on some days and less on others the rest of my life. It's never going to go away [GMV108M686-703].

Sharing also brought out mental health issues, such as depression, that could be addressed within the group. Participants spoke of feeling better about their situation since others shared the “highs and lows” of living with a chronic condition. Sharing provided listeners with hope and perspective about their own life situations. Participants believed that others living with the same or similar conditions best understood the emotional complexities of living day-to-day with a chronic condition. As one participant stated, "...You get out into a group situation where everybody feels exactly the same and then all of a sudden you realize 'hey I'm not alone'. I think that's one of the big things for, DIGMAS, I think that's really important, you don't feel isolated" [GMV_107F335-340].

The ability to empathize and genuinely understand what living with a chronic condition is like was important to the participants.

**Reciprocal Learning**

The learning in the GMVs occurs from the shared experiences of participants and the medical expertise of the physician and the other health care providers. The loose boundaries created changed the typical linear exchange of information from authority to client to a circular flow of questions and answers amongst all participants including the physician. Participants viewed this circular learning as being advantageous to the
physician and to themselves. Participants described sensing that physicians were truly starting to learn what living with a chronic condition was like:

Yeah I, they learn things they wouldn’t have learned in one on one, and I could see that. And even they admit that. Dr. [name] admitted it even in front, to everybody the other day. He said that more than once that he’s had revelations that he would not get from one-on-one visits. [GMV_108M531-536].

The unstructured flow of questions and answers created synergy among all the participants of the GMV. The synergistic effect creates a forum conducive to deep-probing questions resulting in wide-ranging answers. Participants and the physician become engaged in the reciprocal flow of information.

Interviewee: So I mean they’re not really on the spot but twelve different people question them if they so desire to ask. So that gives you quite a round table actually of questions, covers a lot of aspects that you might not have thought of yourself, but someone else did and asked the question for you. And sometimes if you’re a little too timid to ask the questions maybe someone else will ask them for you. So that’s one of the benefits of the group, of course, is the fact that there are a number of people there up to twelve or thereabouts [GMV_116M90-101].

This thorough level of question-and-answer period led to an improved understanding of the chronic condition by the participants at a level, which may never be obtained by attending individual one-on-one physician appointments. An improved understanding might lead to improved management: "The more you can find out about your disease the better you can manage it" [GMV_106F964-965].
Participants further explained that there were questions asked by others that they would never have thought of asking themselves: “And people ask questions as well that, uh, you’ve always wondered about but it isn’t something you would bring up in your own personal, in a one-to-one with your doctor appointment” [GMV_120Fpage 9line7]. One participant spoke in terms of starting to see the larger picture: “And because my thinking is such that sometimes I don’t see the big picture, just a little picture so I just ask little questions whereas others might ask the bigger picture question which I never even thought of but it’s really important to me too. So it’s a sharing kind of thing” [GMV_116M128-133].

**Increased Feelings of Safety**

Over time the group provided the participants with increased feelings of safety. One participant spoke of intimidation during one-on-one office visits:

I let the physician dominate me a little more in a one-on-one situation than I do in a group situation. I’m more likely to open up in a group. I guess it’s because there are witnesses. I realize a doctor is less likely to be verbally abusive or mistreat me when there are other people watching and listening than he would on a one-one-one [GMV_108M554-563].

This same participant spoke about his sense of relief when other GMV participants shared similar stories of unpleasant one-on-one office visits.

Participants expressed the feeling that the group concept brings out the best in everyone, including the physician. Because others were present and interactions were monitored, everyone was particularly thoughtful in their interactions. It was suggested that everyone's behavior is better in a group setting versus a one-on-one physician-client visit.
It is possible that the 'best behavior' attitude creates an improved respect for all parties, thereby slowly bringing down power barriers in one-on-one office visits:

And the best I came up with is that because the doctor is in a group situation. What were the best words I chose last night? I don’t want to say better behaved, but the doctor was more careful in how he treated you in front of other people. When we have a one on one appointment sometimes they’re not very nice; they’re too busy or they’re, they have a bad day. And they’re people just like everybody else, but when he was in, when doctors are in a group situation they’re less prone to that grumpiness. That’s the one thing I thought of last night that I noticed was really different between my individual visits and the group visits [GMV_108M142-152].

Building Relationship with the Physician

Participants spoke of relationship building in terms of increasing trust with their physician. Trust was created when participants perceived the physician as being emotionally present: “In a group situation their [doctors] focus, their attention is focused. When you’re the one that’s sharing they listen and don’t interrupt” [GMV_108M203-207]. Being emotionally present allowed the physician to listen and to be genuine in trying to understand life with a chronic condition: “I trust him [doctor] more when I see that he’s open to learning and figuring out new things that are only happening in group dynamics” [GMV_108M582-584]. Further, in comparison to experiences with one-on-one physician-client visits, the physician in the group medical visit was perceived as being attentive and not in a rush.

