

Qualitative Research

Providing care to vulnerable populations: a qualitative study among GPs working in deprived areas in Montreal, Canada

Christine Loignon^{a,*}, Martin Fortin^a, Christophe Bedos^b, David Barbeau^c,
Alexandrine Boudreault-Fournier^d, Thomas Gottin^a, Émilie Goulet^a,
Elisha Laprise^a and Jeannie L Haggerty^e

^aFaculty of Medicine, Université de Sherbrooke, Sherbrooke, Quebec, ^bFaculty of Dentistry, McGill University, Montréal, Quebec, ^cFaculty of Medicine, University of Montreal, Montreal, Quebec, ^dFaculty of Social Sciences, University of Victoria, Victoria, British Columbia and ^eFaculty of Medicine, McGill University, Montréal, Quebec, Canada.

*Correspondence to Christine Loignon, Department of Family Medicine, Université de Sherbrooke, 150 Place Charles-LeMoine, Longueuil, Quebec, Canada; E-mail: christine.loignon@usherbrooke.ca

Abstract

Background. Communication barriers between persons living in poverty and healthcare professionals reduce care effectiveness. Little is known about the strategies general practitioners (GPs) use to enhance the effectiveness of care for their patients living in poverty.

Objective. The aim of this study was to identify strategies adopted by GPs to deliver appropriate care to patients living in poverty.

Methods. We conducted in-depth semi-structured interviews with 35 GPs practising in Montreal, Canada, who regularly provide care to underprivileged patients in primary care clinics located in deprived urban areas. Analysis consisted of interview debriefing, transcript coding, thematic analysis and data interpretation.

Results. GPs develop specific skills for caring for these patients that are responsive to their complex medical needs and challenging social context. Our respondents used three main strategies in working with their patients: building a personal connection to overcome social distance, aligning medical expectations with patients' social vulnerability and working collaboratively to empower patients. With these strategies, the physicians were able to enhance the patient–physician relationship and to take into account the impact of poverty on illness self-management.

Conclusions. Our results may help GPs improve the health and care experience of their vulnerable patients by adopting these strategies. The strategies' impacts on patients' experience of care and health outcomes should be evaluated as a prelude to integrating them into primary care practice and the training of future physicians.

Key words. Equity, patient-centered care, poverty, vulnerable populations, primary health care.

Introduction

Patients living in poverty, while very diverse, share a common reality: they are more at risk of living with multiple chronic conditions (1), having greater healthcare needs (2) and experiencing barriers when attempting to access primary care (3,4). They may

constitute a challenge for clinicians, who may feel overwhelmed and ill-equipped to manage their health needs (5,6). The social distance between physicians and underprivileged patients may inhibit their relationship, and studies have reported that physicians tend to be more directive with these patients, spend less

time with them and provide less information concerning treatment options (7,8).

This situation is highly problematic; indeed, the quality of the therapeutic relationship is crucial to effective care and to strengthening patients' capacity to manage their own chronic illness. Enhancing the therapeutic relationship is one of the foundations of patient-centred or relationship-centred care (9). It has the potential to foster trust in the patient–physician relationship. One critical element of the quality of relationship between underprivileged patients and GPs is the physicians' ability to develop 'social competence' and adapt their practice to the capabilities and social conditions of persons living in poverty. In effect, to contend with the social and material deprivation of patients living in poverty, GPs and other healthcare professionals need to adapt to these patients' needs and provide them appropriate guidance (8,10).

In Canada, as in many other countries, sociocultural and economic barriers to healthcare represent a heavy burden for persons living on low income or social assistance, persons with disabilities, aboriginal people and recent immigrants and refugees. In Quebec, despite reforms of the universal healthcare system aimed at improving the fit between population needs and medical care, social inequalities are not well addressed and GPs lack resources for providing care to persons living in poverty. To address these well-documented problems, it is crucial to understand how some GPs overcome challenges by adopting best practices for treating persons living in poverty who have complex care needs. The aim of this study was thus to identify the strategies used by GPs for effective delivery of care to patients living in poverty.

