Original Research

Do Patients Really Prefer Individual Outpatient Follow-Up Visits, Compared With Group Medical Visits?

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Objective: Access to outpatient psychiatric care remains problematic in Canada. We have been using group medical visits (GMV) to treat psychiatric outpatients with mood and anxiety disorders. Our study aimed to show that patients are similarly satisfied with GMV and individual psychiatric treatment, hence the concern that patients truly prefer individual treatment may be unfounded.

Method: Our study compared patient satisfaction in people who have had previous individual psychiatric care and are now receiving GMV to determine whether there is a treatment preference.

Results: Questionnaire data were analyzed using repeated measures ANOVA. The ANOVAs showed no differences in patients' experiences with individual treatment, compared with GMV. In addition, we found when asked directly, most patients preferred GMV or had no treatment preference.

Conclusions: These findings indicate that patients' perspectives of individual psychiatric treatment and GMV are roughly equal. This suggests that the method of GMV deserves further study and comparison with other clinical models of psychiatric outpatient treatment.

Les patients préfèrent-ils vraiment les visites de suivi individuelles ambulatoires aux visites médicales en groupe?

Objectif : L'accès aux soins psychiatriques ambulatoires demeure problématique au Canada. Nous avons eu recours aux visites médicales en groupe (VMG) pour traiter les patients externes psychiatriques souffrant de troubles de l'humeur et d'anxiété. Notre étude visait à démontrer que les patients sont semblablement satisfaits des VMG et du traitement individuel psychiatrique. C'est pourquoi il n'est peut-être pas fondé d'affirmer que les patients préfèrent vraiment le traitement individuel.

Méthode : Notre étude comparait la satisfaction de patients qui avaient auparavant reçu des soins psychiatriques individuels et qui avaient maintenant droit à des VMG afin de déterminer s'il existe une préférence de traitement.

Résultats : Les données d'un questionnaire ont été analysées à l'aide de mesures répétées de l'analyse de variance. Les analyses de variance n'indiquaient aucune différence dans les expériences des patients en traitement individuel, comparé aux VMG. En outre, quand nous l'avons demandé directement, nous avons constaté que la plupart des patients préféraient la VMG ou n'avaient aucune préférence de traitement.

Conclusions : Ces résultats indiquent que les points de vue des patients sur le traitement psychiatrique individuel et les VMG sont à peu près égaux, ce qui suggère que la méthode des VMG mérite une étude approfondie et une comparaison avec d'autres modèles cliniques de traitement psychiatrique ambulatoire.

Access to psychiatric care in Canada remains problematic. Patients with nonemergent care needs and nonpsychotic disorders (that is, predominately mood and anxiety disorders) have difficulty accessing timely and comprehensive care from a psychiatrist. A recent finding showed that 83% of patients in British Columbia who were diagnosed with a mental disorder only received care from a family physician.[1] Further, a survey conducted with physicians in British Columbia suggests that the wait time from a general practitioner referral to psychiatric treatment exceeds 5 months.[2] Hence many family physicians no longer even attempt to access psychiatric services for their patients. In light of this problem, we have changed the format of our psychiatric practice, such that we now see patients in GMVs in lieu of individual follow-up visits.

GMVs are not equivalent to group psychotherapy. Rather, GMVs are shared medical appointments lasting 60 minutes (the time and format may vary by practice), in which multiple patients (in our practice usually 6 to 8 patients), meet simultaneously with the psychiatrist. Each patient is allotted about 10 minutes of individual exchange with the psychiatrist. However, as most patients present with mood and (or) anxiety disorders, and the treatments for such disorders are similar across patients, patients are actually receiving an additional 50 minutes of education pertaining to their condition. The GMV model is increasingly used in other aspects of medicine, specifically in the treatment of chronic illnesses, such as hypertension, diabetes, and asthma.[3–13] Given that mental illness is also a chronic condition, it seems logical to adopt this model in psychiatry, as it affords the opportunity to treat patients with homogeneous chronic illnesses in a more efficient format.

There have been no published studies to date examining the use of GMVs in psychiatry. However, we do have some of our own data that speak to the benefit of adopting the GMV model in psychiatry. In addition to our private practice, we also run a psychiatric clinic at the MDABC, where we have adopted the GMV model. We collected survey data from our patients attending GMVs at the MDABC. Our data show high levels of patient satisfaction, increased accessibility to care, increased physician efficiency, and decreased cost to the health care system.[14]

While the previous data we collected show immense support for the use of the GMV model in psychiatry, it is purely descriptive data. Therefore, we cannot say with certainty that GMV is superior to, or even equal to, the traditional model of psychiatric care. In our study, we surveyed and interviewed patients who previously received individual treatment from us, but currently see us in GMVs, and asked them to compare their 2 experiences. The data that we report in our paper comes from a questionnaire developed and administered to patients attending GMVs who had previously had individual outpatient one-to-one treatment. We hypothesized that participants would rate individual treatment and GMVs to be equal. We also hypothesized that participants would feel a greater reduction in stigma associated with their mental illness after partaking in GMVs, compared with individual treatment.