Interviewee: I've heard that so many times that doctor’s stand, you know, they want to get you out.
Interviewer: Oh doctors want to get you out of the office?

Interviewee: As fast as they can [GMV_115F685-690]

One participant spoke of the need to feel secure in her relationship with the physician. She stated that the increased contact time with her physician during GMVs has increased her sense of security: "...but basically it's the contact you want to have with your doctor. And it gives you a feeling of security as well, yeah. I find that that was a real issue with me that I didn't feel secure until I started going to the DIGMAS" [GMV_106F146-148].

The more relaxed, less-structured environment inherent in GMVs lends itself to meaningful relationship building for participants who might be shy in a one-on-one visit or who might need more time to build a trusting patient-provider relationship: “I might say something in a group I wouldn’t say in a one-on-one because of fear of bad treatment” [GMV_108M470]. One woman stated that because GMVs are so relaxed and comfortable even participants who are shy will share.

The recognition participants received from their physician regarding their experiential knowledge of their chronic condition accomplished further relationship building. This recognition flattened the power structure often perceived by clients. Flattening the power created an equality with the participants as the expert of their lived experiences and the physician as the medical expert.

Interviewee Quite often someone who knows more than you do and it’s just a feeling sometimes of isolation and loneliness because you have the disease and it’s a different feeling completely intimidates you. An individual one-on-one interview with your doctor, it’s extremely
different than a group visits. And I think, speaking if this was for myself rather than for the group, I feel a lot more comfortable in groups than one on one. I feel like I’m in a silo if it’s one on one [laughing], it’s just too narrow [GMV_116M111-120].

Interviewer: In a silo?

Interviewee: Well a silo, meaning it’s just one, you know, kind of focus whereas with, um, the group there’s many people focusing on it so it’s a broad holistic approach as opposed to just a one on one approach [GMV_116M122-127].

Other barriers in one-on-one physician visits preventing relationship building, as identified by the participants, included the physician’s time constraints, which create pressure on the physician, leading him to be “grumpy” and short tempered; heavy office workload; hierarchy between the physician and patient; feeling unheard by the physician; and a tense atmosphere. One male participant explains in the following quote how he felt while attending a one-on-one office visit:

Sometimes they’re not short tempered, but short with you because they’re behind with their day and they don’t … I’ve had several one-on-one visits where I didn’t think they were even listening to what I was saying. That doesn’t happen in a group situation . . . . More than once I’ve felt the doctor, what I said went in one ear and out the other [GMV_108M194-202].

Efficiency of Time

Participants commented on the efficiency of GMVs stating various reasons. For example, they felt GMVs were an efficient method to free up their physician’s time for more urgent cases in the office. Participants also commented on their appreciation for not
having to wait in a doctor’s office, and one couple stated that they enjoyed being able to see their doctor together, thereby making better use of their time. Knowing there was a GMV scheduled and only having to phone and say one would be coming was a valued benefit: “Sometimes when you’re looking for a doctor’s appointment it can take months, weeks to get in. This you just phone the day before and say, “I’m coming to the clinic [GMV], and they pull out another chair” [GMV_120Fp.3].

Efficiency of the GMV was contextualized on a larger scale. Two interviewees spoke of the efficient manner in which health care dollars were spent. Other participants spoke of their increased knowledge regarding alternative health care providers: “I would say that the group meetings encourage people to see their dietitian and health nurse. It is usually brought up at the group meetings who would be the person to see. Sometimes it’s an out-of-town number” [GMV_107F671-673]. In the following, a male participant summarizes many of the points mentioned throughout the interviews:

I think groups are extremely efficient for the patient; they’re extremely efficient for the doctor, for the nurse practitioners, for everyone who is part of the group. And so you kind of feel two ways. You feel you’d like to share with a group because you think that they can learn from this problem as well as you can learn from their problems. But you also feel the, the time constrains that doctors have and professionals, medical professionals have. Therefore you don’t like to take up more time if someone who prefers to have a one-on-one visit could better use it. So you know, you kind of free up so that things can happen and your turn comes during the group. I think it is the most efficient way of offering health to people is through groups. I think it’s really important when you can meet with twelve rather than
one. I think that’s really important to that saving of time and the fact that it’s really efficient, from if I’m meeting one-on-one with my doctor, I might have ten to twelve to fifteen minutes at which time I could ask maybe three questions. Where if there is twelve people asking three questions that’s thirty-six questions that I’ve heard the answer to while I was there. So look at that terrific benefit, feedback etc. more knowledge obtained by all. And also the comfort I think that a group brings. The group brings a lot of comfort to patients because they understand they’re part of a group for a reason [GMV_116M243-259].

Clients were concerned about the efficient use of available health care resources as well as both their own and their physician’s time. Time is an important commodity and participants saw time spent at a GMV as being worthwhile.

