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Qualitative Research

General practitioners' perspective on poverty: a qualitative study in Montreal, Canada

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Abstract

Background. Social inequalities in healthcare systems persist worldwide. Physicians' prejudices and negative attitudes towards people living in poverty are one of the determinants of healthcare inequalities. We know very little about general practitioners' (GPs) perceptions of poverty, which shape their attitudes.

Objective. To identify the perceptions of poverty of GPs who deal with it in everyday practice.

Methods. A qualitative study based on interviews with GPs working in deprived urban neighbourhoods. In-depth semi-structured interviews were conducted with physicians working in disadvantaged neighbourhoods in Montreal, Canada. Interviews were audio-recorded and transcribed verbatim. Analysis consisted of interview debriefing, transcript coding, and thematic analysis using an inductive and iterative approach.

Results. Our study revealed two contrasting perceptions of poverty. The global conception of poverty referred to social determinants and was shared by the majority of physicians interviewed, while the moral conception, centring on individual responsibility, was shared by a minority of participants.

Conclusion. The moral judgments and misunderstandings evidenced by GPs regarding poverty suggest avenues for improving general medical training. Understanding social determinants of health should be an important component of this training, to improve access to care for people living in poverty.

Key words: Delivery of healthcare, education, equity, general practitioner, perceptions, poverty, social determinants of health.

Introduction

Healthcare systems, even universal ones such as those in Canada, can increase health inequalities if they do not take into account the needs and socioeconomic living conditions of underserved populations. Indeed, people who have the greatest needs tend to be those who receive less in the health system, a persistent phenomenon called 'inverse care law' (1). Social determinants of health, which are a major source of social inequalities in health, are addressed during mandatory seminars in medical schools, to help residents better shape their future practices (2). This training covers the main dimensions of poverty, related to economic well-being, social isolation, and capability (3).

People living in poverty may experience barriers to healthcare as well as stigma and discrimination from healthcare professionals (4,5). These barriers can be related to structural barriers inherent to deficient organizational arrangements within the healthcare system or to weak healthcare policies for reducing social inequalities (6). In either case, they are also related to prejudices rooted in distorted perceptions of poverty and of people living in precarious situations (6,7). Prejudices concerning poverty and its determinants are

persistent and contribute to limiting access to the healthcare system for people living in poverty (8,9).

Indeed, it seems that lack of knowledge and negative perceptions regarding poverty affect the quality of clinical interactions with populations in precarious situations (10): when it comes to socio-economically disadvantaged patients, physicians tend to be more directive, spend less time, and provide less information concerning treatment options (11).

However, studies have been less concerned with investigating the perceptions and attitudes of general practitioners (GPs) than those of medical students. For example, a study focusing on residents in medicine (12) showed that 25% of them thought that being poor was a consequence of laziness, 50% believed that people living in poverty were more likely to abuse the healthcare system, and 50% thought people living in poverty were less attentive to their health than the rest of the population.

We do not know very much about how physicians view poverty, how they perceive underprivileged persons, and how this might shape their attitudes, behaviours, and actions. Since S. Moscovici's work in social psychology (13), representations are considered to be one of the vectors of the actions of individuals. Social representations, defined as organized sets of knowledge and judgements that a given group develops in relation to an object, influence individuals' perceptions and attitudes.

The aim of this study is to understand how GPs perceive poverty and, in particular, how they perceive their own patients living in poverty.

Method

Study design

We conducted in-depth semi-structured interviews with GPs. A qualitative descriptive approach of this type is relevant for exploring a complex phenomenon about which we know little, such as GPs' perspectives on poverty (14). Our analysis of GPs' statements regarding poverty relies on data from a qualitative research program encompassing two funded studies that are described in detail elsewhere (15).

The conceptual framework for our analysis draws from medical sociology and is based on Moscovici's framework of social representations and Paugam's moral and global conceptions of attribution of poverty (16,17). According to the global conception, poverty is understood as a structural phenomenon caused by social inequalities and pertaining to the politico-economic system. In contrast, according to the moral conception, the attribution of an individual or social cause of poverty is determined by the position of individuals and society relative to poverty. This position is characterized by critical judgment focused on patient behaviour ('They are lazy') or by observation ('They had no chance').

