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'Good' patient / 'bad' patient: clinical learning and the entrenching of inequality[1]

Abstract

This paper develops sociological understanding into the reproduction of inequality in medicine. The material is drawn from a longitudinal study of student experiences of clinical learning that entailed 72 qualitative in-depth interviews with 27 medical students from five medical schools in the United States. To highlight the subtle, yet powerful, ways in which inequality gets entrenched, this paper analyses ideas of the 'good' and the 'bad' patient. 'Bad' patients question not only biomedical knowledge but also medical students' commitment to helping people. 'Good' patients engage with medical students in a manner that upholds biomedical knowledge and enables students to assume the role of the healer and the expert. At the same time, 'good' patients possess cultural skills that align with those of medical practitioners. This alignment is, furthermore, central to definitions of the 'good' patient. Distinctions drawn between 'good' and 'bad' patients thus both embody as well as enforce social inequality. The subtle reproduction of inequality is, however, difficult to discern because judgments about patients entwine with emotion.

Keywords

Inequality, medical education, cultural health capital, emotion

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Introduction

Medicine's hidden curriculum of 'tacit and context specific rules about how doctors should behave, think and feel' (Jaye et al 2006:142), instructs students also on patient worth (Higashi et al 2013). Further, perceptions of patients resting on a 'moral economy' of 'values, behavioral norms and ethical assumptions' matter greatly in guiding interaction with patients and decisions about care (Higashi et al 2013:13). Much research has highlighted that clinician perceptions of patients draw from a repertoire of social stereotypes with understandings of patient character and capacity featuring centrally also in uneven access to healthcare (Feagin and Bennefield 2014; van Ryn et al 2011; Roberts 2011; Barr 2008; Street et al 2007; van Ryn and Burke 2000). Despite some notable exceptions (Dingwall and Murray 1983; Jeffery 1979), doctor perceptions of the 'good' and the 'bad' patient have received little scholarly attention. While 'good' patients are medically interesting and allow the honing of clinical skills (Jeffery 1979; Stimson 1976), 'bad' patients refuse the responsibilities of the 'sick role' (Parsons 1975; Dingwall and Murray 1983), have ailments falling outside the 'sick role' (Freidson 1970; Stimson 1976), and are often characterised as being 'willfully ill' and responsible for their ailment (Jeffery 1979:105).

This paper underscores the significance of *social identities* in definitions of the 'good' and the 'bad' patient. I argue that perceptions of patients are shaped by an alignment, or dislocation, between individual behaviour and interactive styles, and broader social institutions. Pierre Bourdieu (1984) coined the term *cultural capital* to refer to habitual and embodied behaviour and skills that can be utilised 'to produce meaningful situational advantages' because these behaviours and skills match 'the standards of dominant institutions' (Calarco 2011:863). Following Bourdieu, *cultural*

health capital refers to a 'repertoire of cultural skills, verbal and nonverbal competencies, and interactional styles that can influence health care interactions' (Shim 2010:2). Patients, who share with their physicians an unstated understanding of the doctor-patient encounter, navigate the clinical environment with more ease (Shim 2010; Dubbin et al 2013; Willems et al 2005). Ultimately, however, 'cultural capital contributes to the accumulation and exercise of power and the maintenance of inequality.' (Shim 2010:2). Accordingly, this paper understands ideas of the 'good' and the 'bad' patient as 'devices of distancing and distinction' that subtly 'legitimate the position and interests of those who draw the distance.' (Skeggs and Loveday 2012:473).

The influence of 'devices of distancing and distinction' (Skeggs and Loveday 2012:473) lays, in part, in the manner in which judgment entwines with emotion. Even though its power can be hard to discern, emotion plays an important role in decision-making (Wetherell 2012; Cromby 2007, 2011; Burkitt 2014). The role of emotion in decision-making is, however, incompatible with the valorising of impartial rationality that suffuses the project of western modernity (Cromby 2007; Wetherell 2012). The capacity of emotion to shape judgement is especially veiled in medicine due to an emphasis on 'affective neutrality' as central to the role of the doctor (Smith and Kleinman 1989:56; Nettleton et al 2008). Emotions, simultaneously, draw 'from the thickness of sociality itself' (Ahmed 2004:28). Even though situational, and subject to change, private affective experience also incorporates social and cultural values, judgements and representations (Wetherell 2012:16; Burkitt 2014). As such, this paper contends that to more fully understand the reproduction of inequality medicine, we must not only see the distinctions between 'good' and 'bad' patients as

capturing relations of power. We must also begin to trace the power that these distinctions hold to their entanglement with emotion. The intertwining of the social with emotion, and the import of emotion in doctor perceptions and judgement, constitute missing pieces in making sense of how social representations and stereotypes suffuse and shape a field explicitly heeding to the ideal of scientific objectivity and equal treatment of all patients.