Abbreviations

GMV	group medical visit
MDABC	Mood Disorders Association of British Columbia

Clinical Implications

- The GMV model offers clinicians an efficient alternative model of care that appears to satisfy patients' treatment needs.
- GMV was more effective at reducing participants' feelings of stigma associated with having a mental illness, compared with individual treatment.
- The concern among psychiatric colleagues that, if given the choice, patients truly prefer individual care over GMV was not present in our study population.

Limitations

- The sample was small and all participants were patients of the same psychiatrist.
- All patients had engaged in individual treatment with the same psychiatrist before engaging in GMV; therefore, previous experience with individual treatment may have influenced patients' subsequent experiences with GMV.

Method

Participants

In February 2011, the senior author of this paper changed his individual private practice of over 500 patients (90% with a diagnosis of a mood or anxiety disorder) from individual follow-up visits to GMVs. These patients had received individual outpatient follow-up for between 2 and 25 years before he changed his practice to GMVs. At the time patients were surveyed, they had received nearly 1 year of GMVs. Consecutive patients who attended GMVs were asked to participate in the study until the desired sample size was obtained. A total of 111 patients were given questionnaires. Twelve patients either declined to participate or their questionnaires were invalid. Ninety-nine patients (55.6% female) with a mean age of 55.76 years (SD 12.08), and 89% of those asked to participate, were used as the sample in our study. On average, patients had attended an average of 4.89 GMVs (SD 2.96) from February 2011 to February 2012. In our sample, 86.7% of patients reported their primary diagnosis as a mood disorder (that is, major depressive disorder or bipolar disorder), 4.1% reported their primary diagnosis as an anxiety disorder (for example, generalized anxiety disorder, posttraumatic stress disorder, or obsessive–compulsive disorder), and 9.2% reported their primary diagnosis as other (for example, schizophrenia or schizoaffective disorder).

Before creating and distributing the questionnaire, 8 randomly selected patients (3 males and 5 females), with a mean age of 54.88 years (SD 10.29), were contacted

and asked to participate in a semistructured interview with a research psychologist (eAppendix 1 for interview questions). Interviewed patients had seen the senior author of this paper for an average of 12.18 years (SD 4.81). Interviews lasted an average of 33.69 minutes (SD 15.18). Interview responses were used to help generate the questionnaire. All participants received a consent form and gave informed written consent before completing the questionnaire or participating in the interview.

Procedure and Materials

A questionnaire was generated using a 5-point Likert scale to measure patient satisfaction and perceived quality of care of both individual and GMV care (online e Table 1). Scale values were labelled as 5 = excellent, 4 = very good, 3 = good, 2 = fair, and 1 = poor. An additional question was asked about the perceived effect of treatment on the stigma participants felt related to their mental illness. Scale values for this item were labelled as 1 = not at all, 3 = somewhat, and 5 = very much so. Lastly, participants answered a general question asking them to indicate what type of treatment they would prefer if given a choice, individual treatment, GMVs, or no preference. To prevent any order effects, the questionnaire was counterbalanced, such that one-half of the respondents responded to questions pertaining to individual care first and the other one-half of respondents answered questions pertaining to GMV care first. The general question about treatment preference was always answered last. The questionnaire was modelled after Edward B Noffsinger.[15]

The questionnaire was given to all attendees of GMVs over the course of 2 months. Prior to distributing the questionnaire, all patients were informed that completion of the questionnaire was voluntary, that the questionnaire had been approved by the Providence Health Care Ethics Committee, and that responses were anonymous. Participants were asked to complete the questionnaire following their GMV and to leave their completed questionnaires in a drop box located outside the treatment room.

Results

Questionnaire data were analyzed using repeated measures ANOVA with IBM SPSS Statistics 20.0 (IBM SPSS Statistics, Armonk, NY). The within-subjects factor was type of treatment (individual treatment, compared with GMVs). Between-subjects factors included questionnaire form and sex. Length of treatment was used as a covariate in all analyses as the period of time that patients had seen the senior author individually (before he changed his practice to GMVs) was quite varied.