Recruitment

Participants were recruited from among GPs in Montreal, Canada. GPs were invited to participate if they devoted a majority of their time to providing care to patients living in poverty (defined as working poor or individuals on social assistance). GPs working primarily in walk-in clinics were excluded. Our sampling strategy was mixed: We used maximum variation to ensure we recruited physicians with various degrees of experience, practicing family medicine in various underserved areas, caring for various types of underprivileged patients, and working in various types of care organizations. We also used snowball sampling to recruit GPs recognized by peers as having expertise in providing care to deprived populations. GPs were recruited in person, by e-mail, and by phone. A majority were recommended by another participating GP. We stopped recruiting after achieving data saturation (18).

Data collection

The semi-structured individual interviews were conducted in French by three experienced research assistants with backgrounds in anthropology, all using the same interview guide (Box 1). Participants were given the same core questions on care strategies, while probing techniques were used to explore their perceptions and experiences.

Each participant signed a consent form before being interviewed. None of the GPs contacted declined our invitation to participate. The interviews, which lasted 45 to 90 minutes, were audio-recorded and subsequently transcribed verbatim. Ethics approval for this study was obtained from the six Institutional Review and Ethics Boards representing the different locations where we conducted the research.

Analysis

To improve rigour and credibility, the research team conducted the thematic analysis (19) iteratively. The researcher and research assistants held debriefing sessions immediately after each interview to reflect on the data collection, summarize findings, identify emerging hypotheses, and prepare subsequent interviews. Codes for themes and sub-themes were developed through independent analysis of transcripts and consolidated during team discussions. At least two members of the team analysed, summarized, and coded each transcript using NVivo software. Any discrepancies were resolved by reviewing and discussing the transcripts to reach a consensus. Once all transcripts were coded and analysed, the research team met to compare coded data from each interview, create broad categories across the interviews, and identify dominant themes (18). After reaching the point where information from new interviews was redundant, we completed five additional interviews to confirm data saturation had been reached.

Results

In total, 35 GPs participated in the study. The sample consisted of 21 women and 14 men, mostly between 30 and 60 years old (Table 1) and all working in deprived urban areas in Montreal, Canada, where the overall percentage of persons living below the low-income level reached 29% (20). Most participants had previous international experience as residents. Most of them were also involved in humanitarian or political advocacy. Their years of experience in practicing

Box 1. Interview topic guide

Thematic sections

- Physicians' experience of caring for patients living in poverty
- Care strategies for those patients
- Perceptions concerning poverty

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?

medicine ranged from less than 5 years (n = 9), to between 6 and 15 years (n = 18), or more than 15 years (n = 8).

Our study revealed two contrasting perceptions of poverty (Table 2), which corresponded to Paugam's global and moral conceptions of poverty. The global conception of poverty, referring to social determinants, was held by 22 GPs, while the moral conception, centring on individual responsibility, was held by 11 participants.

1 – Perception of poverty based on social determinants

The causes of poverty are structural

A majority of participants (n = 22) subscribed to this conception of poverty, considering that patients' precarious situations were mainly the result of social-structural factors. They pointed to critical linkages between social inequalities in health and the unequal distribution of economic resources among different categories of individuals. These participants denounced the competitive, alienating, and consumerist mentality that exacerbates inequalities between different social classes. For instance, they perceived unemployment, the low quality of housing in poor neighbourhoods, and inexpensive unhealthy food as considerable impediments to people's health:

> *"For me, poverty is not an individual problem; social assistance, unemployment are structural phenomena. We live in a society that creates them. So, as long as we live in such a society, we will have disadvantaged people and poverty."* (Physician A)

Many GPs considered that the healthcare system does not meet the needs of the poorest people, who often face structural barriers (i.e. overloaded hospitals, bureaucracy, navigation of a complex system, dehumanization, and limited continuity of care). According to the participants, this led to resignation or despair among these patients, who consequently tended to avoid seeking care.

Table 1. Sociodemographic characteristics of study participants

Characteristics	N
Age	
21–30	4
31–40	13
41–50	6
51–60	6
60 et +	6
Gender	
Female	21
Male	14
Years of practice	
0–5	9
6–15	18
16 or more	8
Internships during residency	
Quebec	23
International	12

> *"Healthcare is not adapted, so my patients have some experiences of care, either because of prejudice, or whatever ... (...) which seem to them so complex, such a difficult system to get into, that sometimes they are like, 'Aw, heck, I don't feel that bad anyways, I'm not going to see a doctor.'"* (Physician B)

Overall, these participants spoke quite critically of the healthcare system, which they accused of failing to meet the needs of the most stigmatized populations.