In conclusion, group medical visits appear to have a role in the delivery of primary healthcare within the context of chronic conditions. Both male and female participants felt comfortable receiving care for their chronic condition within a group setting and indicated a preference for GMVs over one-on-one physician visits. The initial analysis revealed similarities between the men’s and women’s experiences, rather than differences. On the initial read of the interviews, I was surprised that some of the interviewees who expressed feelings were men and not women, which reveals an obvious researcher bias regarding gender conditioning. Probing the interviews further and asking myself what is not being said, while applying a gender lens, continued to reveal similarities rather than differences between the men’s and women’s responses.
Chapter 5 Discussion

This secondary analysis of nine in-depth interviews with men and women attending heterogeneous group medical visits (GMV) is a first in the literature. This study revealed six themes common to both the men and women: overcoming vulnerability and emotional isolation, connecting and creating community, reciprocal learning, increased feelings of safety, building relationship with the physician, and efficiency of time. It was surprising and intriguing how positive and similar the men's experiences with the GMVs were to the women. In trying to understand why men responded so positively to the GMV concept the framework of normativeness is applied to GMVs. Increasing an understanding of why men, who historically do not seek health care as frequently as women (Noone & Stephens, 2008), have positive experiences with the GMV model of primary care is crucial to promote this form of health care delivery; whereby, men's health outcomes will improve.

Discussion of Similarities in Findings

Sharing of the illness experience.

It was clear from the analysis that having the opportunity to share their illness story was an important element in the experience of the GMV for both men and women. The idea of allowing patients to tell their illness story is not new. Engel in 1977, for instance, wrote of the benefits of allowing patients to tell their illness story. He claimed that while sharing their story, patients would naturally include relevant psychosocial information, which may not otherwise be revealed. Within the context of the GMV, the extended period of time creates a more relaxed environment supporting participants to openly share their illness story. In this relaxed environment, information such as 'personal strategies' of managing their chronic condition, feelings associated with living with a chronic condition, and other information that may not be disclosed during a traditional physician-client
appointment is revealed. The GMV model may remove inherent barriers found in the traditional physician-client appointments for both men and women. Gibbs (2005) speculates that men who are living with a chronic condition are experiencing both a health crisis and a crisis in regards to their own masculinity. In her discussion, she states that in her study men avoided self-management programs due to their belief that they would have to share feelings. It is possible that the physician becomes a transitory object and assists in diffusing gendered norms within the 'safety of numbers' in GMVs. This would account for both men and women expressing their illness/health story to one another within the context of heterogeneous GMVs and assist in explaining why men in Campbell and Gosselin (2007) study, also shared their illness/health story.

The findings reveal that both men and women identified such barriers as physician time constraints, tense atmosphere, the physician’s poor mood, heavy workload, the hierarchy between patient and physician, the patient’s feelings that he or she is not being listened to, and the physician standing during the traditional physician-client appointment that may prevent patients from feeling comfortable in telling their illness story. With such perceived barriers, patients may also deny symptoms, think their self-imposed medication regime is not worth mentioning, may not understand the correlation of their individual lifestyle and their treatment plan, may not know what symptoms are worth reporting, or may feel intimidated by the regular office visit and withhold pertinent information. From the findings, both the men and women felt truly understood and cared about within the context of their chronic condition through the process of telling their illness story to other participants and their physician. According to Stevenson et al., (2000), open discussions between physicians and clients are required to improve compliance to treatment plans.
Open discussions promotes partnerships and builds respect for both parties. Bultman and Svarstad (2000) concur stating a collaborative communication style between the client and the physician has a positive influence on treatment outcomes. Participants, regardless of gender seemed to need to have the physician understand their illness story.

The expanded time also allowed for both men and women to feel comfortable enough to share their illness experience. From the findings, however, it seems that some men and women may not share their illness experience at the first GMV attended. Building trust between participants and providers appears to be important before one's illness story is shared. Arrington et al. (2005), in their study of prostate cancer survivor groups, found that men perceived strict time constraints within the group as a barrier to emotional sharing. This is particularly important in trying to understand why, as the findings of both this and of Campbell and Gosselin's (2007) study point to men reporting a high satisfaction with GMVs. The more relaxed attitude concerning time constraints may assist men to feel a sense of security allowing them to share their emotional experiences of chronic conditions and health experiences.