Methods

Study design and participants

We adopted a qualitative approach based on in-depth semi-structured interviews with general practitioners (GPs). This approach is relevant (11) for exploring a complex phenomenon about which little is known, such as family physicians' experience of providing care to patients living in poverty. Our study relied on Campinha Bacote's (12) concept of cultural competence, which we adapted and developed into the concept of 'social competence,' defined operationally as 'a process based on knowledge, skills and attitudes that supports effective interaction between the physician and patient, despite social distance' (8). We were interested in how social competence evolves through experience with underserved patients and enables physicians to better understand patients' living conditions and adapt care to their needs (8). The findings presented in this article are derived from a qualitative research program encompassing two funded studies that are described in detail elsewhere (8,13).

We recruited GPs in Montreal, Canada, the inclusion criterion being that they had to devote a majority of their time to providing care to patients living in poverty (defined as persons on social assistance or working poor). We excluded physicians who worked primarily in walk-in clinics. We used a mixed purposeful sampling strategy that combined snowball sampling, to recruit physicians recognized by peers as having expertise in providing care among deprived populations (8), and maximum variation sampling, to ensure we recruited physicians with various degrees of experience, practising family medicine in various underserved areas, caring for various types of underprivileged patients and working in various types of care organizations. We recruited physicians in person, by e-mail and by telephone and stopped recruiting when we achieved data saturation (11). Some physicians were recruited in person

through our ethnographic study in clinics. Our presence at those clinics and the involvement of the chief of the medical team helped us identify physicians corresponding to our inclusion criterion. Other physicians, a majority of them initially recommended by a participating physician, were contacted by e-mail or phone.

Data collection and analysis

Three experienced research assistants (A.B.F., E.L., T.G.) conducted semi-structured individual interviews in French, all using the same interview guide. The guide, based on our research questions, covered physicians' experience of caring for patients living in poverty, care strategies for those patients and perceptions concerning poverty. We asked all participants the same core questions on care strategies and used probing techniques to explore their perceptions and experiences (14). Questions included: What do you know about your patients' social context? How do you obtain this information? What do you do to overcome barriers and difficulties encountered when treating patients who live in poverty? What are your strategies to help low-income patients with multiple chronic conditions? Before the interview, each participant signed a consent form. None of the physicians contacted declined our invitation to be interviewed. Interviews lasted 45–90 minutes and were audiorecorded and subsequently transcribed verbatim. We obtained ethical approval from six institutional review and ethics committees representing the different locations where we conducted the research.

The research team (C.L., E.G., T.G.) conducted the thematic analysis (15) iteratively to improve rigour and credibility. In debriefing sessions conducted immediately after each interview, the researcher and research assistants reflected on the data collection, summarized findings, identified emerging hypotheses and prepared subsequent interviews. We developed codes for themes and subthemes through independent analysis of transcripts and consolidated them in team discussions. Each transcript was analysed by at least two members of the team, summarized and coded using NVivo software. They compared their work and resolved any discrepancies by reviewing and discussing the transcripts. Once all transcripts were coded and analyzed, C.L., T.G. and E.G. met to compare coded data from each interview, create broad categories across the interviews and identify dominant themes (15). Upon reaching the point when information from new interviews was redundant, we completed five more interviews to confirm data saturation had been reached. We validated our interpretations with members of a medical team that had participated in our study. We met several times with our co-researchers to share our interpretation, and we kept a logbook for the duration of the study. Among other things, it addressed the researchers' biases and methodological limitations.

Results

We interviewed 35 GPs (21 women and 14 men) working in deprived urban areas (Table 1) in Montreal where the poverty rate reached 29%. They ranged in age from 25 to 75 years and had between 1 and 48 years of experience. They worked in a variety of practices, and most chose to work in clinics where they were paid by salary or where medical teams allowed more time with underserved patients. Almost all had acquired international experience as residents; many were still involved in humanitarian or political activity. Many of our participants were engaged in different patient advocacy activities to improve the healthcare system. Participating physicians perceived themselves as having a social role to play in reducing and attenuating health inequities. From their point of view, 'doctors are privileged' in our society and they have a 'social responsibility' toward society.

