Social Science & Medicine 377 (2025) 118107

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Experiential caring and the mobilisation of peerhood in group clinics

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ARTICLE INFO

Handling Editor: Medical Sociology Office

Keywords:
Peer support
Group clinics
Menopause
Diabetes
Experiential caring
Responsibilisation
Sociomateriality

ABSTRACT

The concept of 'peer support' has generated much interest in mainstream health services. In policy discourse, peer-based initiatives are often described as 'empowering' and seen as contributing to more 'democratic' and 'holistic' forms of care. Focusing on group clinics as one such example, this article challenges the assumption that peer-based initiatives represent a straightforward and unequivocal 'good' when embedded in clinical care. We draw on qualitative data from three studies (2016–2025), including 118 interviews and ethnographic observation in 59 in-person, remote, and hybrid group clinics for diabetes and menopause at 5 primary and secondary care sites in England. Adopting a sociomaterial lens, we uncover how different forms and practices of peerhood emerge (or not) in the circumstances through which these clinics are materialised. We show how biomedical artefacts (e.g. diabetes test results, menopause symptom lists) used as part of consulting play a key role in constituting forms of affiliation and differentiation between patients, in turn determining whether and what forms of peer 'support' (e.g. disciplinary, affirmative) are accomplished. We go on to explore how being presented as a peer as part of clinical consulting brings about new roles and responsibilities for patients, and introduce the term 'experiential caring' to denote a new mode of consulting that mobilises roles, practices, and subjectivities associated with peerhood.

1. Introduction

1.1. Background

The concept of 'peer support' has generated much interest in health and care. While historically situated in activist and self-help movements, the concept is now commonly adopted in mainstream health policy, such as group-based patient education for general 'self-management' (e.g. Expert Patient Programme) or specific conditions (e.g. Desmond). More recently, peer-based initiatives have become part of clinical service provision in some countries through what is known as 'group clinics' (or 'shared medical appointments', 'group medical visits'), where patients have their clinical consultations in groups rather than one-to-one. In policy discourse, peer-based initiatives are often described as 'empowering', and contributing to more 'democratic' and 'holistic' forms of care (NHS England, 2023, 2021). Drawing on extensive research into group clinics in English primary and secondary care, we challenge the assumption that peer-based initiatives represent a straightforward and unequivocal 'good' in care by illustrating the complex ways in which peerhood emerges (or not) in clinical settings.

A significant literature on peer-based initiatives (e.g. peer workers, in-person groups, online forums) for various conditions (e.g. chronic and critical illness, mental health) has associated peer support with numerous benefits, including destigmatisation, knowledge exchange, and emotional support (Haines et al., 2018; Kingod et al., 2017; Repper and Carter, 2011; Thompson et al., 2022). Yet, the concept has arguably remained somewhat vague and presumptive, with the emergence of peerhood often assumed rather than interrogated. A recent systematic review of peer interventions for chronic conditions concluded that relatively few studies explore how peer support works, with little attention given to different versions of 'peerness', or how these might influence possible outcomes (Thompson et al., 2022). Others have highlighted the lack of evidence on the influencing role of meso-level contexts (e.g. setting, organisation type) (McLeish et al., 2023). While some have uncovered theoretical models underpinning peer-based initiatives (i.e. relational, sociopolitical, biomedical) (Mullard et al., 2023), few have explored the process of how one becomes seen as peer, and what is needed for such encounters to translate into different kinds of support.

Peer-based initiatives in clinical care, like group clinics, are a relatively new phenomenon. Recent studies suggest that group clinics emerged for different purposes, ranging from programmes tailored to

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https://doi.org/10.1016/j.socscimed.2025.118107
Received 2 December 2024; Received in revised form 11 April 2025; Accepted 17 April 2025

specific groups (e.g. safety-net clinics for people who are un- or publicly insured in the US) to more general service provision aimed at increasing efficiencies (e.g. replacing certain one-to-one GP appointments in England) (Papoutsi et al., 2022b; Platt et al., 2022; Thompson-Lastad and Rubin, 2020). This literature highlights some psychosocial factors that influence mechanisms of peer support (e.g. group homogeneity across different dimensions, rapport-building, facilitation skills), but offers limited insight on the role of space, place and material arrangements when peer encounters take place in clinical settings. Research on group clinics in the UK has so far mainly focused on high-level clinical outcomes, implementation challenges or patient 'satisfaction' (e.g. Swaithes et al., 2021; Wong et al., 2021).

Studies of peer initiatives outside clinical care (Akrich, 2010; Kingod et al., 2017; Whelan, 2007) vividly highlight the claims-making power (or 'experiential credential', Whelan, 2007) attributed between those who share lived experiences of a health condition, and how bringing these people together can result in 'epistemic communities' (Akrich, 2010) that can be mobilised to contest epistemic claims from medical authorities. How such dynamics play out in group clinics where collectives of patients are brought together to share experiences and learning, but are also situated in – and potentially confined by – the logic and processes involved in formal clinical care (e.g. diagnostic processes, ongoing review of treatment, prescribing) remains largely unexplored. This may further be influenced by the broader contexts through which group clinics are delivered, involving for example in-person, remote, and hybrid modalities.

1.2. *Interrogating 'peer support'*

Drawing on qualitative data from three studies into in-person, hybrid, and remote diabetes and menopause group clinics across five English primary and secondary care sites, this article interrogates the nature and emergence of 'peer support' in group clinics. Adopting a sociomaterial lens, we first ask: How do people interact and come to regard each other as 'peers' (or not) in the sociomaterial arrangements through which group clinics are accomplished? And: how does this influence what types of contributions are made and count as support? We then proceed by asking: How does being (presented as) a 'peer' in (remote) group clinics bring about new roles and responsibilities for patients?