**Constructing meaning from the illness experience.**

Martin and Peterson (2009), in their paper on chronicity, discuss the importance of constructing the illness experience and assigning meaning to it. They state that the process of constructing meaning is dependent upon social and other contexts in which people find themselves. Finding meaning in the experience of a chronic condition is described as an important step for men and women to move forward in learning to live with their new normal (Bottorff, & Hutchinson, 1994; Martin & Peterson; Morse, Ohman, Soderbery, Lundman, 2003). Further, the telling of one’s illness experience creates a bridge of trust, respect, and validation that ties people together (Sandelowski, 1994). Dr. Rachael Remen,
founder and director of the Institute for the Study of Health and Illness, suggests that storytelling is a way for people to create a sense of community and connectedness, especially in an age of increasing technology and isolation. The participants in this analysis seemed to find satisfaction more in having their physician understand their experience, rather than them seeking comfort in creating meaning of their illness experience. This may be due to the length of time the participants have lived with their chronic condition or may be due to their age. Certainly, a younger person diagnosed with a chronic condition will have a different perspective versus an older person.

One man spoke about learning to view the illness experience from a different perspective. While listening to one woman's description of living with the chronic pain of migraine headaches, he realized that there were different ways to contextualize pain. This 'new way' to view pain might not have occurred if this man had attended male-only GMVs. Evangelista, Kagawa-Singer and Dracup (2001), state women construct a more positive meaning to illness in comparison to men. Do GMVs create unique social and cultural norms within the context of living with chronic conditions? According to a social constructionist perspective of gender, this may be what is occurring; men and women redefine their gender and display of gender according to the environment of the GMV. GMVs may be creating a cultural and social environment in which men can engage in health-seeking behaviors, acknowledge their chronic condition, and share their illness experience.

Courtenay (2000) contends that men are unable to express their illness due to the construction of traditional masculinity. The construction of masculinity for men includes trying to conform to socially defined male roles. Such roles make men reluctant to request
help or to seek health care, as these actions would be considered as displays of weakness and, therefore, not masculine. However, within the GMVs, the social norm changes and men enjoy sharing their illness experiences and knowledge as well as seeking further health information. These actions, as well as the observation of health promotion and prevention interventions, were also found in Campbell and Gosselin's (2007) study.

**Leveling of the power structure.**

Benatar (2003) discusses the need to focus on human rights and dignity to decrease the impact of the power differential between health care providers and recipients. Participants spoke of the power differential felt between themselves as individuals and their physician during traditional one-on-one appointments. Findings that show men and women attending the GMVs both felt there was a leveling of the power structure within the GMV. Literature suggests that the leveling of power between the physician and client is important in chronic condition management (Benatar). The GMV may be effective at leveling the power structure through various methods. Campbell and Gosselin (2007) suggest one reason for the effectiveness of the GMV model is that it may relieve the "white-coat syndrome" by shifting the emphasis from the traditional one-on-one physician-patient interaction to a group setting. In the findings, one male interviewee stated that he felt intimidated by his physician's knowledge. Feeling intimidated by knowledge may be a component of the poorly understood "white-coat syndrome." The inherent design of GMVs removes the emphasis from the client and transfers it to the group. The transfer of attention from the single client to a dialogue including all the participants may assist in levelling the power structure, especially for the men and women who feel intimidated by their physician.
Another finding from this secondary analysis, which may help to understand the leveling of the power structure experienced by GMV participants, is the recognition of client as the experiential expert and the physician as the medical expert of the chronic condition. Lee and Lin (2010) suggest that when physicians recognize the uniqueness and personal preferences of their clients, a treatment plan can be created that will increase the efficiency of patient-centered care and ultimately improve patient outcomes. Benatar (2003), while discussing the sharing of power between the physician and patient states, "Such a change in relation to the care of patients with chronic conditions… has had a major impact on both individual well-being and physician satisfaction” (p. 395). A more horizontal power dynamic enables patients to have a voice in their treatment plan (Benatar).

Participants spoke about the opportunities to compare how they are doing on laboratory tests provided by their receiving a copy of their laboratory results. "Friendly” comparison was an effective means of motivating them to “do better” or to see that they were “not so bad off.” This form of sharing clinical information may contribute to the leveling of power experienced by GMV participants. The physician is no longer the sole 'gatekeeper' because clinical information and diagnostic results are shared with the participants. The sharing of clinical and diagnostic information, once deemed as being 'too medical', and the more collaborative decision-making between the physician and client intrinsic to GMVs, may reduce the hierarchy of power and increase the likelihood of trust.

Thorne, Nyhlin & Paterson (2000) in their research suggest that some patients with chronic conditions may, develop mechanisms to confront dismissal (a form of power-over) from their physician; however, many will not develop these mechanisms due to their feelings of vulnerability and dependency on the physician for access to care. One
interviewee stated he would make comments in a GMV that he would not make in a one-on-one appointment due to fear of maltreatment from his physician. This fear of maltreatment, which is an obvious barrier to client's access to primary care, depicts abuse in health care and is an example of the hierarchy of power felt by patients. This same participant spoke about how all participants in GMVs were on their 'best behavior,' allowing for a more trusting and safe environment to be built. The more relaxed environment created in GMVs, in combination with the participants and health care providers being on their 'best behavior,' may work synergistically to decrease feelings of vulnerability and to improve physician-patient relationships, leading to a decrease in the hierarchy of power as perceived by the participants and a decrease in the potential for abuse in health care, thereby allowing clients to receive health care free from prejudice.