Methods

Study design

The material presented here emerges from a longitudinal qualitative study exploring medical student experiences of clinical rotations[i] in the United States. The project was premised on emotion constituting an important, yet understudied element of medical education (McNaughton 2013). The study centred on clinical rotations because the clinical years entail processes of professional socialisation that transmit to students the 'normative expectations for behaviour and emotions' (Jaye et al 2010:60). The study began from two broad research questions: What kinds of experience do clinical rotations give rise to? How do emotions feature in the experiences of medical students undertaking clinical rotations? The research centred on the lived experience of rotations and adopted a phenomenological approach (Creswell 2013). With a total of 72 interviews conducted with 27 participants across two years, the study aimed at producing in-depth understanding of rotations as these were experienced by participants. The longitudinal character of the study (Thomson and Holland 2003) further facilitated the search for in-depth insight.

The researcher has no background in medical education beyond scholarly interest. The longitudinal structure of the study and the use of in-depth interviews were aimed at addressing this lack of insider knowledge on the part of the researcher. The outsider status of the researcher proved meaningful in at least two respects. First, participants went to great lengths in describing experiences to the researcher who was seen to lack understanding of the training process. Second, being an outsider allowed the researcher to ask questions that could have been seen as self-evident among those immersed in medical education.

The first interview started with questions 'can you tell me what brought you to medicine?' and 'can you tell me about your experience of rotations so far?' As the study progressed, it became clear that encounters with patients generated complex feelings. The importance of patient encounters frequently emerged in response to questions such as 'can you tell me about your *best experience* during the rotations so far?' or 'can you tell me about the *most difficult experience* you have had during rotations?' The significance of 'good' and 'bad' patients in participant responses generated the need to probe these categories further. Themes in the data – that 'bad' patients have wrong priorities, little knowledge, and are difficult to deal with, and that 'good' patients are active, compliant[ii] and knowledgeable – were remarkably common among participants.

Importantly, this research could not access unmediated emotional experience. No interaction with patients was observed. Rather than emotion per se, the study focused on retrospective accounts of significant experiences. Participant interpretation of significant events – even though subjective, partial and retrospective – is meaningful

and sociologically interesting (Luker 2008). Interviews, furthermore, 'offer the most direct means by which individuals negotiate experience and through which we can approach and interpret this experience' (Månsson 2002:25). Emotionally meaningful experiences and the 'emotional labour' (Hochschild 1983) performed by students also in interviews are situated in the context of 'professional feeling rules' (Burkitt 2014:139; Hochschild 1983) of medicine that tend towards 'affective neutrality' (Smith and Kleinman 1989).

Participants were recruited via a message posted on a medical student mailing list. Five students responded to this call for participants, with four forwarding a recruitment message and an informed consent letter to peers. Subsequently, further 22 participants contacted the researcher directly. Apart from two interviews – cut short due to technical difficulties and participant availability – interviews lasted 60-90 minutes. The interviews were conducted using Skype, which enabled interviewing participants across vast geographical distances. All but four of the interviews took place in a setting, such as private apartment or an empty hospital meeting room, where the interviewee was alone. The study design and materials were vetted and approved by the Institutional Review Board at the author's institution. Participants are identified by pseudonym only.

Coding and data analysis

Interviews were recorded and transcribed in verbatim. The initial coding took place when checking transcripts for accuracy through comparing transcripts with recordings. The transcripts were coded again through a close reading of the material.

The codes reflected 'significant statements' or themes (Creswell 2013) with regards to rotations, patients and patient encounters. The themes were collected together in separate Word documents and later organized according to subthemes. For example, all participant discussions of the 'good' patient were collected together before the material was organized to subthemes such as 'good' patients as invested or active. This data then became the basis for the 'textural description' (Creswell 2013) included in the results section of this paper.

While the results section aims to capture participant experience and voice, the analysis draws on literature into medical education around notions such as the 'hidden curriculum' (Hafferty 1998; Hafferty and Hafler 2011; Jaye et al 2006). As this research considers student identities as central to experiences of rotations and perceptions of patients, the analysis also turns sociological material into the subtle reproduction of inequality through assumptions and ascriptions of knowledge and taste (Bourdieu 1984; Lawler 2005; Shim 2010; Skeggs and Loveday 2012). The themes presented in the results section are those that were most prevalent in the data. This study is, however, limited as coding and analysis were conducted solely by the author.