Table 1. Description of participants (*N* = 35)

Characteristics	<i>n</i>
Age	
21–30	4
31–40	13
41–50	6
51–60	6
61+	6
Gender	
Female	21
Male	14
Years of experience	
0–5	9
6–15	11
16–30	7
31+	8
Type of organization ^a	
LSCs (salary)	12
LSCs + FMG (salary)	6
Integrated network clinics (fee-for-services)	4
ER (fee-for-services)	6
Community clinic (salary)	6
Other (salary and fee-for-services)	1

^aLocal community services centres (LSCs) provide health and social services (preventive and curative services) and various professionals work in these organizations. A family medicine group (FMG) is a group of physicians working closely with nurses to provide services to registered patients. FMGs are built upon pre-existing structures (CLSC, private practice, etc.) and are a strategy to facilitate access to family physicians. Integrated network clinics are also built upon pre-existing structures (private clinics) and were created to reduce ER visits. They provide extended hours of services and offer on-site lab and radiology services. They have been created by merging a traditional network clinic and a family medicine group, to which a team of health professionals has been added.

Our participants acknowledged the difficulties of caring for people living in poverty, the majority of whom live with multiple chronic conditions. Some GPs described patients' passive or negative attitudes toward health or chronic illness self-management and their low health literacy, as well as frustration over patients' not keeping appointments and neglecting significant health issues. Many of our participants reported that they had felt empathetic toward persons facing poverty issues even before beginning to practise medicine and that they had developed, over the course of their practice, a particular interest in a specific vulnerable subgroup of patients living in poverty, such as indigenous populations, immigrants or homeless persons. They alluded to a proliferation of systemic barriers for underprivileged patients within the healthcare system, especially concerning access to good quality of care for persons with mental health problems.

The following sections present three main strategies physicians used in working with patients living in poverty: (i) building a personal connection to overcome social distance; (ii) aligning their expectations with patients' social vulnerability and (iii) collaborating with other professionals to empower patients. Participants indicated that they used these strategies to varying degrees and depending on the type of patient. Some of them used the strategies more intensively than others, notably physicians with more experience and those who had developed over time a greater expertise in caring for socially marginalized patients.

Building a personal connection to overcome social distance

Physicians described spending time getting to know their patients, including finding out about their levels of material, social and health

deprivation. According to them, this personal connection was an essential step in developing mutual trust and overcoming social distance.

I need to know what's happening in her life, where she's living. I need to understand that this month, she's unemployed. I need to pay attention to all that. (MD 6)

Physicians reported using self-disclosure as a strategy to reduce this social (and/or cultural) distance and create a 'bridge of trust' with their patients, sometimes even sharing personal life anecdotes or events to connect with patients.

I'm no psychiatrist. But having the space ... to dialogue—not all the time, it doesn't always have to take an hour—but to say, 'We don't know each other yet; let's take an hour and go over things.' Then, they say what they wanted to say, and after that, there's a bond of trust established. Lots of people have said to me, 'My God, no one has ever asked me all these questions.' (MD 1)

Physicians recognized that the hardship and difficult social conditions (violence, food insecurity, insalubrious housing, etc.) often experienced by patients living in poverty could interfere with their care relationship. They indicated that, to deepen the relationship, it was important that they recognize patients' suffering and communicate this to them. The physicians invested considerable energy in searching for ways to convey empathy and listen actively, while setting clear limits with the patients and with themselves.

I would say that, given the especially chaotic lives of our patients, you can't not be [caring]. You know, a woman who was raped in prison for three months—you can't not care. You have to care. And we realize that this is part of the therapy in this clinic, which is that we're all listening carefully. We know that's part of the therapy, and we do it, and we take the time it takes to do it. (MD 10)

Aligning physicians' expectations with social vulnerability

Participants reported that, with experience over time, they developed the ability to understand poverty and its impact on patients' health and behaviours. Many explained, for instance, that unhealthy behaviours and self-damaging attitudes sometimes echoed the hurt, stress and stigmatization that patients experienced:

You have no social value because economically you have no value and politically you have no value. We see that these people integrate that view profoundly, it goes right to their core, that I'm garbage, I'm not worth anything. And that leads to all kinds of behaviours in relation to one's health, one's body, that are absolutely self-destructive. (MD 4)

Participants considered their knowledge about their patients' material deprivation and experience of stigma to be useful. They took social factors into account to adapt treatment plans to their patients' situation and vulnerability. Examples included lowering their expectations regarding healthy self-care behaviour and preventive recourse to care, and building on their patients' own sense of competency.