All 9 items asking about patients' experiences with individual treatment were averaged to compute an overall individual treatment score for each participant (mean 4.42, SD 0.64), and all 9 items asking about patients' experiences with GMVs were averaged to compute an overall GMV score for each participant (mean 4.17, SD 0.70). The Cronbach alpha for the 9-item individual scale is 0.91 and the Cronbach alpha for the 9-item GMV scale is 0.90 (online eTable 1 for scale items, as well as means and standard deviations for each individual item). The main effect of type of treatment was not significant ($F = 1.71$, $df = 1/88$, $P = 0.19$), and there were no significant interactions. The ANOVA showed no significant main effects and no significant interaction effect for the between-subjects factors of sex and form.

The one item asking about the effect of treatment on patients' experiences with stigma (online eTable 1) was analyzed separately, as we interpreted this as a separate dimension. The ANOVA showed a significant main effect of treatment type ($F = 4.53$, $df = 1/81$, $P = 0.04$), such that participants reported that GMVs (mean 3.53, SD 1.28) were significantly better than individual treatment (mean 3.19, SD 1.33) at reducing their feelings of stigma associated with having a mental illness. There were no other significant within-subject effects. The between-subjects factor of form was significant ($F = 6.26$, $df = 1/81$, $P = 0.01$). Participants who answered questions about individual treatment first (mean 3.68, SD 1.13) indicated a greater reduction in feelings of stigma, compared with participants who answered questions about GMVs first (mean 3.08, SD 1.11), regardless of treatment type. This finding does not appear to be meaningful as there were no significant interactions with treatment type and there was no effect of form for the overall treatment variables.

Lastly, we looked at the descriptive statistics for the general question about treatment preference. The data show that slightly more participants indicated a preference for GMVs (participants who prefer GMVs = 38.4%, participants who have no treatment preference = 31.3%, and participants who prefer individual treatment = 30.3%; $n = 99$).

Discussion

Overall, patients reported their experiences with both individual treatment and GMVs to be quite positive. Average ratings for both individual treatment and GMVs were between very good and excellent. Further, when patients were directly asked about their treatment preferences, a plurality indicated they preferred GMVs (38%) over individual treatment (30%). The remaining 31% of participants indicated they had no treatment preference. Our findings do not support the widespread belief that patients prefer individual psychiatric treatment to GMVs.

We also found that GMVs have an additional benefit when compared with individual treatment. GMVs were more effective at reducing participants' feelings of stigma associated with having a mental illness. This is likely due to the support felt from the group. When patients engage in a form of group therapy, many have a realization that they are not alone and their situation may not be as bad as they had originally thought. These thoughts and realizations can help further contribute to recovery.[16]

While the results presented here lend support to our hypothesis that patients regard individual psychiatric

treatment and GMVs to be roughly equivalent, there are several limitations to our study, most notably, the sample was biased. The sample was small and all participants were patients of the same psychiatrist. It is possible that patients' responses were influenced by their desire to please the psychiatrist and also by the factor of novelty of treatment. Participants had only ever attended GMVs with one psychiatrist, hence GMVs conducted by a different doctor may differ in quality. In addition, all patients had engaged in individual treatment with the same psychiatrist before engaging in GMVs. Previous experience with individual treatment may have influenced patients' subsequent experiences with GMVs; therefore, the adoption of this model in a different context may have different results. All participants had been in treatment for a minimum of 2 years prior to partaking in the study and therefore had time to learn about their illnesses and experience the effects of treatment. It is possible that patients who had never engaged in any type of treatment may have different views on individual psychiatric treatment and GMVs.

In addition, our questionnaire could be improved. Although privacy and confidentiality concerns are addressed at the beginning of every GMV, we did not generate a question in the study focusing on this specific issue. This may be a question of interest in future studies, as the ability to self-disclose may be considered an advantage of individual treatment.

Future research should aim to look at patients' perspectives of individual treatment, compared with GMVs using a more controlled model of study. Ideally, the sample would consist of participants experiencing mood and (or) anxiety disorders who had never experienced any psychiatric treatment in the past, and therefore there would be no biases introduced based on previous experience and different style of treatment received. Participants would then be randomly assigned to 1 of 2 groups, either individual treatment or GMV, and 2 or more different psychiatrists would provide treatment in the study to control for any physician effects. Though it would likely be difficult to obtain this type of sample, this study design would remedy the limitations discussed above, and provide stronger evidence for the adoption of GMVs in psychiatric practice.

Conclusions

It was hypothesized and found that patients reported their experiences with individual psychiatric treatment and GMVs to be roughly equivalent. These data lend further support to our previous findings that patients in GMVs are very satisfied with the care and treatment received.[14] There is no evidence from our work that patients prefer individual treatment to GMVs. Based on our findings here, we suggest further study of this time-efficient and cost-effective model of outpatient psychiatric care and comparison with other clinical models.

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