1.2.1. *Peer support as emergent, situated, and sociomaterially constituted*

An emerging body of studies highlights particular circumstances that play a role in determining when and how others' experiences come to count as relevant knowledge and support. Studies of online community groups have, for example, uncovered the role of platform affordances in shaping how patients share experiences and when such information comes to be used (Akrich, 2010; Maslen and Lupton, 2019). Similarly, a study of motor neurone disease and Parkinson's support groups has demonstrated how outcomes associated with peer support rely on complex identity work mediated by the role of the different media (Mazanderani et al., 2012). Collectively, this literature suggests the importance of examining the situated, emergent nature of peerhood; whether and how experiences or views come to be seen as valuable and relevant to others relies on complex interdependencies between people and the circumstances in which these interactions take place.

Relevant theoretical work in sociology, organisation studies, and science studies has argued for taking seriously the role of material arrangements (e.g. objects, artefacts, infrastructures) in constituting social life (Knorr Cetina, 1997; Mol, 2002; Suchman, 2007). In developing the term 'sociomaterial' (Mol, 2002; Suchman, 2007), these theorisations challenge the ontological separation of social phenomena and material things. Aiming to articulate how this constitutes everyday organisational practice, Orlikowski (2006) introduced the notion of 'scaffolding' to describe how material arrangements '*structure human activity by* supporting *and guiding it, while at the same time configuring and disciplining it'* (p.462). Similarly, object-centred approaches to sociality (Knorr Cetina, 1997; Suchman, 2005) highlight how objects and artefacts can exhibit affiliative power in shaping forms of affiliation (or dissociation) between people through common object orientations. Indeed, a study on the performative role of numerical data in care has shown how numbers shape consultations by orienting patients and clinicians to particular frames, values and representations (Essén and Oborn, 2017), suggesting such artefacts need to be considered when examining how peer relations emerge in group-based care.

1.2.2. *Constructing new patient roles and responsibilities*

Broader questions relate to patient roles and responsibilities projected through peer-based models of clinical care. Previous studies of new service delivery models have demonstrated how narratives of patient 'empowerment' are often closely linked with a neoliberal agenda to shift responsibility towards self-managing 'expert' patients (Hutchison and Holdsworth, 2021; May et al., 2014). Such discourse is evident in the promotion of group clinics in the UK, with the oft-cited two-fold aim of: 1) improving 'self-management' through peer support and 2) increasing service efficiencies (Hayhoe et al., 2017; Jones et al., 2019). These ambitions are arguably at odds with more idealistic, critical pedagogical philosophies that have traditionally underpinned peer-based initiatives.

Taking our cue from citizenship literature, which has uncovered how new identities and practices are coproduced by processes of biomedicalisation and technoscientific development (e.g. genomics, datafication) (Rabinow, 2022; Rose and Novas, 2005), we explore new forms of patienthood associated with what may be called an 'experiential turn' where new modes of health service delivery are increasingly designed to promote experiential knowledge sharing between those considered as 'peers'. We develop the term 'experiential caring' to denote a new mode of consulting that mobilises roles, practices, and subjectivities associated with peerhood.

2. Methods

2.1. *Overview of studies and datasets*

This article draws on three connected studies on group clinics (2016–2025, see supplemental file for a detailed overview). Study A, conducted before the Covid-19 pandemic, involved the implementation and mixed-methods evaluation of in-person group clinics for young people (16–25) living with diabetes in socioeconomically deprived areas (Papoutsi et al., 2022a). Study B used qualitative methods to examine the spread and scale-up of video consultations, including group delivery, during early emergency phases of the Covid-19 pandemic in 2020 (Papoutsi et al., 2022b). Study C used mixed methods to enhance understanding of the role of video and hybrid group clinics in systems under pressure after the Covid-19 emergency period (Papoutsi et al., 2024).

Our analysis is informed by processes of data generation across study sites and methods, bringing a longitudinal lens to surface shifting temporal contexts in how peerhood has been mobilised in group clinics. In this article, we primarily draw on in-depth qualitative data from two hospital outpatient centres delivering group clinics for diabetes (study A) and three general practice sites delivering group clinics for diabetes and menopause (studies B and C) (see Table 1 for details). Two (out of five) general practice sites in studies B and C prematurely discontinued group clinics due to key staff leaving and insufficient infrastructure support, limiting scope for detailed analysis (this data has contributed to analysis reported elsewhere).

At these five sites, we conducted ethnographic observations in 59 in-person, video and hybrid group clinics (of which 49 were audio- or video-recorded), 104 qualitative interviews with 48 patients/carers (including some who declined participation in group clinics) and 43 NHS staff involved in running group clinics or the wider service (some of

Table 1
Characteristics of included study sites[a].

Clinical sites (pseudonyms)	Location	Site characteristics	Types of group clinics observed	Clinical lead for group clinics
Moordale hospital (Study A)	East London	Outer city, high levels of ethnic diversity and deprivation	Diabetes for young people aged 16–25 (in-person), bimonthly sessions over two years[b]	Consultant and nurse
Cliveden hospital (Study A)	North-West London	Outer city, high levels of ethnic diversity and deprivation	Diabetes for young people aged 16–25 (in-person), bimonthly sessions over one year[b]	Consultant and nurse
Strandview GP surgery (Studies B and C)	South-East London	Urban, 15,000 patients, 6 GPs, high levels of ethnic diversity and deprivation	Diabetes reviews[c] (mostly hybrid), twice-weekly	Clinical pharmacist
Cress Hill PCN (4 surgeries) (Study C)	East of England	Rural, 45,000 patients, 13 GP partners, predominantly white British, low level of deprivation	Primarily menopause consultations[c] (video), fortnightly	Nurse, GP and social navigator
Yard Medical Centre (Study C)	Northern England	Semi-rural, 12,000 patients, 5 GP partners, predominantly white British, low level of deprivation	Menopause consultations[c] (video), monthly	GP

[a] This excludes 2 sites where group clinics were prematurely discontinued (reported on elsewhere).

[b] Involving some recurring patients.

[c] There were delivered to replace one-to-one appointments, involving different groups of patients in each session.

whom participated in repeat interviews). This was supplemented by interviews with 14 national and local decision-makers, programme managers, staff at other practices, third sector and industry stakeholders; observations of broader implementation processes (e.g. group clinics training, promotion seminars); and informal conversations.