> *"I think that the system is not sufficiently adapted to clients who are more disorganized, meaning people who often go for a consultation in an emergency situation; prevention is difficult to achieve, and then delivery of care: they go for a consultation when they're really sick, otherwise they don't have a family doctor, or they've missed three appointments, or they haven't been to see a hematologist because it was a six-month wait, they didn't go for their echocardiogram because they don't have a day planner, so they forgot they had an appointment."* (Physician W)

Above all, GPs decried the lack of resources and the low value placed on community-based primary care practice among vulnerable populations, unrealistic productivity expectations, the trend toward privatization that reduces access to many healthcare services for persons in poverty, and the inflexible, complex administrative system. Two GPs expressed their own frank perspective concerning the systemic issues preventing the system from responding to the needs of persons living in poverty:

> *"I've always said, the healthcare system doesn't want me as a doctor, because I'm not a doctor who does high output; while the current system requires performance in terms of quantity of patients seen. On the other hand, once my patients have seen me, of course, they don't need to go for 15 more consultations elsewhere."* (Physician J)
>
> *"Because often, you feel incompetent because you end up in situations where you have a patient in front of you, and you say, 'You need to see such and such a specialist, you need such and such a test; we'll send a letter now, and you'll get it in six months.' Well, the patient calls you up and comes back every six months. And, well, you end up feeling like you're doing your job wrong, and you get home at night thinking, 'Well, I didn't do very good work there.'"* (Physician D)

Marginality, social isolation

Participants emphasized that patients living in precarious situations often internalized the negative images associated with their condition in political discourse, media, and even communications with healthcare providers. The widespread idea that 'poverty is a choice' generates contempt, pity, and ignorance. Many GPs said they had patients who were discredited and discarded by institutions (persons with drug addiction problems stigmatized in hospitals, for example), by specialists (infantilization of homeless people), or by public opinion (which often considers the marginal as inactive or useless to society).

> "*But with respect to very disadvantaged people, society often conveys the image that 'You're nobody, you are a social parasite,*

Table 2. Participating physicians' perceptions of poverty

Perceptions of poverty	Causes of poverty	Impacts of poverty
Social determinants	• Societal injustice • Unsuitable health system	• Internalization of marginalization • Social isolation
Individual responsibility	• Low literacy • Unhealthy lifestyles	• Abuse/Manipulation • Passivity

you're a waste. You are worthless socially because you're worth nothing economically and politically, because from all points of view, you don't amount to much.' So like it or not, these people absorb this image deeply, they absorb it into their bones: I'm a waste, I'm worthless, I'm nothing. And this causes all sorts of behaviours toward health, toward the body, that are downright destructive, that express 'Well, I'm a waste?'" (Physician C)

In addition, these GPs reported that people living in poverty suffered from social isolation. According to participants, social isolation was more prevalent in the most marginalized populations, such as the elderly, the homeless, or people with mental illness or drug addiction problems. These patients are often isolated due to monetary, educational, or job-related deprivation:

"Another way in which patients can be vulnerable is isolation. We see many elderly patients who have lost their social network. And obviously we see it a lot among immigrants, young immigrant families who don't speak French yet. We also see it in women who have been victims of domestic violence. There are shelters for women victims of violence; they are also isolated and they have lots of difficulties." (Physician D)

Finally, the participating GPs suggested that the most vulnerable patients might reproduce parental patterns, leave school early, and not be reached by health-promoting messages. Because of their lack of education and skills, they then have a lot of difficulty finding jobs and tend to adopt cheaper, unhealthier eating habits due to a lack of education and financial resources:

"It's chronic under-stimulation over several generations; we often see that the parents had maybe one or two jobs, they didn't really have good jobs, and children repeat these patterns –they do not go to school much, they drop out more than the average, they are not encouraged by their family to pursue their studies, so they do not have many financial resources." (Physician E)

2—Perception of poverty based on individual responsibility

The causes of poverty are individual

Adhering to this conception of poverty, some participants (n = 11) in our study considered that patients were individually responsible for their precarious situations. GPs felt that the causes of poverty were, at least to some extent, related to patients' behaviours. The low literacy of people living in poverty was a recurring factor in participants' remarks. According to them, such patients have limited intellectual resources and, consequently, limited critical analysis and insufficient reflexivity, which prevents them from dealing with adversity.