Saying that we understand them, that we know it's difficult; saying, 'well, is there some little thing you could do, something easy, not complicated?' (MD 6)

To keep focusing on their strengths, yes. Because, it's like society in general, the environment is always there to remind you of your shortcomings. I would say especially, as in the role of parent, I've been struck by how important it is to respect them. To say to them, you're the expert now. (MD 19)

According to participants, acknowledging their patients' social vulnerability and identifying patients' strengths helped them avoid judgmental attitudes. They adapted their biomedical language and were attentive to non-verbal gestures to verify whether patients understood their recommendations. They avoided infantilizing patients by explaining clearly, slowly and respectfully and by using simple metaphors. They did not lecture their patients about their noncompliance, but continued encouraging them to modify their lifestyle and adherence to treatment.

You always have to start with what the person is ready to change. But mainly you need to listen, try to understand exactly where they're coming from and what their strong points are, how to find what will motivate them in particular. (MD 14)

The physicians said they needed to accept that some of their patients would achieve only minimal change with their chronic illnesses. Nevertheless, they indicated that they persisted in communicating with patients respectfully about how to improve their health, since they achieved some success with this approach.

So, with our relationship and over time, he started to make changes in his life, obviously within the possibilities that he had. He was really, really happy to make those changes... Before, he drank two to four quarts of soft drink, and he stopped that. (MD 4)

Collaborating with other professionals to empower patients

Participants noted that teamwork was a fundamental strategy in caring for patients experiencing poverty, and that professional collaboration fostered access and relational continuity for their patients. Physicians did not simply delegate patient follow-up to other professionals; they recognized the added value of that expertise and integrated it into their chronic care management. They relied on their team to help patients navigate the healthcare system and obtain services from community organizations.

You have to learn it, you have to make mistakes, you have to let others help you. For sure, with the heavier clientele, we need the multidisciplinary team. I've learned a lot from the people in other professions that I've work with, especially with regard to relationships. (MD 3)

Encouraging patients to actively manage their own chronic condition, which often involves consulting various healthcare professionals in different places, requires what one patient called a 'back-up team.' Physicians described it as a trio that could take different forms, although usually it would be a team consisting of a physician, a nurse (or a receptionist) and a social worker (or a psychologist).

'Do you have problems with debt? Do you have money problems? There's help available for that; you know, we have a social worker. There are ways of helping you with that.' ... when you know he [the patient] has no money, well then,... it's very hard for him to change his eating habits. (MD 11)

Many participants reported that involvement in a cohesive team allowed them to learn from their peers and colleagues and increase their competence to offer better preventive care to the most vulnerable patients. They emphasized the team's solidarity and the mutual support among physicians and different professionals as they dealt with the problems presented by certain patients living in very difficult situations.

There's a fundamental difference between a group and a team. A group, it's people who come together around individual interests they share. You can find lots and lots of groups. A team, it's

people who share the same convictions, and a team is tested and proven in hard times. (MD 22)

For us, the team, it helps a lot when we support each other. We often have little chats over coffee together. If we didn't do that, none of us would still be there. (MD 24)

According to our most experienced participants, the three main strategies described above took shape through empathy and experience. Repeat contacts with patients living in poverty and openness to other providers' experiences and approaches with persons in poverty were key in acquiring social competence. As one participant mentioned:

It's not something you learn through one method; you learn it by osmosis ... in the thick of the action (MD 22)

Discussion

Our participants developed three main strategies aligned with social competence that, according to their observations, seemed to be appropriate to the needs and capabilities of persons living in poverty: building personal connections to overcome social distance, aligning physicians' expectations with patients' social vulnerability and collaborating with other professionals to empower patients. Our results demonstrate how these social competence strategies led GPs to take specific actions, such as suspending judgment by creating space to check assumptions and expectations, taking time to explore patients' socio-economic conditions, creating bridges of trust through appropriate self-disclosure and exploring patients' competencies. According to our participants, these actions appeared to have a beneficial impact on the patient-physician relationship and on patients' self-care over the long term.