Participants

The study sample is self-selected. Accordingly, only perspectives from students wanting to share their experience are included. However, each participant received a $50 gift card per interview as a thank you for taking part. While not big enough to coerce participation (Hewison and Haines 2006), this stipend is thought to have

encouraged participation among students who may otherwise have not considered taking part.

Thirteen participants were male, fourteen female. All participants were in their 20s and had completed a bachelor's degree. While there is great complexity to defining social class (Bourdieu 1984; Lawler 2005; Latimer and Munro 2015), in this study, assumptions about participant social class were arrived at through three different means: level of education, self-defined social class, and parental occupation. Participants had not only gained a bachelor's degree but were upwardly mobile in accessing a higher degree. Of the 27 participants, 26 were asked for their parents' occupations, and to self-define their social class. All self-defined their social class as middle, upper middle or upper class. Parental occupations – that in order of prevalence were physician, financial consultant, teacher, attorney, engineer, professor, and small business owner – also locate participants within higher social classes. Eighteen participants were white, and five Asian or South Asian American. Importantly, no African American or Latino/a students responded to the call for participants.

Results

Below, I first outline interview data capturing the importance of the 'hidden curriculum' (Hafferty 1998; Hafferty and Hafler 2011; Jaye et al 2006) in medical student learning. I then present data on the 'good' and the 'bad' patient. Following the phenomenological approach (Creswell 2013), the material below constitutes textural description that highlights the most prominent themes in the data and aims to capture student voice and experience.

Learning about the 'good' and the 'bad' patient

During clinical rotations, you 'learn on the job' (Amar). Much important material is, however, 'not something they teach you. But it is something that you learn' (Amar). In addition to acquiring medical and scientific knowledge, students learn rules that are 'unspoken but very obvious and well known, you know, like the hierarchies and the punishments for violating them' (Beth). Relationships within medical teams are strictly hierarchical. Accordingly, '[a]nyone can tell a medical student what to do. So you're the lowest' (Stephen). This hierarchy instructs students on how to behave: 'I think whenever somebody higher-up says something, we just kind of go along with it' (Jessica).

The informal and hidden curricula that subtly instruct medical students on appropriate behaviour are integral also to the culture of medical school and to peer interactions: 'a lot of third year is learning from other people's mistakes' (Sullivan). Discomfort and a desire to avoid being chastised or humiliated encourage students to act according to the largely unarticulated rules around appropriate behaviour: 'you hear these stories and you're like, uuh, it's *so uncomfortable*' (Sullivan). Stories of failure among peers give rise to 'that self-conscious feeling' (Isabel) that, in turn, plays an important role in students learning to act according to the hidden rules.

There are powerful messages about patients – messages excluded from the formal curriculum – that medical students encounter. Understandings of the 'good' and the 'bad' patient are conveyed through interactions within medical teams. With 'bad'

patients, residents[iii] and attendings[iv] 'seem very jaded. They seem like, "oh, we can't do anything about them, so whatever", you know, they don't care' (Clare). Gestures can be revealing: 'I think a lot of it is like, you know, the face that they'll make afterwards or an eye roll or something like that' (Mary). Sometimes disproval is explicitly stated to members of the medical team:

> the wife of this guy was crying 'cause her husband had been through a lot. He'd been in the hospital for a long time without insurance. And she was like, "oh, I just want to go home, when can he go home?" And the surgeon's like "he can go home when I say he's ready". And when we were leaving, he's like "stupid fucking people" and like rolls his eyes. And the other doctors laughed (Monica).

Residents and attendings speak differently of patients seen as 'good' or 'bad':

> For good patients, it's usually like, when they present the patient, they're like, "this lady's super sweet, this guy is super sweet, I feel really bad for him". And if it's a bad patient, it'll start out with an eye roll and "oh, our favorite patient". Like, some sort of sarcastic comment about them. But it's pretty evident from the start, their feelings on the patient. It's not really hidden in any way (Isabel).

Messages about patients are also subtly conveyed in casual conversations within medical teams: 'Sometimes we talk about like, how it's interesting that patients on Medicaid that don't work at all, so they're like living on welfare, and they say they can't afford their prescriptions, have iPhones. And leather purses' (Chloe). Throwaway remarks convey what is expected of patients also beyond health behaviour. As Beth observes: 'If I had a dollar for every time, on OB [obstetrics],

when I heard "this is America, we speak English", I could pay my tuition upfront for the rest of the school term' (Beth).