"They watch TV a lot. They don't read so many books. I have no TV, I read Le Devoir [a daily Quebec newspaper aimed at a socially progressive readership] every day. I don't think any of my patients read Le Devoir (...)" (Physician F)

Some participants noted that certain patients have poor compliance or have strong addiction problems. Alcohol and drug use was repeatedly raised by GPs as a problem they cannot solve, since such addictions are primarily determined by patient behaviours.

"Because there are patients who stink, there are patients who are not compliant, there are patients who will say things that are not nice, there are patients who have personality disorders, and we don't like that. Anyway, there's nothing we can do for them. They are drug addicts anyways. And that is their problem." (Physician G)

"Of course, clearly many people have compliance problems. I think that, definitely, the more educated you are, the more affluent you are, the greater the chances of good compliance." (Physician V)

Passivity and manipulation

Laziness and manipulation emerged as significant topics in participants' responses. The GPs distinguished between patients who complain and who have the right to complain, and those who abuse the system and view themselves as 'being entitled' to social assistance. Specifically, the participants labelled native-born Quebecois on social assistance as lazy, compared to immigrant patients whose poverty situation has a certain legitimacy due to difficult living conditions, lack of familiarity with Quebec culture, or even tragedies experienced prior to immigrating. Thus, GPs tended to display more understanding for non-native patients living in situations of poverty than for Quebec-born patients who, as they saw it, depend on social assistance while having many opportunities to avoid it:

"But I think the big difference between these two populations is not primarily the respect they have for us, it's us, the respect we have for them. It is also about how we judge people. You know, we have the tendency to admire someone who left his country, came here, and who did something with his life, more than someone who was born here, who perhaps, in our opinion, had all the opportunities – although probably not – and who chose in the end to remain in his misery." (Physician H)

Participants also thought that some patients had a passive attitude and would tend to manipulate and to blame the system for their condition.

"It depends on the patient. It is not always easy. There are some who are trying to trick you. Listen, I've been manipulated. I look back on situations where this is obvious, papers….welfare, work-related accidents. Asking me for prescriptions for this medication or that problem, I have no problem with that; but people who come telling me 'Look, I am going through some rough times at work, sign the papers please.'" (Physician I)

In sum, physicians who adhered to a conception of individual responsibility tended to exhibit prejudices towards certain patients in situations of poverty. They expressed a lack of understanding, even exasperation, regarding patients who missed their appointments, did not follow their prescriptions, or refused to change life habits (e.g. substance abuse) that were injurious to their health.

Discussion

Summary

Although all of the participating physicians served deprived populations, they had varying opinions on poverty, its causes, and its implications. Two main perceptions of poverty stood out: (i) a perception of poverty based on social determinants (global conception of poverty) and (ii) a perception of poverty based on individual responsibility (moral conception of poverty).

Most GPs interviewed viewed poverty in a global and structural context rather than in an individual, moral one. However, a minority of them saw their patient's precarious life situations as an outcome of laziness and passivity. A few physicians felt that some of the most disadvantaged patients might not deserve social assistance, as it keeps them in a passive attitude. These physicians found it more challenging to deal with certain patients, such as those with drug addiction problems, unemployed, or receiving social assistance, and sometimes projected misconceptions or prejudices onto them by perceiving them as lacking in personal will.

Comments concerning individual responsibility for poverty also suggested a gradient of empathy towards certain populations affected by poverty. Physicians who had little experience with addicts or homeless patients felt that immigrant populations were more deserving of governmental assistance and of physicians' empathy than native-born Quebecois patients. Our analysis of perceptions of poverty thus shows that some GPs' opinions, when constructed around the notion of individual responsibility for poverty, were founded on a sense of morality. The dichotomy between a perception of poverty revolving around structural effects and one based on a moral judgment goes back to 16th century England, when Elizabethan laws for relief of the poor made a distinction between those members of the population who were unable to work (physical handicapped) and deserved some social assistance, and those who refused to work and did not deserve such support.

Strengths and limitations of the study

Perceptions of poverty were captured through two perspectives: one global, one moral. Our results rely only on what participants said, without comparing their statements to their actual general practice with patients. Conducting systematic observations of each physician interviewed in a clinical setting and in the context of practice might have enriched our results.