I am postulating that the physical set-up of the GMV may also contribute to the flattening of the perceived power structure. In the GMVs that I have been involved with, and in the literature, that discusses 'the set up' of a GMV, the physician frequently sits in front of the participants with the participants seated in a semi-circle facing forward. Having the physician and participants all seated may have a psychological impact on the participants’ perceptions of power over, felt in traditional one-on-one physician-client appointments during which, the findings show, the physician is often standing. The physical set-up of the GMV may also contribute to the relaxed atmosphere described by the participants. Participants addressed the perception that the physician had more time in a GMV and did not appear to be as rushed as in a one-on-one patient-physician visit.

In relation to the leveling of power within the GMV between the physician and participants, one must also consider any power structures that may exist amongst men and
women or amongst the men who attend heterogeneous GMVs. The power relations between men and women affect men's and women's behaviors, and vulnerabilities relating to health and gender. Gender norms are constructed and learned differently, according to the various settings men and women are situated. In rural communities, where the primary study was conducted, there may also be personality ‘clashes’ that occurs within the community, which could potentially 'spill over' into the GMV. The concept of power within a GMV is dynamic and could change depending on many variables. Variables including socio-economic, ethnicity, religion, age, and historical perspective.

**Reciprocal learning.**

Findings from this secondary analysis concur with Campbell and Gosselin's (2007) study on a male-only GMV regarding participants’ feelings of having extended time with the physician. In both studies, the extended time provided the physician and participants with an environment to explore questions more thoroughly. Learning also occurred from other participants’ questions and insights, resulting in vaster health knowledge; and, in this analysis, it also led to an increased personal comprehension of the men’s and women's chronic condition. As evidenced in this and in Campbell and Gosselin's study, the social environment created in GMVs seems to support men in asking health questions and seeking answers. This is important because research indicates that when men actually do seek help from health care professionals they ask fewer questions than women do (Courtenay, 2000). The findings suggest that men may find the environment of GMVs more favourable because of the use of humour and bantering.

Aside from the physiological benefits of humour and laughter, psychological benefits have also been documented (Martin and Kupier, 1993). In terms of gender, humour is an important element in men's social interactions as it provides them with a
strategy of disclosure (Oliffe et al., 2009). Men's form of teasing among one another is altered when in the presence of women. Because of this it is possible that heterogeneous GMVs are effective as men may not 'cross the line' as they may in a men's only GMV, and the use of humour may be appreciated by women as it 'lightens' the environment. Men's use of humour during GMVs may provide insight as to how men differ from women's approach to living with a chronic condition. Within the context of GMVs, men may find the more 'filtered' humour in the presence of women eases resistance to disclosing personal information and asking health-related questions.

**Building of a trusting relationship.**

Experiencing the development of trust with the physician was important to both men and women. Trust was built when participants saw the physician thinking of the chronic condition from the perspective of *living* with the chronic condition versus from the biomedical perspective. Before attending GMVs, participants felt that their physician had not understood the 'experience' of living with a chronic condition. The men and women felt this level of understanding from the physician was important and absent in their traditional one-on-one physician-client appointments. Thom and Campbell’s (1997) research regarding patient-physician trust found that trust, for some patients, meant that their physician had an understanding of their personal experience.

The building of a trusting relationship is vital between the client and physician (Kalliainen & Lichtman, 2010; Thom, Hall, & Pawlson, 2004). An important finding of this analysis is that participants felt an increased trust in their physician. An improved level of trust in the physician-client relationship is cited as improving the use of preventive medicine (Kalliainen & Lichtman), adherence to treatment plan (Kalliainen & Lichtman; McKinstry et al. 2009; Shipman, 2010), patient satisfaction, and overall client care (Clancy,
Brown et al. 2003; Kalliainen & Lichtman; McKinstry et al.; Shipman, 2010.). Trust has also been cited as reducing anxiety and increasing a client’s sense of being cared for (Thom & Campbell, 1997). If GMVs are able to improve the trust relationship, and an improved trust relationship has a positive impact on both the physician and client, that, in and of itself, adds credence to the role that GMVs may play in providing effective primary care to men and women living with chronic conditions. Trust is a fundamental component of effective relationships regardless of gender.

**Overcoming emotional isolation.**

This analysis revealed that both men and women experienced emotional and social isolation before attending GMVs. By attending GMVs, and through the process of telling their illness experience, community was created among the participants. The sense of belonging to a 'community of people disadvantaged by their disease' relieved the emotional isolation and loneliness felt by both the men and women. As explained by the interviewees, this emotional isolation and loneliness is, in part, because they felt alone in their experience of living with a chronic condition and because of a direct effect of their chronic condition.