Students may not always agree with the messages about patients they encounter. The behaviour of residents and attendings is, however, rarely openly criticised. Even when 'people will make off-color remarks about patients, which I don't like' the comments are commonly 'nothing worth getting, getting bent out of shape over' (Matthew). The importance of ignoring even troubling faculty behaviour relates, in part, to the role faculty play in the assessment of student performance and, furthermore, in the career trajectories of medical students: 'you kind of don't want to raise conflict because they're evaluating you [yeah]. And your evaluation kind of determines your career' (Isabel). The system of evaluation shapes the manner in which discomfort can be expressed: '*everybody above me* in the rank order hierarchy is potentially interviewing or, you know, evaluating me at some point. And so you can't really complain' (Carla). The structure of assessment results in difficult experiences not being discussed. As Sullivan notes in regards to her feelings about a difficult patient: 'I did want to talk to the attending about it, but she is the chief of our rotation. So, it's something I think I might want to talk to her about when she isn't grading me' (Sullivan).

While disagreement with resident and attending behaviour can be expressed to close friends or partners, the culture of medical school, generally, discourages being vocal about unequal treatment observed. Vivan has, for example, noticed that 'black patients are a little bit neglected' (Vivan). However, noting this to faculty or peers is difficult: 'I think people would think I was like pretending, or trying to act like a

saint… I'd seem like a hypocrite' (Vivan). Bringing up issues, such as racism, is

avoided: 'I don't feel like I can talk about it because people will feel attacked' (Beth).

As outlined above, medical students encounter pervasive messages about the 'good'

and the 'bad' patient through interactions within clinical environments. Below, I

outline these messages in more depth.

Good patient

Active

The 'good' patients are, first and foremost, seen as 'active participants in their

healthcare' (Sullivan). A 'good' patient is 'involved in his or her health, as opposed to

just leaving it to the doctor' (Amar). 'Good' patients 'want to figure out what's

happening and they're motivated to like, learn about their disease and take charge of

it' (Monica). 'Good' patients 'seem open to discussing their health problems and what

they can do' (Grace). Active engagement is, simultaneously, thought to demonstrate

when patients '*want to* help themselves get better' (Grace). How engaged and active a

patient is deemed to be is often assessed on the basis of interaction. Asking questions

'shows me that they, they want to take part in their care. And that they want to

understand what's going on' (Myra). 'Good' patients are experienced as 'willing to let

you help them as best you can' (Bob). Simultaneously, a 'good' patient 'trusts and

respects their doctor as well as the staff' (Jessica) and 'recognizes that a doctor is

someone who just wants to help them' (Stephen).

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Being invested in one's health involves effort that 'good' patients show also outside the medical encounter. 'Good' patients 'find ways to maintain their health. Exercise. Try and eat as best as you can under the conditions you have' (Ben). However, some participants also recognise that the ability to take care of oneself and one's family entwines with privilege: 'You need some level of income and some level of money, I guess, financial abilities to take care of yourself. So if you don't have that, that's also going to affect you not being a good patient' (Amar).

Compliant and knowledgeable

In addition to being active and engaged, a 'good' patient '[w]ants to do what it takes to improve their health. Follows the doctor's orders' (Sarah). 'Good' patients are, as such, compliant. A 'good' patient:

> takes their medications as prescribed. Follows up on all the referrals
> and lab orders and imaging that was ordered. Comes to their follow-up
> appointments. Makes sure that they tell the doctor if anything is going
> on (Jessica).

Simultaneously, a 'good' patient is 'grateful of the care that they're receiving' (Jessica).

Knowledge of one's health is highly valued: 'the most amazing patients are patients who are very knowledgeable in terms of their health' (Amar). Vivan describes a 'good' patient as 'a good historian' who is both open and 'good at communicating' (Vivan). The importance of the ability to recount medically relevant information is also conveyed in Vivan's account of his best patient:

all his past medical history and any problems, he was very forthcoming

with. And when it came time to explain, you know, what he had to do

and how to handle his disease going forward, he was very receptive.

He was listening. He asked good questions that kind of indicated that

he knew what was going on and he was thankful that, you know, I took

the time to explain stuff to him (Vivan).

Knowing one's medical history is seen to 'demonstrate their, like, proactiveness and their self-interest in their healthcare' (Bo). Compliance, simultaneously, enables doctors 'to make sure that the patient gets the best care possible' (Jessica). Positive patient involvement is deemed to make medicine easier: 'having someone that's invested in that decision-making process with you can make it easier' (Bo). Yet, some recognise that openness and compliance are not automatic. While 'a good patient is honest and upfront' (Beth), honesty is understood to rest on trust. Further, 'some people are going to *reasonably* feel that they can't be honest with their doctor' (Beth).