Earlier studies have stressed the importance of not blaming patients for non-compliance and of providing socio-humanistic training to healthcare professionals (16). GPs in this study were aware of the negative effects of 'felt stigma', which is very detrimental for those patients. Scambler (17) reported that felt stigma ('internalized sense of shame') is more disruptive for patients than enacted stigma ('discrimination against others for being imperfect'). Physicians with significant social competence may help reduce felt stigma by taking steps to deepen relationships with patients and thereby reinforce preventive recourse to healthcare instead of consultations in crisis, as reported by Dixon-Woods (18).

Our results support two tenets observed in Hudon *et al.*'s (19) recent review of patient-centered care in chronic disease management: 'start with the patient's situation,' and 'advocate for the patient in the healthcare system.' Our study provides complementary observations. According to participating physicians, they were not only aware of their patients' social context, but also aligned their expectations with their patients' capabilities. This helped them avoid the judgments regarding non-compliance or missed appointments that have been reported among physicians in many studies (20). They were able to avoid unrealistic expectations, again in contrast to what the literature has reported (21). Working in collaboration with other health professionals and staff in community organizations, they identified their patients' capacity to self-manage their chronic illness and worked with them to gain better access to the health system.

Most of our participants were salaried and worked in primary care clinics that are supportive of patient-centered care, allowing time with patients and providing access to a multidisciplinary team. Our results support the conclusion that, from the physicians' perspective, a longitudinal care relationship and team care coordination may improve the health and care experience of low-income patients

(22). However, our respondents' ways of adapting communications to fit the needs of those patients were not conventional. Barriers in delivery of care to low-income patients are prevalent and documented in Canada and many other countries. Our results support Fiscella's (23) contention that efforts by physicians and other providers to treat vulnerable groups need to be recognized and supported.

Socially competent physicians' sharing of responsibility with larger teams to manage chronic illness in low-income patients bears similarities to the case-management model used for patients with severe mental health problems. In that model, the designated coordinator intentionally shares the therapeutic relationship with a small team to avoid creating dependency in a relationship with a single provider (24). This is healthy for the patient and reduces the risk of clinician burnout. The inclusion of team members in the therapeutic alliance is expected not only to increase the comprehensiveness of care available to patients living in poverty but also to sustain clinicians' social competence.

Our study has certain limitations. First, it is limited to the experience of physicians. Considering the various professionals involved in chronic care for low-income patients, it could be relevant to explore the strategies used by other professionals. Patients' perspectives on physicians' strategies identified in this study are also important and should be explored in future research. Second, our respondents practised in different deprived areas within one specific urban location. It could be interesting to compare the experiences of physicians and other professionals in other geographic contexts, such as rural areas or other cities. Finally, future studies could also employ different methodologies, such as longitudinal studies, to assess strategies' influence on patients' health over the long term.

Despite these limitations, the communication and relationship-building strategies identified here, which our participants have reported as being helpful in treating vulnerable patients living in poverty, can likely be applied in other practice contexts. They can be integrated into primary care practice and into the training of future physicians. The strategies were congruent with the social competence process model of care inspired by Campinha Bacote. In effect, physicians acknowledged their privileged social status, developed detailed knowledge about poverty conditions, were able to sustain positive therapeutic alliances, and adapted their practice to the patients' agendas and priorities (9). Our results suggest it could be valuable to adopt experiential learning approaches and to incorporate courses on poverty and social inequalities into the medical education curriculum to better prepare future generations of physicians to address care inequities. Service learning and critical reflection activities could potentially improve physician knowledge and attitudes toward patients living in poverty.

Declaration

Funding: Canadian Institutes of Health Research (CIHR MOP200361); Fonds de recherche du Québec - Santé (FRQ-S 16364).

Ethical approval: Charles-LeMoine Hospital Research Centre and five other ethics committees.

Conflict of interest: none.

Acknowledgements

We would like to express our gratitude to the participants for sharing their experience. We are grateful to all our colleagues for their comments on previous versions of this manuscript. We thank Duncan Sanderson for his comments and his contributions to the linguistic revision of the text. We also thank Donna Riley for editing the manuscript.