As non-clinical, academic researchers, we were not involved in the delivery of group clinics, but funded to evaluate this new model of clinical service provision. Two researchers (one co-author, one in wider study team) had personal experience with the health issues discussed in group clinics, which enabled us to grapple with some of the nuances in seeking care for menopause and diabetes. The team (all women, mostly White British/European, varied socioeconomic backgrounds) however lacked diversity in gender and ethnicity. Although gender concordance facilitated our observations and interviews in menopause group clinics (as noted by some participants), there may equally have been some dynamics relating to e.g. racial dis/concordances less obvious to us or less likely to be shared with us.

2.2. Analytical procedure

All three studies focused on how patients related to one another within group clinics, and how varying forms of knowledge and support were negotiated between patients (and with staff). Consistent with our sociomaterial lens, we were sensitised to paying attention to material arrangements (e.g. teleconferencing arrangements, room design, artefacts) that might co-constitute these processes. One co-author (CP) was involved in all studies, ensuring that this line of enquiry was followed over time and across settings (e.g. in field notes, interview guides).

Data were analysed using the principles of abductive analysis (Timmermans and Tavory, 2022), an approach focused on theory construction. Analysis took place alongside data collection, with preliminary analyses used to identify theoretical literature deemed of potential relevance to the phenomena observed. This included social theory on peer support, patient expertise, patienthood, and citizenship. We sought index cases of new or surprising findings, and developed propositional arguments to explain these, which were refined based on further data collection and re-analysis. While we were initially interested in the role of consultation modality and group make-up (e.g. patients' backgrounds, interests), we were struck by data excerpts indicating relationships between artefacts and the ways in which peerhood was performed and described by participants. We subsequently re-analysed relevant data, looking for variations in practices and experiences of peerhood across participants, health conditions, and study sites, enabling us to uncover how peerhood was coshaped by the sociomaterial contexts through which group clinics materialised.

Alongside this process of comparing and contrasting, we developed a higher-order analysis to bring these differently emerging but connected practices of peerhood in different settings together, informed by a responsibilisation and citizenship lens. This part of our analysis was strongly guided by our interviews with patients, which helped us understand the rationale behind the peer-based care practices we observed, as well as the broader implications in terms of how ('good') patienthood is assumed and performed in group clinics.

Ethical approvals were granted for Study A by Office for Research Ethics Committees Northern Ireland (17/NI/0019), Study B by the NHS East Midlands Leicester Central Research Ethics Committee (20/EM0128), and Study C by the London Hampstead Research Ethics Committee and UK Health Research Authority (22/PR/0277).

3. Findings

3.1. Background and context

Across our five study sites, group clinics lasted around 1–1.5 hours, each with approximately 5–10 patients, typically delivered by a clinical lead (e.g. GP, nurse, clinical pharmacist) and a facilitator (e.g. receptionist, social navigator, healthcare assistant). Most group clinics included elements of clinical review (e.g. diagnosis, treatment review), patient discussion, and education, though the relative focus on each of these elements varied between settings (as described below). At some sites, staff received training in delivering (remote) group clinics from a commercial provider. While this training covered aspects of facilitation (e.g. establishing ground rules around mutual respect and confidentiality), these sessions did not explicitly focus on cultivating peer relations. Rather, there appeared to be an implicit assumption that 'peer support' would occur organically simply from bringing people with the same condition together.

While instances of, what may be referred to as, 'peer support' (e.g. experiential or practical knowledge sharing, psychological validation, emotional support) were evident from group clinic observations and patient interviews, what precisely these practices entailed differed between group clinics and across settings. To unpack this, we focused on the ways in which patients came to see others as peers (or not) in the circumstances through which group clinics were materialised, and how this determined what or whose contributions came to count and translate into support.

3.2. The sociomaterial constitution of peerhood in group clinics

Across studies, peerhood in group clinics was not a given, but a complex and situated process in which patients negotiated similarities and differences with others presented as 'peers'. Specifically, we found that artefacts (test results, glucose readings, symptom lists) and the way these were mobilised was consequential for the types of support accomplished, and partly determined what ‘care’ in group clinics looked like. In describing menopause and diabetes group clinics below, we distinguish two main ways in which artefacts transformed how patients related to each other, and how this in turn constituted practices of peerhood performed by patients.

3.2.1. Scaffolding difference through test results

In diabetes care across settings, group clinics tended to focus on reviewing ongoing disease progression, self-management, and treatment. In many group clinics, especially in general practice, this was complemented by a discussion of recent test results or glucose readings. Nearly all patients had an established diagnosis and readily identified with others on the basis of this. In interviews, patients commonly referred to being “*in the same boat” or “in the same position”* as other patients in group clinics. However, despite this identification, actual or perceived difference within this category became an implicit focus in how patients considered others, with biomedical artefacts (test results, glucose readings) playing a central role in how patients related to one another, in turn shaping forms of peerhood performed.

At ’Strandview’ GP surgery, hybrid group clinics for people living with type 2 diabetes were delivered to replace one-to-one diabetes reviews. These clinics centred on the ‘results board’, which included every patient’s latest test results (e.g. Hba1c, cholesterol, BMI). Hung up on a large notice board in the room and depicted on a PowerPoint for those joining online, this board took centre stage, with in-person participants seated towards the board and remote participants’ screens mostly taken up by the slide (Fig. 1). Continuously referring to the results board, the clinical lead would take turns reviewing each patient’s numbers while other patients listened or contributed to the discussion.