Engenders positive feeling

The 'good' patient engenders positive feeling in medical students: 'there's a certain portion of people who are, like, "okay, doctor said to do this, this is what we're doing," and that's great. I love that' (Michael). Patient engagement can, furthermore, generate care: 'I love patients who are like eager to learn about why they're at the doctor' (Bo). While participants readily emphasised that every patient is afforded a similar level of assistance, being proactive and compliant is also often seen to yield results. If doctors 'know the patient has done whatever they can and they are taking steps alongside themselves, they are more willing to help' (Amar). Ability to help

generates further positive feeling: 'it's nice to have a win in the doctor's category and say, "I really helped this person today"' (Chris).

There is also often a sense of ease to encounters with 'good' patients: 'a good patient is someone that you can talk easily with. Yeah, and just be able to enjoy the visit *while* doing the things that you need to be doing as well' (Sarah). With a 'good' patient, 'you really feel like this is a team effort, you know. The doctor and the patient are working together towards this goal. And I think it's wonderful' (Clare). Connections forged with patients shape medical students' relationships with patients. A sense of connection is important in providing extra care: 'if you care about somebody then that means you're going to go above and beyond what you have to' (Mary).

Bad patient

Wrong priorities

A patient who 'abuses the system to get, you know, drugs' (Mary) is frequently considered a 'bad' patient. Additionally, 'bad' patients 'try to sell their medications to someone else and then lie to us that, "oh yeah, my medication dose, I lost it"' (Myra). The 'bad' patient is also resistant to doctor's recommendations: 'The bad patient doesn't take their medications. Doesn't go to follow-up appointments' (Sarah). The lack of compliance is, furthermore, seen to underlie a need for further medical intervention: 'they have the need for more extensive medical care *because* they weren't doing the things that could have prevented this' (Sarah).

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'Bad' patients make bad choices. As Lou explains, rather than his prescription, a 'bad' patient 'bought cigarettes and his medication would have been four dollars' (Lou). The wrong priorities are often seen to relate to a lack of care for one's health; a 'bad' patient 'isn't very invested in their own health' (Jessica). A 'bad' patient is 'uninterested in making any changes that they might need to in order to change their health outcome' (Bo). Additionally, 'bad' patients 'expect everything to be made better and they're not taking an active part in their healthcare' (Stephen). 'Bad' patients are also not communicative: 'you ask them a question and they kind of stare at you or give you a one word answer, or like seem to have no idea what's going on with their health' (Grace). With uncommunicative patients 'it's really hard for us to kind of get a deeper understanding of why they're there' (Myra). 'Bad' patients can also be outright aggressive and rude: '[b]ad patients are hostile… they just kind of treat everyone poorly' (Isabel). Aggression is, however, also at times seen as understandable: 'I think for a lot of patients who don't follow up or seem like bad patients, it's really just because of fear and not because they don't care' (Jessica).

Limited knowledge and resources

'Bad' patients' unhealthy behaviour is often seen to relate to patients 'not really realizing the importance of what the doctor is trying to do for them' (Jessica). Many 'bad' patients are thought to lack education and 'if they have low levels of education, it's hard to have high levels of health literacy' (Grace). At the same time, however, a 'bad patient is somebody who questions the motives, questions the knowledge' of doctors (Stephen).

While 'bad' patients are seen to prioritise unhealthy behaviours, many medical students understand that the ability to follow doctors' orders relies on resources. 'Bad' patients 'just can't follow up, financially' (Jessica). Furthermore: 'if you can't get yourself the care that the doctor wants you to do, if you don't have money to do that, that unintentionally puts you in the bad patient category' (Amar). And yet, being a 'bad' patient also limits options for care: 'if you don't want to be a good patient, if you don't want to take care of yourself, that automatically puts you in an inferior entitlement of treatment' (Amar). 'Bad' patients are simultaneously seen as both, constrained by their circumstances *and* unwilling to engage in healthy behaviour: 'They don't have enough money to buy vegetables and fruit and stuff like that. And they, like, a lot of them don't wanna change' (Chloe). Some participants understand healthy behaviour as a choice. As Stephen explains:

> You can go to any drug store and buy a blood pressure cuff. It's not always a very good blood pressure cuff, but you can get one. Any person can be taught where to put the blood pressure cuff, any person can be taught how to take somebody else's blood pressure as long as they have a stethoscope and a blood pressure cuff (Stephen).

Access to technology to improve health, such as a blood pressure cuff is, furthermore, seen as 'pretty much universally available' (Stephen).