References

1. Macleod U, Mitchell E, Black M, Spence G. Comorbidity and socioeconomic deprivation: an observational study of the prevalence of comorbidity in general practice. *Eur J Gen Pract* 2004; 10: 24–6.
2. Mercer SW, Guthrie B, Furler J, Watt GC, Hart JT. Multimorbidity and the inverse care law in primary care. *BMJ* 2012; 344: e4152.
3. Hutchison B. Disparities in healthcare access and use: yackety-yack, yackety-yack. *Healthc Policy*. 2007; 3: 10–8.
4. Agency for Healthcare Research and Quality. *2012 National Healthcare Disparities Report*. Rockville, MD: U.S. Department of Health and Human Services; 2013. http://www.ahrq.gov/research/findings/nhqrdr/nhqrdr12/nhqrdr12_prov.pdf (accessed 18 September 2013).
5. Willems S, De Maesschalck S, Deveugele M, Derese A, De Maeseneer J. Socio-economic status of the patient and doctor-patient communication: does it make a difference? *Patient Educ Couns* 2005; 56: 139–46.
6. Malat J. Expanding research on the racial disparity in medical treatment with ideas from sociology. *Health (London)* 2006; 10: 303–21.
7. Bloch G, Rozmovits L, Giambone B. Barriers to primary care responsiveness to poverty as a risk factor for health. *BMC Fam Pract* 2011; 12: 62.
8. Loignon C, Haggerty JL, Fortin M *et al*. Physicians' social competence in the provision of care to persons living in poverty: research protocol. *BMC Health Serv Res* 2010; 10: 79.
9. Loignon C, Boudreault-Fournier A. Adaptability of physicians offering primary care to the poor: social competency revisited. *Healthc Policy* 2013; 9(Spec Issue): 59–70.
10. Loignon C, Boudreault-Fournier A. From paternalism to benevolent coaching: new model of care. *Can Fam Physician* 2012; 58: 1194–5, e618–9.
11. Patton MQ. *Qualitative Research and Evaluation Methods*. Thousand Oaks, CA: Sage Publications, 2002.
12. Campinha-Bacote J. The process of cultural competence in the delivery of healthcare services: a model of care. *J Transcult Nurs* 2002; 13:181–184; discussion 200–181.
13. Loignon C, Haggerty JL, Fortin M *et al*. What makes primary care effective for people in poverty living with multiple chronic conditions?: study protocol. *BMC Health Serv Res* 2010; 10: 320.
14. Kelly SE. Qualitative interviewing techniques and styles. In: Bourgeault I, Dingwall R, de Vries R (eds.) *The SAGE Handbook of Qualitative Methods in Health Research*. London, UK: Sage Publications; 2010:319.
15. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006; 3: 77–101.
16. Loignon C, Allison P, Landry A *et al*. Providing humanistic care: dentists' experiences in deprived areas. *J Dent Res* 2010; 89: 991–5.
17. Scambler G. Health-related stigma. *Social Health Illn* 2009; 31: 441–55.
18. Dixon-Woods M, Cavers D, Agarwal S *et al*. Conducting a critical interpretive synthesis of the literature on access to healthcare by vulnerable groups. *BMC Med Res Methodol* 2006; 6: 35.
19. Hudon C, Fortin M, Haggerty J *et al*. Patient-centered care in chronic disease management: a thematic analysis of the literature in family medicine. *Patient Educ Couns* 2012; 88: 170–6.
20. Willems SJ, Swinnen W, De Maeseneer JM. The GP's perception of poverty: a qualitative study. *Fam Pract* 2005; 22: 177–83.
21. Monnickendam M, Monnickendam SM, Katz C, Katan J. Health care for the poor—an exploration of primary-care physicians' perceptions of poor patients and of their helping behaviors. *Soc Sci Med* 2007; 64: 1463–74.
22. Nutting PA, Crabtree BF, Miller WL *et al*. Journey to the patient-centered medical home: a qualitative analysis of the experiences of practices in the National Demonstration Project. *Ann Fam Med* 2010; 8(suppl 1): S45–56; S92.
23. Fiscella K. Health care reform and equity: promise, pitfalls, and prescriptions. *Ann Fam Med* 2011; 9: 78–84.
24. Howgego IM, Yellowlees P, Owen C, Meldrum L, Dark F. The therapeutic alliance: the key to effective patient outcome? A descriptive review of the evidence in community mental health case management. *Aust N Z J Psychiatry* 2003; 37: 169–83.