It is also reasonable to expect that there may be discrepancies between physicians' perceptions and those of their patients. Comparing the two perspectives would likely produce a wealth of lessons on how to improve access to the healthcare system. It is possible as well that selection bias might have affected our results, as we used snowball sampling to recruit GPs who had significant experience with patients living in poverty. Finally, we acknowledge that, given the intrinsic limitations of qualitative design, our findings cannot be generalized to the broader Canadian context or to other countries. However, we used three strategies to improve the external validity of our study, thereby improving the transferability of our findings at a theoretical level: maximum variation sampling, achieving data saturation, and detailed documentation of our methodology. We are thus confident that our findings are transferable to similar context in others countries or provinces with a universal healthcare system.

Comparison with existing literature

The literature shows that socioeconomically disadvantaged persons are the least well-served in terms of healthcare services (1) and the least likely to have a family physician (21). They experience negative healthcare interactions and sometimes feel judged by physicians (22–25). Several studies have looked at healthcare professionals' perceptions regarding persons living on social assistance (26), as well as at medical students' perceptions with respect to poverty, but few studies have considered physicians' point of view.

Our study complements the work done by Willems et al. (10), showing that most physicians working in disadvantaged areas are aware of the social dimensions of poverty. It differs, however, in that it focused only on GPs working in underserved neighbourhoods and adopted a medical sociology perspective, which allowed us to highlight both global and moral conceptions of poverty, investigating their repercussions on medical practice. In two previous studies, we documented how a lack of adequate preparation as well as insufficient evidence-based knowledge on poverty and inverse care law could lead some GPs to experience a sense of powerlessness and to engage in discriminatory behaviour towards low-income patients (27).

It is clear that clinicians face challenges in delivering care to socioeconomically disadvantaged patients and are not always well prepared to take social context into account to create therapeutic alliances. Health professionals, particularly physicians, sometimes do not understand these patients' social situations. Primary care physicians, however, occupy a highly influential position in people's lives (28), close to their personal and day-to-day experiences.

Hence, it is important to ensure family medicine residents are better educated concerning the impact of poverty on health and healthcare, especially by arranging residencies in socioeconomically disadvantaged areas. Becoming familiar with poverty situations is likely to help future physicians develop social competencies (29). Generally speaking, direct experience with social settings different from one's own contributes to a deeper understanding of causes and behaviours associated with a given social phenomenon (30). However, contact with poverty situations may not always be sufficient to elicit empathy and improve understanding of such situations (31), notably due to the social distance separating physicians from the most disadvantaged patients (32). Unfortunately, few medical residency programs offer satisfactory and well-resourced training programs that prepare future family physicians to cope with poverty issues in the healthcare process. The GPs in our study also raised important issues concerning the healthcare system barriers that prevent patients living in poverty from receiving the best available care. We can hypothesize that some prejudices or misunderstandings towards certain patients living in poverty may be exacerbated by structural barriers and by the healthcare system's failure to respond to the neediest populations.

Implications for practice and training

This study helps identify GPs' perceptions regarding poverty. Our results suggest that physician training should cover not only knowledge of health sciences, but also social factors that influence health, such as living, working, and housing conditions, and level of education.

The results of this study will be used to improve GP training, to make them aware that an approach that stigmatizes or infantilizes disadvantaged persons can have adverse consequences on their access to care, and to encourage GPs to adopt a more open view of social realities, without judging the people to whom they are providing care.

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References

1. Mercer SW, Watt GC. The inverse care law: clinical primary care encounters in deprived and affluent areas of Scotland. *Ann Fam Med* 2007; 5: 503–10.