It is well known that social isolation, loneliness, and inadequate social support affect the psychological well being and physical health of people (Alpass & Neville, 2003; Beal, 2006; Thorne et al.; 2000; Tomaka, Thompson & Palacios, 2006), especially in an older adult population (Alpass & Neville; Beal, 2006; Tomaka et al.). Considering the average age of men and women in this secondary analysis, this knowledge is relevant. There is a growing body of literature suggesting that for older people with chronic conditions spiritual well being is an important (Evangelista, Kagawa-Singer, & Dracup). One component of spiritual well being is the feeling of connectedness. According to
Fisher, Kobayashi, Hogg-Jackson and Roth (2006) in their report regarding older adult's social isolation in British Columbia, social integration and participation in society are important for the older adult and their feeling of 'healthy aging'. Many participants referred to the GMV as a 'social outing' or as a place for socialization. This feeling of a GMV being a place for socialization cannot be dismissed or undervalued. Literature on social support demonstrates a direct association with improved mental and physical health (Denton, Prus, & Walters, 2004) and a strong and protective effect on health (WHO, 2005). Keller and Henrich (1999) suggest that the protective effect of social support is important for both men and women, but is even greater for men. The social aspect of GMVs may play a large role in the positive experience expressed by both the men and women.

The men and women in this secondary analysis found the ability to express their illness story, especially to their physician and to an understanding audience of like individuals, to be very beneficial. It appears to be irrelevant that the audience was of mixed sex; what seemed to matter, was the common link of living with a chronic condition and having someone truly understand the experience. Gender does not seem to make a difference regarding the basic experiences shared by men and women living with chronic conditions: the need to tell, and the satisfaction in and support received from telling, one's illness story. This may be a cultural norm for people living in Northern British Columbian communities, which are not experienced in an urban setting.

**Using Normativeness to Develop Deeper Understanding**

Courtenay (2000) suggests that the social experiences of men and women guide their beliefs and behaviors. GMVs provide men and women with a new social experience within the context of receiving primary care. Within this context, men and women may elicit different demonstrations of health beliefs and behaviors. This 'new culture' that
GMVs appear to establish may help shed light on why men express having had a positive experience and why they return to this model of primary care delivery, whether the GMV is homogenous, as in Campbell and Gosselin's (2007), or heterogeneous, as in the primary research for this secondary analysis, according to gender. Men's demonstration of having positive experiences with GMVs through returning attendance and stating the desire to return (Campbell & Gosselin) are positive indicators that GMVs may be an acceptable and favourable model for men to receive primary care.

Empirical research supports the belief that men are reluctant to seek help from health care professionals (O'Brien, Hunt, & Hart, 2005). The need to try to understand why men find GMVs an acceptable mode of primary care is important to promote men's health and for the prevention of disease. The theory of Normativeness contributes to an understanding of this area of knowledge development. The theory guiding normativeness (Addis & Mahalik, 2003) is that when people perceive a 'problem' as being normal they are more likely to seek help for that problem. Likewise, when people perceive a 'problem' as being abnormal, they will not seek help. Relating this to men, Mahalik (2000) suggests there are three norms that influence men and their health behaviour.

The three norms described by Mahalik (2000) are descriptive, injunctive, and cohesive masculine norms. Addis and Mahalik (2003) define descriptive norms as 'men’s observations of what other men do in particular situations'. In the context of the GMV model, when men observe other male participants becoming active in their health care, for example, through following treatment plans, having preventative screening procedures, or discussing feelings of depression, then this becomes normal.
In both this secondary analysis and in concurring findings in Campbell and Gosselin’s (2007) research of a men-only GMV, male participants stated that they learned from other men's questions, which included some they would not have thought to ask themselves. In addition, men in both studies stated questions were asked that they felt would not have been addressed in a traditional one-on-one physician-patient appointment. The dialogue concerning health and health-related topics appears to be a key element in trying to understand why men like the GMV model of primary care delivery. Linking the above findings with the concept of descriptive norms suggests that within the context of the GMV model, men asking health-related questions and listening to other men seeking answers to health questions becomes normal.

The second norm is the injunctive norm. Injunctive norms, as described by Addis and Mahalik (2003), impact perceived normativeness of a problem through the cultural aspects of masculinity. These researchers use the example of the normative cultural expectation that 'men should be strong and independent.' The findings from this secondary analysis may be used to understand the role of injunctive norms in the cultural construct of GMVs. The findings revealed that men found comfort in being able to tell their illness story to an audience who were able to identify with the feelings associated with living with a chronic condition. It may be that within the GMV, the cultural norm of male stoicism (Martin & Peterson, 2009) is lessened, therefore, assisting men to tell their illness story. Campbell and Gosselin (2007) also reported in their study, that men told their illness story. Campbell and Gosselin further state that men shared their experiences and knowledge of diagnostic procedures, medication regimes, and diet and exercise strategies. Within the
cultural context of the GMV, learning and sharing about health and illness experiences becomes normative for men.

