Shared medical appointments

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With rapidly escalating healthcare demand driven by aging populations and increasing case complexity, healthcare systems globally are facing unprecedented and rising deficits, with the prospect of punishing cuts to essential services. Consequently, novel models providing safe and effective care for patients whilst reducing healthcare costs are urgently sought. One such innovation is the shared medical appointment (SMA).

Shared medical appointments

First proposed by Noffsinger,(1) SMAs were conceived as a clinical encounter in which patients receive healthcare in a group setting from one or more health professionals. Including patient education and counselling, physical examination, and clinical support, patients attending SMAs usually share a key attribute, such as medical condition.

Sharing elements with traditional patient education groups, SMAs uniquely incorporate clinical interventions such as history taking, examination and clinical management. During appointments of approximately 90 minutes, up to 12 patients can share experiences, interact with facilitating professionals as a group, as well as receiving one-to-one care. Variations on this model have the clinical component delivered in a group setting, with patients able to listen and contribute to other consultations, or as private one-to-one consultations held in parallel with group work. Patients newly diagnosed with diabetes, for example, may receive interactive education on the condition and treatment options as a group, accompanied by one-to-one sessions with a doctor for examination and personalized management, returning to the group to discuss lifestyle. In this way SMAs combine two effective models, group peer support and clinical one-to-one care, whilst significantly reducing clinical time commitment.

How and where do SMAs work?

Kirsh et al. proposed a number of causal mechanisms for beneficial effects of SMAs.(2) The group setting promotes self-management through learning from others' experiences; it allows more equitable relationships to develop between patients and professionals, engendering greater trust, whilst enabling professionals to learn from patients how best to support their needs; and patients and professionals gain from having more time in the consultation. Interestingly, these mechanisms map closely to the theorized 'curative factors' of the group psychotherapy which inspired SMAs.(3)

Whilst investigating the effectiveness of SMAs is not without methodological challenges, a growing body of research into their use now exists. The strongest clinical evidence is in diabetes, where SMAs result in demonstrable improvements in HbA1c and blood pressure.(4)

However, studies have successfully used SMAs in a wide variety of other conditions and settings, both primary and secondary care, including cancer survivorship care,(5) high utilisation of medical care,(4) pain management,(6) substance misuse,(7) elderly health screening,(8) and chronic heart disease.(3) Technology, including video conferencing, has also been used to provide SMAs for patients living in rural settings or those with mobility difficulties.(9)

Researchers have considered a range of patient related outcomes of SMAs, suggesting that they can facilitate effective information giving, improving patients' knowledge about their condition and its management,(3,5) and leading to more effective self-care.(10) Patients participating in SMAs report fewer symptoms,(10) and express greater satisfaction with and perceived access to care;(3,11) quality of care and quality of life are also more highly rated in SMAs.(10)

SMAs in practice

Healthcare system outcomes were central to Noffsinger's original proposal, and subsequent studies support SMAs ability to improve access to care,(3) whilst reducing both routine and emergency healthcare use.(3,4) However, evidence of impact on overall healthcare expenditure is conflicting, with both higher and lower costs resulting from introduction of SMAs in different studies,(4) and it is likely that their widespread adoption would prove costly at least initially in terms of development and implementation.(5)

Most literature focuses on advantages of SMAs, but challenges clearly exist in this still novel mode of consulting. Chief among these is likely to be the issue of confidentiality:(3) patients will have varying degrees of comfort with sharing medical information in a group setting, while professionals fearful of breaches of confidentiality will need to develop skilful approaches to the management of such information sharing.

In addition, the established model of doctor-patient consultation is deeply ingrained: there may be reluctance from both professionals and patients to engage with SMAs, and just as they will not be appropriate for all conditions or settings, SMAs will not be for everyone. Nevertheless, it seems clear that SMAs can be successfully delivered, and efforts are already being made to support training and implementation needs for the use of SMAs in primary care.(12)

Whilst the overall number of studies remains small, and the strength of evidence is marred by heterogeneity of studies and settings, the evidence base on SMAs is growing and facilitated peer-interaction alongside traditional individualised management has the potential for

significant added value for patients and healthcare professionals. Further research is needed to define the most effective model of SMAs and how and where they may be most usefully implemented in practice, as well as to evaluate their effectiveness in improving quality of care and reducing healthcare costs.

Contributors

BH is Clinical Lecturer in Primary Care in the Department of Primary Care and Public Health, Imperial College London, and is funded by the National Institute for Health Research (NIHR). AV is Primary Care Faculty Development Lead in the Department of Primary Care and Public Health, Imperial College London. SK is Director of Undergraduate Education in the Department of Primary Care and Public Health, Imperial College London. All authors worked to shape the article and contributed to the text of the manuscript. BH brought individual contributions together in the final draft. All authors approved the final manuscript.

Competing interests

We have read and understood BMJ policy on declaration of interests and declare the following interests: BH, AV and SK are General Practitioners working in the NHS.

Licence

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