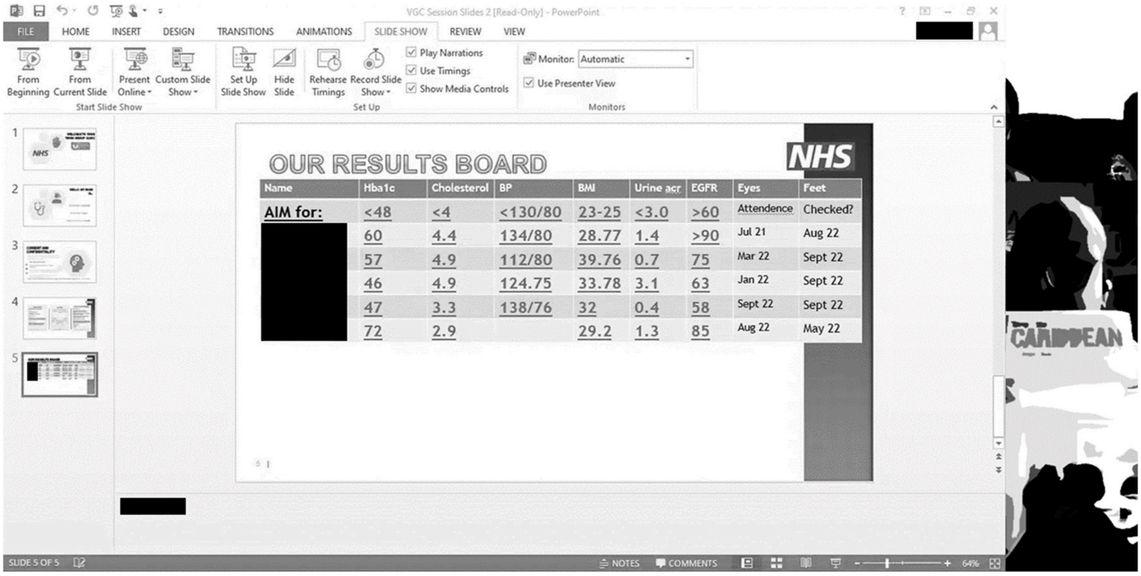
While primarily intended to guide consultation aspects of group clinics, the use of this board came to perform a central role in how patients related to one another. For patients and staff, displayed test results presented numerical ’facts’, and were seen as a reliable representation of how well someone was ‘self-managing’. Assuming a causal relationship between self-management and these figures, the ability to compare against each other created a standard or norm by which individuals – and their presumed expertise – could be judged. These differentiations between patients were partly reinforced by facilitators who implicitly or explicitly used numbers on the board to present patients as ‘good’ or ‘bad’ examples – such as in the following fieldnote: "*Avery has shared why his results are good. Now if I look here, Joslyn, yours have gone up. So think of the reasons why this might be. It could be some of us don’t like taking medication […] and not exercising enough.*” (verbatim excerpt (pseudonymised), hybrid group clinic 4, Strandview).

Differentiations between peers based on numerical figures came to define the specific peerhood role occupied by different individuals. Our post-clinic interviews repeatedly indicated that patients with results within or close to the biomedically defined ‘normal’ range came to be seen, by staff and (some) other patients, as peers who ought to be listened to and learned from, acquiring the status of a ‘good self-manager’ (i.e. an individual who takes ‘responsibility’ and possesses the knowledge to ‘self-manage’ effectively; (Ellis et al., 2017). In contrast, those with results significantly out of range were met with judgement or concern in some of our observations and patient interviews (e.g. seen as an example of what *not* to do*)*. This is exemplified in the patient interview excerpt below:

> *You learn from other people’s experience. Like because we want to know facts like about data. If you do this, what will happen? You want to know cause and effect. […] I want to get to John’s [results] because he’s done, his figures are very good, he’s a bit disciplined compared to me. […] Even Vee (patient with results furthest out of range) didn’t want to take the medication. Although it is good for her. […] So they are doing also something wrong.* (Interview (pseudonymised), Patient MH01, Strandview)

The quote above indicates how this patient positions herself against ‘better’ or ‘worse’ peers, in turn shaping how she approaches her peer role in relation to them. Indeed, during the group clinic, we observed her repeatedly seeking advice from John while she approached Vee with performative expressions of concern (appearing to want to instil the need for action).

In secondary care (‘Mooredale’ and ‘Cliveden’ hospitals), in-person group clinics were delivered for young people living with diabetes (primarily type 1) to increase patient engagement with self-care and treatment, with a core group of patients attending repeatedly. In this setting, test results similarly came to co-constitute forms of peerhood occupied by different individuals through anticipated (rather than presented) difference. Unlike in primary care, test results were not shared by default. Instead, more emphasis was placed on education and self-management, with patients using sensor-based glucose monitoring



☑ Play Narrations
☑ Use Timings
☑ Show Media Controls
Monitor: Automatic
☑ Use Presenter View

OUR RESULTS BOARD

Name	Hba1c	Cholesterol	BP	BMI	Urine acr	EGFR	Eyes	Feet
AIM for:	<48	<4	<130/80	23-25	<3.0	>60	Attendence	Checked?
[redacted]	60	4.4	134/80	28.77	1.4	>90	Jul 21	Aug 22
[redacted]	57	4.9	112/80	39.76	0.7	75	Mar 22	Sept 22
[redacted]	46	4.9	124.75	33.78	3.1	63	Jan 22	Sept 22
[redacted]	47	3.3	138/76	32	0.4	58	Sept 22	Sept 22
[redacted]	72	2.9		29.2	1.3	85	Aug 22	May 22

[redacted]

Fig. 1. Remote view of hybrid group clinic for diabetes (results board in centre, remote participants top right, in-person participants bottom right) (group clinic 1, Strandview).

systems offered the opportunity to share their readings once peer relationships had been established over time. A nurse would review a person's individual charts in the group, point out highs and lows, and invite a collective discussion on why these might have occurred. Because this happened in the context of existing peer relationships, these figures did not necessarily co-shape the process of acquiring a particular 'peer' status (as with general practice clinics), but rather posed a risk to one's established peer credentials. As a result, some patients hesitated to share their charts for fear that perceived differences with other patients would lead to judgment and threaten their position as peer, as exemplified in below field note:

> *Patient 1: I don't know about sharing. Clinician: You don't like to, OK. Patient 1: Because it's like up and down and you guys are going to be like, 'what, this girl is unconscious' […] I don't really want anybody else to see it with the high blood sugars, anyway.*
>
> *[… after the group clinic] Youth worker: What did you guys think about [patient 2's] readings, her stats? Patient 1: Great, yeah. Now I don't feel too bad about sharing mine. […] I feel like I've got similar readings, so whatever was told to her, I was just like, OK, I'm going to do that for the next time. (Group clinic 12, Moordale)*

While the above patient is comfortable indicating that her readings are likely to be high, sharing her charts with the group appears to feel different. The visible and 'factual' nature of these numbers seems to evoke fears of being othered to a greater extent than verbal discussions of difference.