The third norm described by Addis and Mahalik (2003) is the cohesive masculine norm. Defining this norm is the perception men create when they perceive how popular men act, think, and feel towards certain problems or situations. Examples of the cohesive masculine norm are provided by Canadian actor Jim Carrey, who publically discussed his experiences with depression, and Canadian actor Michael J. Fox, who discussed his experience with Parkinson disease. When male public figures make public presentations of their experiences with disease or mental health conditions, as in these two examples, men's perceptions of the normativeness of mental health conditions or disease experience may be altered. Within the context of GMVs, the sharing of their illness and/or health experiences by local ‘celebrities’ may assist to change men's attitudes and perceptions of health and health promotion. Normative masculinity may be very influential in GMVs in small rural communities, due to most people knowing each other or 'knowing of' one another. The findings did not reveal substantive data to support the cohesive masculine norm; however, the original research questions did not lend themselves to elicit such responses.

**Limitations**

There are obvious limitations to this study. First, this research is a secondary analysis. The original research was conducted to seek information to answer the question of why GMVs work, to determine the benefits of attending GMVs, and to make suggestions for improvement, from the participants’ and providers’ perspective. Secondly, the interviews were from four different physician clinics in the NHA offering the GMV model of primary care. There are more than four clinics offering GMVs in the NHA, so the experiences may be dissimilar due to the education and training specific to delivering
GMVs in the geographic location within the NHA. A further limitation is the balance between men and women in each of the GMVs and whether there is a power structure within GMVs that has not been explored. A potential bias in the selection of the participants is also another limitation of this study. The primary care clinics had suggested which of their clients would be 'good' to interview; in their best interest, they may have chosen their most enthusiastic GMV clients. In addition, the small sample size used for this secondary analysis is another limitation, especially for making any generalizations. Another limitation of this study is that only individuals who wanted to be interviewed were part of the primary study. There may be participants who attend GMVs who do not want to be interviewed, and these men and women may have had different experiences. In addition, the men and women who have chosen not to continue seeking their primary care via the GMV model were not included in the primary study. These men and women would provide different perspectives and insights to the experience of receiving primary care in a GMV.

Additionally, areas that may have revealed gender differences with deeper probing were not part of the primary study. These limitations may have influenced the lack of gender differences found in the analysis. A further limitation may also be that the ages of the interviewees were similar. With the age of the nine interviewees being so similar, the historical context in which they received health care may also be similar, therefore reflecting similar experiences of attending GMVs. The average age of the nine participants, therefore, provides a view from this particular generation; younger and older men and women may have different perceptions and insights from attending GMVs. Consequently, generalizing these findings to other age groups would be difficult. There is
also an assumption that, because they continued to receive primary care in this format, the men and women who were interviewed enjoyed the GMV model. A further limitation is how long the men and women have lived with their chronic condition. Newly diagnosed individuals may act differently and seek different information within a GMV. Lastly, an area that limits the analysis is if the participants attended GMVs where the same people attended. This would change the dynamics of the GMV and the information shared.

**Conclusion and Implications**

This study reveals that GMVs bring men and women together and encourage the sharing of knowledge, the providing of support, the strengthening and formation of relationships, the creation of community, and the leveling of power. The hierarchy of power experienced by clients in traditional one-on-one physician-client appointments is real and is a barrier to receiving the quality of primary care Canadians deserve. Further research into this area focusing on clients in Northern communities is important and relevant to the delivery of primary care in Northern British Columbia. This research may add credence to the value of delivering primary care in a GMV model.

This analysis adds further evidence to the therapeutic role of telling one’s illness experience, uniquely, the role of telling it in a GMV setting. Through the process of telling their illness experience, both men and women living with a chronic condition were able to make sense of their experience and to start living within their new normal. GMV participants create community within a new social context, relieving loneliness and emotional isolation. Long-term benefits of GMVs need to be studied and should include both psychosocial and clinical evaluations. Physician and other health care team members’ experiences and feelings also need to be explored and evaluated. This analysis
demonstrates the importance of the physician-client relationship and the appreciation consumers of health care have for a more relaxed and informal environment.

Significant findings from this small analysis of nine interviewees are decreasing loneliness and relieving emotional isolation. Alone, these findings may not carry weight to support further research into GMVs, especially in the present economy and accompanying pressures for financial accountability. However, in combination with the other positive experiences that participants expressed, GMVs warrant further research and study. It is important to remember that the primary study was conducted in rural communities within the NHA. One must question the social networks of these communities and the social networks of the individual participants. It may be that lay-person-led support groups with invited professionals could produce the same result.