Difficult to deal with and to care for

'Bad' patients can be frustrating to deal with: 'when you're taking the time out of your day to explain and help them, sometimes they just don't care, or they're watching the

TV. Or – that can be frustrating' (Vivan). The seeming disregard for doctors' opinions and orders can also generate anger:

> I do respect when a patients says, "well I would rather not take this
> medication, I'd rather have a different medication" or other things like
> that. But to disregard and question the motives, knowledge, and ability
> of somebody else that is doing nothing but trying to help them,
> infuriates me (Stephen).

Communication problems with 'bad' patients can also lead to uncomfortable encounters:

> I would walk in the room and the [patient's] mother would just give
> me one-word answers. And it was just, it was awkward. So I'd be in
> there for about thirty seconds because she wasn't really saying
> anything before I would leave (Chloe).

Encounters with 'bad' patients generate not only frustration, but also feelings of powerlessness: 'the one thing that is always hard for me is someone who's just not interested… it's hard to help those people. It really is. And you feel powerless' (John). 'Bad' patients are, accordingly, treated differently compared to the 'good' patients: 'I'm not saying that they don't help the patient that is a bad patient. But I mean, it's obvious, if you think all your efforts are wasted, you are maybe unintentionally not going to put all your efforts in doing that for the patient' (Amar). 'Bad' patients are also at times afforded less sympathy:

> it's kind of disheartening to see somebody in that situation. It's like "oh
> well, I mean, I'm sorry you got lung cancer from smoking for forty-
> five years" but how sorry – I mean, it's unfortunate. It's unfortunate.

> And you never *don't* think that. But at the same time, there's a lot of
>
> steps you can do to prevent that (Sarah).

Discussion

The power of hidden messages

Even when, formally, all patients receive the same care, informally, medical students observe 'good' patients being afforded time, care and appreciation that 'bad' patients are thought not to deserve, nor to want. Messages about the 'good' and the 'bad' patient are a part of the hidden and informal curricula (Hafferty 1998; Hafferty and Hafler 2011; Higashi et al 2013; O'Donnell 2014) of medical school. Embedded in the hidden curriculum are also 'professional feeling rules' (Burkitt 2014:139) shaped, in part, through an emphasis on 'affective neutrality' (Smith and Kleinman 1989:57). Values beyond 'affective neutrality' are, however, also at play in the 'professional feeling rules' (Burkitt 2014:139) acquired in medical school. The hidden curriculum also contains ascriptions of patient worth (Higashi et al 2013). Interest and indifference on the part of residents and attendings convey to medical students who is, and who is not, worthy of extra effort. These messages are reproduced through peer interactions and the culture of medical school that defines health as an individual achievement and, through this, risks side-lining the impact of broader inequality on health and illness. The significance of understandings of the 'good' and the 'bad' patient is amplified through the power that residents and attendings conveying these messages hold. Disputing the hidden instruction carries substantial danger: being seen as academically inept, hypocritical or aggressive.

Gestures such as 'eye rolls' can make students uncomfortable. There are, however, few avenues for airing feelings that arise in relation to challenging patient encounters or faculty behaviour. Unease that is not articulated constitutes a part of medicine's 'null curriculum' (O'Donnell 2014:8) that, through trivialising emotion, asserts that emotional disquiet experienced during rotations is peripheral, detrimental even, to medical practice. Furthermore, in an educational context where confidence, toughness and assertiveness characterise the ideal doctor (Halpern 2014), 'difficult emotions become objects of dread, to be avoided at all costs.' (Shapiro 2008:14). Students can feel that emotional discomfort marks them as unsuited to the practice of medicine and, accordingly, seek to hide uncomfortable feelings (McNaughton 2013:75). Learning the 'professional feeling rules' (Burkitt 2014:139) that emphasize 'affective neutrality' (Smith and Kleinman 1989:56) not only encourage hiding emotion but also make discerning the social stereotypes that shape classification of patients more difficult.

Judgment and self-worth

The power of the messages about 'good' and 'bad' patients rests, in part, on the way in which 'good' patients enable doctors to help and, as such, to perform a role experienced as central to medicine. Importantly, what is being recognised by 'good' patients is not only doctors' expertise, but also their commitment to helping people. Additionally, talking to a person who is receptive and appreciative is meaningful. Being seen as valid and valuable matters in the constitution of self-worth (Honneth 2001). Positive affect on the part of patients has, accordingly, been found to generate more positive physician communication (Street et al 2007:594). Expressions of

positive regard are, simultaneously, socially and culturally located. Patient messages of respect and gratitude need to align with ideas of respect and appreciation among medical professionals for these messages to be perceived as such.