2. Westerhaus M, Finnegan A, Haidar M *et al*. The necessity of social medicine in medical education. *Acad Med* 2015; 90: 565–8.
3. Wagle U. Rethinking poverty: definition and measurement. *Int Soc Sci J* 2002; 54: 155–165.
4. Loignon C, Allison P, Landry A *et al*. Providing humanistic care: dentists' experiences in deprived areas. *J Dent Res* 2010; 89: 991–5.
5. Williamson DL, Stewart MJ, Hayward K *et al*. Low-income Canadians' experiences with health-related services: implications for health care reform. *Health Policy* 2006; 76: 106–21.
6. Raphael D. *Poverty and policy in Canada. Implications for health and quality of life*. Toronto: Canadian Scholars Publishers, 2007.
7. Hudon C, Loignon C, Grabovschi C *et al*. Medical education for equity in health: a participatory action research involving persons living in poverty and healthcare professionals. *BMC Med Educ* 2016; 16: 106.
8. 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.
9. Veugelers PJ, Yip AM. Socioeconomic disparities in health care use: Does universal coverage reduce inequalities in health? *J Epidemiol Community Health* 2003; 57: 424–8.
10. Willems SJ, Swinnen W, De Maeseneer JM. The GP's perception of poverty: a qualitative study. *Fam Pract* 2005; 22: 177–83.
11. Bloch G, Rozmovits L, Giambrone B. Barriers to primary care responsiveness to poverty as a risk factor for health. *BMC Fam Pract* 2011; 12: 62.
12. Price JH, Desmond SM, Snyder FF, Kimmel SR. Perceptions of family practice residents regarding health care and poor patients. *J Fam Pract* 1988; 27: 615–21.
13. Moscovici S. Preface. In: Herzlich C (ed). *Santé et maladie. Analyse d'une représentation sociale*. Paris: Mouton, 1984.
14. Patton MQ. *Qualitative Research and Evaluation Methods*. Thousand Oaks, CA: Sage Publications, 2002.
15. Loignon C, Haggerty JL, Fortin M, Bedos CP, Allen D, Barbeau D. Physicians' social competence in the provision of care to persons living in poverty: research protocol. *BMC Health Serv Res* 2010; 10: 79.
16. Moscovici S. L'ère des représentations sociales. In: Doise W, Palmonari A (eds). *L'étude des représentations sociales*. Neuchâtel: Delachaux et Niestlé, 1986.
17. Paugam S, Selz M. La perception de la pauvreté en Europe depuis le milieu des années 1970. Analyse des variations structurelles et conjoncturelles. *Econ Stat* 2005; 383: 283–305.
18. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006; 3: 77–101.
19. Bardin L. *L'analyse de contenu*. 8th ed. Paris: PUF, 1996.
20. *Annuaire Statistique Agglomération de Montréal, Recensement de 2011 Enquête nationale auprès des ménages de* 2011, Ville de Montréal, 178–179.
21. Lasser KE, Himmelstein DU, Woolhandler S. Access to care, health status, and health disparities in the United States and Canada: results of a cross-national population-based survey. *Am J Public Health* 2006; 96: 1300–7.
22. Hutchison B. Disparities in healthcare access and use: yackety-yack, yackety-yack. *Health Policy* 2007; 3: 10–13.
23. Loignon C, Bedos C, Sévigny R, Leduc N. Understanding the self-care strategies of patients with asthma. *Patient Educ Couns* 2009; 75: 256–62.
24. Mercer SW, Cawston PG, Bikker AP. Quality in general practice consultations; a qualitative study of the views of patients living in an area of high socio-economic deprivation in Scotland. *BMC Fam Pract* 2007; 8: 22.
25. Reid C. *The Wounds of Exlcusion: Poverty, Women's Health and Social Justice*. Walnut Creek, CA: Left Coast Press, 2007.
26. Friedmann J. Rethinking poverty: Empowerment and Citizen Rights. *Int Soc Sci J* 1996; 48: 161–172.
27. Loignon C, Boudreault-Fournier A, Truchon K, Labrousse Y, Fortin B. Medical residents reflect on their prejudices toward poverty: A photovoice training project. *BMC Med Educ* 2014; 14: 1050.
28. Price JH, Desmond SM, Snyder FF, Kimmel SR. Perceptions of family practice residents regarding health care and poor patients. *J Fam Pract* 1988; 27: 615–21.
29. Godkin MA, Savageau JA. The effect of a global multiculturalism track on cultural competence of preclinical medical students. *Fam Med* 2001; 33: 178–86.
30. Wasson LT. Do International Experiences Develop Cultural Sensitivity and Desire for Multicultural Practice among Medical Students and Residents? *Virtual Mentor* 2006; 8: 826–30.
31. Wear D, Kuczewski MG. Medical students' perceptions of the poor: what impact can medical education have? *Acad Med* 2008; 83: 639–645.
32. Loignon C, Hudon C, Goulet É *et al*. Perceived barriers to healthcare for persons living in poverty in Quebec, Canada: the EQUIhealThY project. *Int J Equity Health* 2015; 14: 4.