With chronic conditions on the rise, health care dollars tighter, and fewer practicing family physicians, GMVs appear to have a role in the delivery of efficient and effective primary care. From these findings, however, and considering that chronic conditions are primarily static, the question arises: do GMVs that are focused on chronic conditions need to be led by a physician? With nurse practitioners (NP) emerging more in the delivery of primary care and with their wide scope of practice, NP led GMVs may be an affordable and effective delivery of primary care. Comparative studies between physician-led GMVs focusing on chronic conditions and nurse practitioner-led GMVs would add to the body of knowledge.

Lastly, available literature fails to address how to sustain men's attendance and their engagement in their health and attending GMVs. The assumption that men have a positive experience and feel GMVs are worth their time is not unreasonable. Further research needs
to be conducted to learn how to obtain men's initial attendance to GMVs and then how to maintain their attendance and interest in their health.
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Appendix A Six Essential Elements as Identified by the CCM

Community

Community is a fundamental element and an essential component for proper implementation of the CCM. A cornerstone of this element is the notion that, when residents of a community become aware of available resources, they will embark on a commitment to use the services in a productive and effective manner. The concept of community includes the individual’s interaction with the community and the partnerships created within the healthcare system. The need for developing partnerships between existing community groups is a further principle of the concept of community. It is also thought that these partnerships will provide support, assist in the development of mutually identified voids in services, and reduce redundancy in services. Creating strong partnerships aids in creating a deeper mutual understandings of both patient and provider perspectives. These relationships support the development of a stronger commitment to healthy community development. Moreover, the healthy relationships create active voices in the community to advocate for positive change with community planners. This positive respectful working relationship with community planners and healthcare delivery systems is encouraged to create a synergistic effect creating positive community development (Robert Wood Johnson Foundation, n.d.).

Health System

The second element core to the CCM is the health system, which includes the cultural organization and mechanisms to promote safe, high-quality care to the people in the community being served. Imperative to the success of the implementation is open support from the most senior leaders to the providers of care. Improvement strategies must be thought out and orientated towards a comprehensive system change, and errors must be
managed systematically to ensure quality improvement and prevention of similar errors from reoccurring. A large part of the health system element is the concept of facilitating coordination of patient care and data across various health-related organizations (Robert Wood Johnson Foundation, n.d.).

**Self-Management Support**

The core of the Chronic Care Model is an informed and activated patient. This principle is derived from literature suggesting that patients are the real experts of their disease. Patients must be provided with the tools to assist them in managing their chronic condition, and an emphasis must be placed on the significant role they play in their health management. It is essential for healthcare providers to receive training in self-management support strategies and to work collaboratively with patients on problem-solving skills and acceptable treatment plans (Robert Wood Johnson Foundation, n.d.).

**Delivery System Design**

This element of the Chronic Care Model emphasizes the delivery of effective, efficient clinical care and support for patient self-management. It focuses on the formation of teams to deliver evidence-based, culturally sensitive, primary care. Team members have specific roles and tasks that contribute to the teams’ ability to deliver improved healthcare including regular follow-up (Robert Wood Johnson Foundation, n.d.).

**Decision Support**

Decision support can be broken down into two equally important components. The first component is the utilization of evidence-based guideline care into routine clinical practice. The second is to educate patients on these guidelines to promote active participation in their own care. For decision support to stay current, providers of care must use recent evidence-based practices and start using new models of provider education. The
use of new models of care will require from the physician a paradigm shift in how they deliver primary care. Finally, the Robert Wood Johnson Foundation advocates the utilization of specialists in the care of complex patients as the last component of decision support.

**Clinical Information Systems**

At the root of the clinical information model is creating an organized and systematic approach to individual patient data and aggregate data to identify subpopulation needs. An efficient information system would also allow for recalls and reminders for both providers and patients to maintain standards of best practice guidelines. Furthermore, the clinical information system should allow for the sharing of patient information across the spectrum of providers to assist in the coordination of continuous quality patient care. The clinical information system should also allow for monitoring the performance of the practice team to ensure continued quality improvement (Robert Wood Johnson Foundation, n.d.). Additionally, effective clinical information systems may decrease the number of patients with chronic conditions who are lost due to inefficient follow-up (Renders et al). Central computerized systems can be of additional value, as they may provide feedback to providers and can generate reminders to providers concerning the management of their patients. Further, the data will be used to measure improvements in the performance of healthcare professionals and patient outcomes. The Health Council of Canada states: Canada needs to move much more quickly to adopt a modern, secure, and efficient means of storing and sharing patient information. A modern information system will help streamline the patient journey and eliminate delays caused by the shuffling of paper patient files. Electronic medical records will enhance patient safety by making all relevant information available to healthcare workers (p. 34, 2005). The CCM provides a central
organization and coordinating structure that brings the resources of an entire system to the fingertips of all healthcare providers. Siminerio (2005), from research on implementing the CCM in diabetes care, concludes that an integrated technology system is crucial for the success in implementing the CCM.