Across diabetes sites, the anticipation of difference between patients meant that the presence of peers in group clinics did not necessarily translate into straightforward 'support' for all involved. While meeting others with higher results or readings was considered inspiring for some, such differences also served to individualise disease progression in less positive ways. This is, for example, reflected in the interview excerpts below where patients describe how 'being differently the same' (Mazanderani et al., 2012) led to feelings of failure and self-blame:

> *I feel like being around people who probably have good sugars will make me feel like 'wow, oh my gosh, like I need to do something'. Because how is everybody else around me managing to control theirs, but I can't manage to control mine. (Interview, Patient 8, Mooredale)*
>
> *There was someone who was on Metformin but they only take one tablet two times a day. So I'm taking four. Two in the morning and two in the evening. He's taking two, one in the morning and one in the evening, why? That kind of thing. What does he do that I'm not doing to get me down to one? (Interview, Patient KM01, Strandview)*

In short, meeting peers (or those presented as such) was not an unequivocal 'good' or a straightforward source of 'support', but rather led to different practices of peerhood coshaped by the ways in which group clinics were materialised. In diabetes group clinics, the foregrounding of individual difference based on test results and glucose readings meant that performances of peerhood took on a disciplinary form, broadly serving to reinforce biomedical regimes of self-control.

3.2.2. Scaffolding sameness through symptom lists

In menopause group clinics at 'Yard' and 'Cress Hill' (general practice), artefacts - in this case, symptom lists – similarly functioned to organise peerhood by presenting a reference for interactions between patients. However, rather than constituting difference, these artefacts ordered connections in ways that surfaced commonality in experiences between patients, thus functioning as 'scaffolding' (Orlikowski, 2006) for peerhood to develop.

In contrast to diabetes group clinics where patients had a shared pre-existing diagnosis, most individuals were triaged to menopause group clinics for *suspected* (peri-)menopause, and did not necessarily immediately identify with each other as 'peers' based on this. In interviews and observations, patients frequently referred to initially being "*in denial*" or experiencing self-doubt about their potential menopause, citing the persistence of menstruation, being "*past menopause*", or alternative conditions (e.g. mental health, underactive thyroid).

Conscious of this self-doubt, and the possible effects of stigma around menopause, facilitators across sites initiated group clinics with a symptom-sharing exercise as a "discussion starter" to help people open up about their experiences. At Cress Hill, the Greene Climacteric scale of symptoms (a scientifically validated measurement scale of psychological, somatic, and vasomotor symptoms) was displayed using screen-sharing functionalities (Fig. 2), following which people were asked to raise a hand or shout if they had experienced any of the symptoms (informally referred to as "*symptom bingo"* by one patient). At Yard, people were asked to write their "*top three"* symptoms in the meeting chat, with those judged to be of relevance to (peri-)menopause selected by the clinical facilitator, following which others were asked to raise their (virtual) hand if they had experienced similar symptoms.

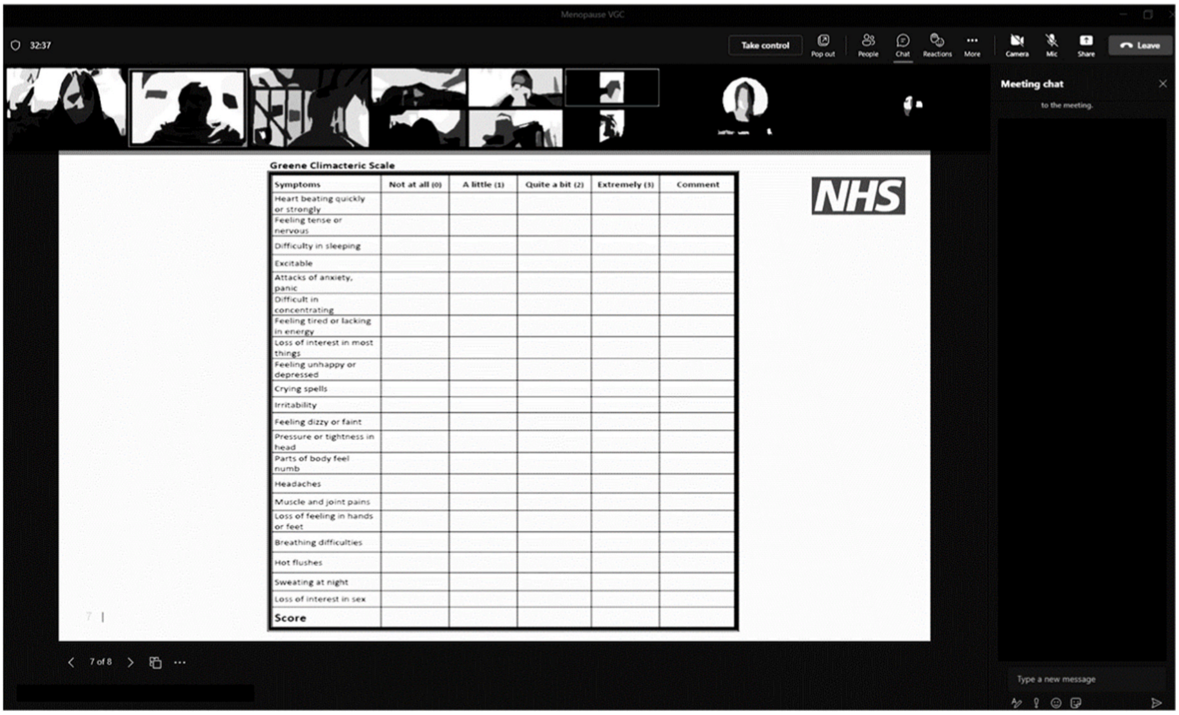
These symptom lists, visually displayed on screen and verbally emphasized through facilitation, performed as scaffolding that enabled connecting the embodied experiences of patients together *and* assigning those connections to (peri-)menopause. This meant that the emergence of peerhood here, as organised through symptom lists, not only offered a sense of validation, but also constituted a process of diagnosis-by-association:

