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EDITORIAL

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There's been a lot of creative thinking going on about ambulatory care practice. Practitioners have been considering several alternatives to the traditional one-on-one medical appointment. One idea is to get rid of the appointment part and have patients be seen the day they call the clinic—so-called open access. Another is to expand the scheduled visit to include other patients with similar problems, aptly named a group visit. A third idea combines the first two, and this idea is known as the drop-in group medical appointment, or DIGMA for short. A lot of creative thinking, but very little empirical work.

In this issue of **ecp**, there's an article that helps fill the void. Coleman and others[1] report on a randomized trial of monthly group visits in adults with chronic illness. The intervention was associated with significantly less acute care utilization. Patients randomized to group visits had about half as many emergency department (ED) visits (0.65 per patient vs. 1.08 control) and one third as many hospitalizations (0.44 per patient vs. 0.81 control).

To be fair, group visits were not a trivial intervention. The typical intervention patient attended over 10 group visits—visits they would not have otherwise had. The typical group visit was 2 hours long and involved multiple providers. Each visit included a prepared presentation, simple mechanical activities (blood pressure checks, immunizations, and medication refills), and open time for questions (both about the presentation and personal health concerns). Is the time and financial investment involved in 10 group visits justified to prevent half of an ED visit and to reduce hospitalizations by a third? Probably.

Why did group visits reduce the need for urgent care? Because patients are seen more frequently, maybe their problems are diagnosed sooner and valuable interventions are initiated earlier. But the patients weren't just seen more frequently—they were seen differently. Maybe they simply feel better when they have a long interaction with providers. Maybe being able to share their experience with others who have similar problems helps them deal with the waxing–waning course of chronic disease. I'm not sure which is right, but it's interesting and important to think about.

Reducing urgent care utilization is also the goal of another study in this issue. Washington and colleagues[2] used a consensus process to develop guidelines for deferred care in patients presenting to the ED with musculoskeletal complaints. Although we don't learn anything about health outcomes, we do learn a great deal about patient acceptability. (Urgent care clinicians will immediately see the relevance

This paper is available at ecp.acponline.org.

of the effort.) Guidelines were tested in terms of patient acceptability as opposed to health outcomes.

One quarter of 448 patients presenting with musculoskeletal complaints met the guideline—that is, they were deemed eligible for deferred care. Of these, nearly three quarters agreed to be deferred (i.e., they went home and returned for an appointment, with a median wait of 3 days). Almost 90% of these patients kept their appointments.

Why would so many patients agree to deferred care? Is it because a clinic visit in urgent care settings is so rushed that it meets very few patient needs? Or is it because what the patient wanted most was reassurance that nothing major was wrong and that need was met by the nurse applying the guideline? Fodder for future work.

This issue of **ecp** also features articles on the health messages the public receives. Burke and coworkers examined how popular magazines portray breast cancer.[3] They specifically examined vignettes about individual patients—tangible stories that tend to stick in readers' minds. These vignettes were primarily about younger women. Only 3% involved women over age 60, although in the real world over half of new breast cancer cases involve women in this age group.

This is clearly a mismatch. But what are the boundaries of the magazine's responsibilities? They need to engage readers, presumably with engaging stories. Dreaded disease in young people with young families is a good way to do that. And no one's suggesting that the stories aren't true. But are they fair? Do the magazines have obligations beyond accuracy? Should they ensure that the vignettes are representative of the underlying age distribution of the disease? Should there be quotas (for every story about a 40-year-old, there should be 10 about women over 60)? Tough questions.

Finally, the editorial debate in this issue considers messages coming from health organizations.[4,5] There's a tension between engaging a target audience and portraying the problem fairly (i.e., not exaggerating). How health communicators balance these interests depends on how they view their charge: to persuade or to inform?

So there you have it—our 15th issue of **ecp**. I hope you find it both engaging and informative.

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