Implicitly, the compliance of 'good' patients also upholds the authority of the doctor while 'bad' patients do not comply with the 'sick role' (Parsons 1975; Jeffery 1979; Dingwall and Murray 1983) or accept doctors' expertise. Not only do 'good' patients allow the doctor to act as the healer and the expert, 'good' patients espouse the orientation towards action that suffuses biomedicine (Lupton 2012). The valuing of dialogue that is present in participant accounts of 'good' patients also embodies a trend in medicine whereby paternalistic attitudes are giving way to increased patient involvement (Lupton 2012; Heritage and Maynard 2006). A focus on dialogue, simultaneously, calls on patients to shoulder more responsibility. Dialogue can ease some of the burden of making decisions that lies on the shoulders of the expert. The drive towards patient involvement, simultaneously, risks making patient reflexivity an unstated requirement that serves to separate 'good' and worthy patients from patients seen as less committed to their health and, accordingly, as less deserving of the additional care given to 'good' patients.

Judgment and the reproduction of inequality

Importantly, 'good' patients possess cultural health capital: 'linguistic facility, a proactive attitude toward accumulating knowledge, the ability to understand and use biomedical information, and an instrumental approach to disease management.' (Shim 2010:2). 'Good' patients are, as such, skilled at navigating the biomedical sphere.

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Negotiating the health arena entails showing trust in the biomedical expert and possessing interactive skills that align with medical practitioners' unstated and, often, unrealised expectations. This alignment facilitates more fluent exchanges, feelings of ease and, frequently, greater care and attention. As research indicates, patients seen as 'better communicators' are met with more positive affect (Street et al 2007:594). At the same time, those without cultural health capital encounter less reassurance, listening and empathy (Smith et al 2009:1806). While questions that 'good' patients ask are seen as appropriate and respectful, the seemingly laconic answers given by 'bad' patients are interpreted as signifying a lack of interest or understanding. Asking biomedically relevant questions and disclosing pertinent information can, indisputably, help doctors. The capacity to ask relevant questions is, however, also seen to convey responsibility and, further, worth and deservedness. Even though cultural health capital is unevenly available (Shim 2010), the possession of cultural health capital comes to entwine with perceptions of positive moral character.

While 'good' patients are characterised as motivated to learn about and to control their condition, 'bad' patients often refuse to act in a manner expected of patients (Jeffery 1979). Importantly, these expectations relate also to values around ideal subjectivity in today's neoliberal societies. The indifference that 'bad' patients are thought to display challenges the ideal of self-responsibility and, as such, signals someone falling short on the level of ideal personhood (Rose 1999). By not displaying self-responsible selfhood, 'bad' patients can, simultaneously, be considered guilty of causing their illness through personal negligence. Thus, in a subtle but powerful way, inequality is reproduced 'through symbolic and cultural forms – through, for example,

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the means by which people become judged as morally worthwhile, or as having the right kind of knowledge or 'taste'.' (Lawler 2005:797).

The requirement for active involvement also normalises and privileges the interactional and emotional skills of patients able to display reflexivity (Giddens 1991). Reflexivity, however, is an aptitude more aligned with middle class dispositions and with cultural and economic capital that facilitate authoring one's life (Skeggs 1997, 2004; Adkins 2002). Especially in the United States, where 'society's white-racist roots and contemporary structural-racist realities' (Feagin and Bennefield 2014:6) curtail access to economic, cultural and political resources on the part of people of color, the valorising of reflexivity also subtly reproduces white privilege. In other words, the cultural and emotional capital that is normalised and valued is, due to complex histories of racism, more readily available to whites. Furthermore, when concern for one's health is understood to equate following doctor's orders and engaging in thoughtful dialogue, reasons underlying mistrust in medical authority – that shape communication and that stem from continuing marginalisation and centuries of injustice – can be side-lined. Lack of reflexivity is cast simply as an individual failing that hinders health. Simultaneously, self-responsibility and self-management:

> become the mechanisms by which class [and race] inequality is
> reproduced and refigured, individualized as a marker of personal
> volition and inclusion, excluding groups from belonging and
> participation through assumptions about their own take up of a
> particular form of agency, one to which they do not have access
> (Skeggs 2004:60).

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The hiding of the classed, as well as racialised, roots of interaction and behaviour that are valued in medicine risks blaming and disenfranchising patients whose cultural and economic resources misalign with what is deemed valuable within medical institutions. Medicine is, by the same token, positioned as a neutral field outside the social and the historical while the seeming impartiality of medicine helps to hide the subtle judgments that draw on and reproduce inequality.

The idea of the 'good' patient also entwines with the ability to undertake and sustain a healthy lifestyle. Many participants understand the capacity to choose healthy behaviours primarily as an individual accomplishment rather than something shaped by social location. Hallway conversations about patients who use their limited resources on clothes and technology, rather than on medicine, consolidate the idea that those with lesser means are irresponsible and, accordingly, guilty of causing their own ill health. It is unlikely that the wealthier patients' non-medical purchases would be perceived in a similar manner as signs of irresponsibility or ignorance.