> *Patient 1: Pins and needles! Facilitator: Yea, pins and needles. Patient 2: Yea, I get pins and needles a lot more than I used to. Patient 3: Yes, definitely. Facilitator: Sometimes we go through this list and everybody goes 'oh actually I have got that but I haven't seen it as connected'. Fun list this is, isn't it!* (Menopause video group clinic 1, Cress Hill)
>
> The GP reads out the symptoms she and others have entered in the meeting chat. *GP: 'Moodiness', anyone feeling moody?* [Five patients raise or wave their hand] *GP: Yep, got quite a lot of moodiness. 'Night sweats', anyone got that?* [Two patients and the GP raise or wave their hand] [...] *GP: So, we are all very much in the same kind of territory. Some of us more than others, some of us are probably further down the line, but we're all experiencing a variety of the same kind of territory of symptoms.* (Menopause video group clinic 5, Yard)

While people had considered how their bodily experiences might relate to known signs and symptoms of menopause before joining the group clinic, the presence of others who could corroborate their individual experience of these symptoms appeared to be transformational in moving from denial to acceptance. Indeed, in most interviews with participants of menopause group clinics, this process of self-validation via peers (through the symptom list, but also other identified similarities such as age) was presented as one of the most rewarding aspects of the clinic, and in many cases actively influenced their decision to start treatment.

> *I've heard of HRT [Hormone Replacement Therapy]. You know everything like that. And I think, probably in a way, I wanted to suffer because … I would like myself a lot to my mum. My mum never did anything. She, you know, suffered gracefully. […] [But] there were a couple of other young girls on there as well, on the call. And then … […] you think 'Oh, it's not just me'. There were the younger girls there. So you know, it's like oh well, maybe it's the menopause then, you know, maybe it is. (Interview, Patient BN01, Yard)*
>
> *There was a lot of nodding going on. So you know when the doctor said 'Do you feel this?'. And I was like 'yes', and everyone else going, 'Ohh yeah, me too'. So I think the realisation starts hitting a bit more and then you feel a bit more normal. That you're not abnormal, if that makes sense. So definitely the group situation helps because I think those people that are like, 'Oh, no, I'm absolutely not peri-menopausal' then it starts clicking that, maybe, actually they are. (Interview, Patient LT01, Cress Hill)*

While most patient interviewees described a sense of peerhood emerging from this focus on commonality in symptoms, it generated



Greene Climacteric Scale

Symptoms	Not at all (0)	A little (1)	Quite a bit (2)	Extremely (3)	Comment
Heart beating quickly or strongly					
Feeling tense or nervous					
Difficulty in sleeping					
Excitable					
Attacks of anxiety, panic					
Difficult in concentrating					
Feeling tired or lacking in energy					
Loss of interest in most things					
Feeling unhappy or depressed					
Crying spells					
Irritability					
Feeling dizzy or faint					
Pressure or tightness in head					
Parts of body feel numb					
Headaches					
Muscle and joint pains					
Loss of feeling in hands or feet					
Breathing difficulties					
Hot flushes					
Sweating at night					
Loss of interest in sex					
Score					

Fig. 2. Remote view of video-based menopause group clinic during symptom sharing exercise (symptom list in centre, facilitator and participants on top) (group clinic 4, Cress Hill).

experiences of otherness in some cases. A few interviewees described feeling embarrassed or not wanting to discuss symptoms they saw as idiosyncratic, e.g. "*I was the only person who seemed to have any problem with hair loss which I found very embarrassing*" (Interview, Patient BH01, Cress Hill). In another case, this prevented someone from discussing the main reason for requesting an appointment: "*I mean we can all be sort of 'we're all girls and we're all friends together' but again I don't really want to be telling them that my sex life is awful*" (Interview, Patient CT01, Cress Hill).

Hence, in menopause care, a focus on how experiences were aligned came to produce affirmative forms of peerhood centred on what actions may be taken to resolve collective suffering, but this was in some cases at the cost of caring for patients who perceived themselves to have idiosyncratic needs.

3.3. Mobilisations of peerhood as a clinical resource in care

We have described the ways in which patients come to identify with others as peers in different contexts, and how this co-constitutes what type of peer 'support' is accomplished in practice (or not). In this final section, we focus on how being presented as a peer in clinical consulting brings about new roles and responsibilities for patients. We introduce the term 'experiential caring' to denote a new mode of consulting that mobilises a particular set of roles, practices, and subjectivities associated with peerhood. The concept extends previous work by focusing on how possessing 'experiential credential' (Whelan, 2007) projects an assumed responsibility onto peers, and can be purposefully mobilised by staff as part of care (who themselves may lack such a credential). In referring to 'experiential', we do not claim that these practices of caring necessarily focus on experiential knowledge. Rather, we signify how the epistemic authority that comes with being (seen as) a peer in care produces responsibilities for patients *and* a clinical resource for staff.

3.3.1. Experiential caring: A new mode of care delivery

Across conditions and settings, experiential caring occurred through a) practices of caring that patients performed themselves to help others considered as peers and b) practices of caring where staff utilised the experiential status of other patients to add credentials to particular treatment advice (for example, using peers with good experiences of HRT to 'evidence' the positive effects of treatment).

Across settings, we observed multiple recurring practices of caring that patients performed to help others. In addition to psychological validation and knowledge sharing (e.g. experiential, practical 'know-how') described in earlier sections, this included patients purposefully using themselves as a good or bad example to others; reinforcing or contextualising advice given by staff (e.g. promoting an educational course, or advising how to inject); sharing concerns about others' wellbeing or self-care practices; and making contributions specifically for the benefit of others (e.g. asking the clinician questions anticipated to be helpful for others). Indeed, a sense of responsibilisation was commonplace across patient interviews, with implicit and explicit references to certain roles patients felt they had to perform as peers. As reflected in below interview excerpts, being a peer as part of clinical care reconfigures traditional notions of what it means to be a 'good patient', with individuals made to feel responsible to care not only for themselves, but also those presented as peers.

