Common Myths, Concerns and Misconceptions

The case for "why" to offer GMVs has been established through applied research examining key performance indices relating to clinical outcomes, patient satisfaction, provider satisfaction, and cost. However, perceptions of GMVs on the part of patients and providers can often be driven by past experiences or previous research.

Confidentiality

Myth: One of the main concerns regarding GMVs is the increased risk of patient confidentiality being breached due to it becoming a shared group responsibility rather than a single provider's fiduciary duty.

Response: In over 17 years in the US, no GMV-related confidentiality complaints have been filed (Lawson, 2019), and moreover, previous research has shown GMVs to actually increase trust between patients and providers (Housden et al. 2016).

Attendance

Myth: GMVs are revenue generators, or can cause providers to lose revenue.

Response: GMVs are typically run at cost (neutral) for providers, with roughly as many patients seen in the GMV as would be seen in the same amount of time using the typical model of primary care. Attendance management is a key process that will determine the financial feasibility of a GMV in any given context. Where too large an attendance could negatively impact care quality, enough "no shows" in a given session can result in a situation where costs exceed revenues. Since neither outcome is desirable, GMVs are usually planned to be cost-neutral using a structured process of attendance management processes involving invitations, confirmations, reminders, and other administrative attendance management tools (Cohen et al. 2017; Wadsworth et al. 2019).

Rigorous evidence

Myth: GMV scientific validation and testing does not have robust body of literature as other medical interventions or delivery models (Ramdas & Darzi, 2017).

Response: GMVs are not easily amenable to randomized controlled trials, as patients and primary care choices are not easily amenable to either randomization or controlled conditions (Ramdas & Darzi, 2017). Despite this limitation, an increasing number of RCTs are being conducted on GMVs as their ubiquity grows, while existing descriptive research continues to undergo specialization and systematic review (Shibuya et al. 2018).

Patient resistance

Myth: Resistance from patients in adopting GMVs typically emerges from concerns about privacy, confidentiality and quality of care.

Response: The concerns about privacy are usually associated with GMV misconceptions (e.g. receiving physical examinations in front of a group), whereas concerns about perceived care quality (time spent with provider) and confidentiality typically dissipate as patients become more familiar with the GMV format and culture (Hannay, 2019). In a US-based study, response rates for invitations that were sent by physicians were 90%, 50% for those sent by nurses, and 10-20% for those sent by administrative staff (Lawson, 2012).

Provider resistance

Myth: Sharing a degree of clinical autonomy during patient encounters may represent a disruption to clinical routine, and thus requires a professional adaptation that some providers might not see value in making. Some concerns and questions arise when allowing "patient-led" appointments, such as quality of care, appointment efficiency, and medically relevant and accurate consultations.

Response: Providers frequently increase the use of GMVs in their practice after the first encounter, with one UK study citing a 100% satisfaction rate for providers who increased their GMV use after their initial trial (Lawson, 2012).