Familiarity, feeling, and the reproduction of inequality
In interactions within medical teams, some patients are explicitly identified as sweet or, alternatively, bad and difficult. Statements that profess sympathy for the 'good' patient identify and justify worth, but also embody a sense of connection. The plight of the 'good' patient is easier to recognise. Feelings of care engender investment in a patient's wellbeing and generate further effort, also outside what is customarily expected of medical practitioners.

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Emotions felt about patients are not, however, purely internal nor do emotions exist independently of complex and changing social meaning (Burkitt 2014; Wetherell 2012; Cromby 2007, 2011; Ahmed 2004). Feelings, simultaneously, 'rehearse associations that are already in place' (Ahmed 2004:39). Much research indicates that social stereotypes influence doctor-patient interaction and seemingly neutral decisions around diagnosis and treatment (van Ryn et al 2011; Roberts 2011; Barr 2008; Street et al 2007; Feagin and Bennefield 2014). What is felt towards a patient – whether a patient is understood as pleasant or not – entwines with familiarity that doctors and medical students feel with patients. Importantly, *familiarity generates understanding* (Bourdieu 1999). The racial and socio-economic background of doctors and medical students is crucially important here. While participants were not asked to define their 'good' patients according to race or social class, 'good' patients were characterised by the possession of cultural health capital that is associated with higher socioeconomic standing (Shim 2010).

The 'good' patients are afforded sympathy that, while partially based on a desire not to see another human suffer, also rests on social familiarity. Judgment premised on feeling is, in turn, both subtle and powerful in reproducing inequality. Even when difficult to discern, emotions 'both motivate and organize activity' (Cromby 2007:99). Feelings about patients entwine with what is often a sincere commitment to helping people and with the difficulty of helping patients whose ailments spring from myriad inequality outside the scope of biomedicine. 'Bad' patients who cannot be helped bring to focus the limits of medicine in a profoundly unequal world. These patients embody inequality that medicine alone cannot resolve. Understanding emotions engendered by patient encounters as shaped by class and race-based

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familiarity is challenging also because emotion remains marginal in the context of medical education (McNaughton 2013). This marginality, furthermore, continues to erode our means of fully appreciating the entwining of social stereotypes with emotion, and with clinical judgment.

Conclusions

While 'good' patients validate medical students' commitment to medicine and to helping people, the challenge of 'bad' patients relates to the impact of interactional distance, as well as to the difficulty of helping patients whose problems stem from causes outside the biomedical frame. Simultaneously, perceptions of 'good' and 'bad' patients capture ideas of normal and ideal selfhood, and constitute 'devices of distancing and distinction' (Skeggs and Loveday 2012:473) that ascertain worth according to a patient's possession of cultural health capital. As such, the distinction between 'good' and 'bad' patients both embodies and enforces inequality. The hidden and the informal curricula that convey messages about patient worth (Higashi et al 2013) are thus central also to the reproduction of inequality in medicine from early on in student doctors' careers.

To more fully understand the manner in which inequality is reproduced in medicine we must not only conceptualise ideas of the 'good' and the 'bad' patient as 'devices of distancing and distinction' (Skeggs and Loveday 2012:473), we must also consider the manner in which judgment entwines with emotion. Making space not only for emotion but also for the entwining of emotion with social stereotypes is a tremendous feat due to the side-lining of emotion in western modernity in general, and in medical education and medicine in particular. This, however, is a challenge that needs to be

met to produce more nuanced and, ultimately, more useful understanding of the subtle yet powerful reproduction of inequality in medicine and access to healthcare. While social stereotypes shaping perceptions of patients suffuse society more generally, by remaining unaware of the roots and the implications of distinctions between 'good' and 'bad' patients, clinical learning contributes to the reproduction of inequality that continues to resonate through medicine.

Acknowledgements

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[i] Rotations refer to 2-8 week clinical placements in fields such as family medicine, obstetrics and gynaecology, paediatrics, surgery, internal medicine, psychiatry, neurology, and radiology that students undertake during the third and fourth year of medical school.

[ii] Terms such as adherence and concordance commonly replace the notion of compliance in much sociology today. The terms allocate responsibility differently with non-compliance indicating individual failure on the part of the patient and the lack of concordance referring to a failed consultation (Armstrong 2014).

[iii] Resident has graduated from medical school and is undertaking postgraduate training in their chosen field under the supervision of an attending physician.

[iv] An attending physician has completed residency and supervises medical students and residents.