> *You're a live example to somebody. Somebody else can learn from you. But if you keep all that information to yourself or you feel shy and don't want to speak out it, you're not doing … you may only do yourself good but not others. (Interview, Patient MH01, Strandview)*

> *If it wasn't thanks to us [two of the patients] making her [another patient] realise that she shouldn't have done that, then she wouldn't have admitted it and then realised that she did wrong. So in some sense, it worked out well. […] Because they [other patients] may think it was normal. And then we tell them it's not normal. (Interview 15, Patient 10, Moordale)*

As in the section above, the types of caring that were performed between patients, and whether these came to be recognised and used as 'support', relied on how different versions of peerhood emerged in the circumstances through which group clinics were accomplished. In diabetes group clinics, where peerhood became (re)structured by difference based on biomedical tests and readings, practices of experiential caring often focused on encouraging or reinforcing behaviours seen as helping others ‘control’ or improve these narrow indicators for disease progression. In menopause group clinics, where peerhood emerged through orienting patients to commonality as organised by symptom lists, experiential caring involved validating others and affirming the (justified) need for (biomedical) action (e.g. by commencing HRT).

Informally referred to as "*the magic of group consultations*" by one clinical lead (ethnographic observation, Strandview), staff came to recognise and purposefully use the presence of (assumed) peers as a clinical resource. Specifically, in diabetes care, staff praised group clinics for the unique ways in which peers influenced each other to become (re-)moralised as ‘good self-managers’. For staff, a successful group clinic was one where ‘good self-managers’ attempted to influence peers who were perceived as less willing to engage with biomedical treatment advice (in ways that staff could not). As noted by the clinical lead at Strandview, "*in a peer-to-peer conversation, people have levers that they can effect*":

> *I was lucky enough to have a boy and a girl in the group, so the boy took off the boys that were doing badly and the girl took off the girls. And from that conversation, so much happened. […] she was sort of saying to the others ‘Look, I’ll pick you up, I’ll take you to my spin class, you just need to come’, kind of thing, right. And that’s when the realisation dawned upon Angela [a patient the clinician was concerned about], I think, that actually, I can do something about this, you know, it doesn’t have to define me, I can define it, I’m hoping anyway. […] that was the power, that actually there were two people who actually came, engaged, made a success of it, and were able to vocalise it to the others. (Interview (pseudonymised), Clinical lead, Strandview)*

In menopause care, the presence of peers similarly came to be utilised as a resource in care. Here, the psychological transition from denial to acceptance as brought about by emerging peerhood was an important condition for staff to meet their consultation objective: to enable patients to engage with clinical advice without being constrained by self-questioning or denial. Such a rationale is, for example, reflected in the below quote from the clinical lead at Yard:

> *There is something psychological that happens when you’re like, ‘Oh, it’s not just me’. There’s this sort of relief that they get when they hear other people saying it, as opposed to when I say it. They do often go ‘ohhh’ (uninterested nod) when I do it. But I think this is at a different level. It’s on a more emotional level. There is something that allows you to then engage with [the consultation]. ‘Yeah, I can do. I’m not alone. I can do something about this.’ (Interview, GP, Yard)*

At the two menopause sites, staff at times even attempted to claim experiential authority by presenting themselves as peers: “*the fact that I’m going through it is part of illustrating that it is an everyone thing, you might as well just accept it*” (Interview, GP, Menopause site 4). At one menopause site, this actively informed recruitment, where facilitators with lived experiences of (peri-)menopause were preferred.

3.3.2. Resistance and exclusion

There were some patients who were not able to meaningfully participate in, or resisted being inscribed into, the role of being a peer.

At one site, we observed three instances where group clinics included patients who had difficulties in speaking or understanding the group discussion (e.g. due to hearing impairments, language barriers) without the necessary support in place. These individuals had to rely on a caregiver (or a bilingual receptionist in one case), and this appeared to significantly constrain their ability to participate in peer elements of group clinics (e.g. due to only ‘essential’ clinical information being translated).

There were also a few patients who described purposefully minimising their engagement in group clinics or who prematurely left. Some, although not all, of these patients expressed concerns about emotional distress from hearing others’ struggles, an increased burden of treatment (relative to a one-to-one consultation), or privacy. This is, for instance, reflected in below quote where an interviewee alludes to the implicit pressure to ‘help others’ by sharing intimate health information. In doing so, she gives the example of another patient in her clinic who refused to share details with the clinician while other patients were present:

> *Like that guy said ‘I’ll have it on a one-to-one’ […] he said he had a couple of other questions. At the start, they did say ‘If you’ve got any other questions, and you want a one-to-one, you can have one’. But it was like he was in a pincer movement to say it in the forum because it could help other people. Well, that wasn’t what he wanted to do. […] Because all eyes are then on you and you’re just going ‘I’ll keep schtum’. Because I don’t want to be coerced or cowed into giving out information like that. (Interview, Patient KM01, Strandview)*

In another case, a man described choosing to join hybrid diabetes sessions remotely as it enables him to get this prescription while avoiding peer elements of the clinic (by turning camera and microphone off). These subtle forms of resistance illustrate how enacting ’good’ patienthood as part of peer-based services requires patients to engage in complex negotiations between individual versus collective concerns, such as not taking up too much time with one’s own care needs or sharing private illness experiences. While it may be an option to resist a peer role completely, doing so may compromise one’s ability to fully participate in care.

4. Discussion

Our study has critically interrogated the idea of ‘peer support’ as put forward in recent policies that promote peer-based initiatives as part of clinical care. We have done this by examining whether and how patients come to regard each other as peers in different group clinics, and how this in turn projects particular roles, responsibilities, and practices. Our findings resonate with a small number of studies that highlight the constitutive role of identity negotiations in determining whether and how knowledge and support are shared between patients (Locock and Brown, 2010; Mazanderani et al., 2012). We build on this literature by elucidating the sociomaterial nature of such negotiations, and how this subsequently shapes what forms of support are achieved (or not). Further, in introducing the concept of ‘experiential caring’, we have begun to conceptualise how peer-based initiatives of care inscribe patients to engage in particular practices of caring for others as part of their own care, and how particular practices, roles and subjectivities associated with peerhood present a new resource in care. We purposefully refer to this as ‘caring’ because of the ways in which these practices become mobilised as modes of clinical care (e.g. influencing treatment decisions, encouraging compliance).

The mobilisation of peerhood in group-based care provides a new dimension to long-standing debates around patient autonomy and care. In some ways, peer-based initiatives in care may seemingly help resolve identified tensions between patient autonomy (i.e. being able to make your own decisions) and what Pilnick terms ‘abandonment’ (i.e. being left to your own devices) in consumerist, choice-driven models of care (Mol, 2008; Pilnick, 2023). Group clinics enabled patients to share thoughts and experiences with others facing similar decisions about (self-)care (e.g. starting HRT). They also allowed patients to share practical ‘know-how’ (e.g. on daily living with diabetes (Pols, 2014), in a context where resources for intensive healthcare support are limited. For healthcare professionals, group clinics afforded the subtle use of peerhood to enact ‘soft influence’ on patients without presenting as overly paternalistic. These aspects were seen as beneficial by many patients and staff alike. However, our findings also highlight the importance of paying attention to how group-based forms of care reconfigure patient roles and responsibilities. Being a ‘good’ patient in group clinics involved a complex balancing act of looking after oneself while also being increasingly responsible for the success of care received by others, sometimes with significant implications for the type and extent of care one gets (e.g. when individual vis-à-vis group needs are conflicting).

Further, the associative role of biomedical artefacts in group clinics shows that even sincere attempts to 'democratise' care through peer-based initiatives may be overly idealistic without considering the material nature of these encounters. Previous studies have demonstrated how peer-based initiatives can lead to possibly detrimental consequences such as downward comparison or feeling othered (Locock and Brown, 2010; McLeish et al., 2023). We add to this by demonstrating how such comparisons become entangled with specific materials and arrangements in which people come together. Where others have rightly highlighted the critical role of societal structures (e.g. race, class) (Mullard et al., 2023; Turner et al., 2021), we find that peer relations are also co-constituted by seemingly mundane or practical 'things' that are imbued with tacit commitments to particular framings of illness and care, in turn shaping what forms of experiential caring are performed.

While we focused mainly on the performativity of artefacts in group clinics (the role of which was most pertinent across settings), capacities and constraints for acting also became differently available through the broader ways in which people, technologies, and other 'things' were configured in different group clinics (e.g. online, hybrid, in-person). This was particularly evident in how patients creatively experimented with the possibilities of teleconferencing arrangements (e.g. turning mic or camera off), reportedly either to distance themselves from their projected peer role, or conversely, to feel safer in intimately engaging with peers (due to a greater sense of emotional distance and personal control).

A strength of this research is the breadth of our dataset, reflecting substantive engagement with different healthcare organisations, group clinic types and modalities over the last 10 years. This enabled a nuanced understanding of how peerhood becomes constituted and mobilised in different contexts. However, by excluding sites that discontinued group clinics prematurely, we may have missed accounts on the emergence and sustenance of peerhood when group clinics are unexpectedly terminated (e.g. in the case of recurring groups of patients). Previous studies of recurrent participation in group clinics have highlighted how trust and intimacy between peers develops over time, with variable effects on the nature and outcomes of these engagements (Papoutsi et al., 2022a; Platt et al., 2022; Thompson-Lastad et al., 2025). Further work is needed to examine how peerhood manifests longer-term and in other settings.

We conclude that the emergence, nature and possible outcomes of peerhood must be considered in the social and material conditions in which it is enacted (or not). We have highlighted a range of complications that can arise when patients are invited to be a 'peer' as part of their clinical care. These do not only relate to the moral and emotional work involved in peerhood, but also to how clinical processes unfold when performed with collectives of patients. We have shown how clinical artefacts, in particular, can offer a readily available foundation for peer comparison, and may risk overshadowing an appreciation of other aspects of difference (e.g. medical histories, social circumstances, personal preferences) between patients in clinical encounters. The clinical and moral implications of such a transformational shift in how care is delivered, including how this informs the ways in which clinicians come to understand their patients and patients understand themselves, are ripe for investigation.

CRediT authorship contribution statement

Jackie van Dael: Writing – review & editing, Writing – original draft, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Sara Shaw:** Writing – review & editing, Project administration, Methodology, Investigation, Funding acquisition, Conceptualization. **Chrysanthi Papoutsi:** Writing – review & editing, Writing – original draft, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization.

Ethical statement

Ethical approvals were granted for Study A by Office for Research Ethics Committees Northern Ireland (17/NI/0019), Study B by the NHS East Midlands Leicester Central Research Ethics Committee (20/EM0128), and Study C by the London Hampstead Research Ethics Committee and UK Health Research Authority (22/PR/0277).

Acknowledgements

The authors would like to thank all individuals who took part in the studies reported on in this article, as well as our PPI members who have provided helpful reflections on early findings. We would also like to thank the broader study teams involved in this research, especially Claire Reidy and Sara Shasha'h for supporting aspects of data collection in study C, and Sarah Finer for leadership in study A. We also thank the anonymous reviewers for their helpful comments on the original manuscript.

The studies reported in this article were funded by the National Institute for Health and Care Research (NIHR) Health and Social Care Delivery Research (HSDR) Programme (ref 15/25/20 for Study A and NIHR133895 for Study C) and the Health Foundation (for Study B). The views expressed are those of the author(s) and not necessarily those of the NIHR, the Health Foundation, or the Department of Health and Social Care.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.socscimed.2025.118107.

Data availability

The data that has been used is confidential.

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