The use of socioeconomic status in frontline professional work with ambiguous problems: and analysis based on qualitative vignette interviews

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1. Introduction

In caring for clients with complex psychosocial problems frontline professionals work with clients with many different social status characteristics. Similar to the wider population, frontline professionals in healthcare may experience difficulties in understanding the needs of people with different social status characteristics than their own. Regarding that people think from their own frame, with their own assumptions, understanding between people is easier when they have more in common. One can only estimate what the world is like for other people based on assumptions (REF). Often people use implicit assumptions, which involves associations outside conscious awareness that lead to an evaluation of a person on the basis of irrelevant characteristics such as race or gender (FitzGerald and Hurst 2017).

Literature on healthcare decision making shows that implicit assumptions based on social characteristics are correlated with differential diagnosis, number of questions asked, number of tests ordered, treatment decisions and quality of care (Moskowitz, Stone et al. 2012, FitzGerald and Hurst 2017, Ricks, Abbyad et al. 2021). For example, female patients are statistically more diagnosed with unexplained symptoms compared to men with the same complaints and low SES Latina and black women are more likely to have intrauterine contraception recommended than low SES white women (Dehlendorf, Ruskin et al. 2010, Claréus and Renström 2019). Therefore, women's rehabilitation could be prolonged and negative healthcare experiences may lower their probability to partake treatment. Moreover, sociological research shows that certain social categories more often possess socially valued positions. For instance, children with lower social status tend to be devalued in school, not because they are less smart, but because teachers estimate them as being less smart because of their behavior and views (van der Waal and de Koster 2015, van der Waal 2022). More research is needed to show not only if but also how assumptions about socioeconomic status play a role in healthcare decisions of professionals. Therefore, our research question is as follows: *How do frontline professionals in healthcare react differently to cues associated with varying characteristics of socioeconomic status?* This question grasps the mechanisms through which frontline professionals interpret socioeconomic status characteristics when making treatment decisions with clients, and thus, what their arguments and

standards are regarding the content of stereotypes. This question will be answered through a qualitative vignette study with general practitioners who work with patients with combined psychosocial problems.

By answering this question, this study contributes to the scientific literature in three ways: First, there has been much research into stereotypes. The content of existing research shows the influence of socioeconomic status on decision making. However, this research shows a mixed image, sometimes clients with higher socioeconomic status and sometimes those with lower socioeconomic status characteristics are being positively rated (Harrits and Møller 2013, Raaphorst 2018). There are indications that the same signals evoke different associations for people from different classes. Thus, there are different standards at play. We have limited knowledge about evaluations/ standards that are employed. Qualitative research is needed to investigate the mechanisms through which this happens.

Second, methodologically, research on professional bias often uses between person designs and studies are mostly based on quantitative data (but, see: Raaphorst, Groeneveld et al. 2018, Harrits 2019). While such designs are appropriate to uncover whether implicit or explicit bias is the case, they are however not suitable to research the reasoning behind the use of stereotypes. As such, a within person design is called for. Our qualitative design also enables including various characteristics of socioeconomic status and asking follow-up questions about various dimensions. Moreover, understanding the role of social status in professional decision making could increase professional-client understanding and possibilities to offer appropriate care for all clients. This is especially relevant in a context where professionals work with clients with varying social status characteristics, with ambiguous problems that cross professional domains and where there is much room for interpretation.

In what follows, […]

2.1 Conceptualizing socioeconomic status

In this study, socioeconomic status is conceptualized as a combination of economic and social status and cultural class. We include these three dimensions in our conceptualization, because this enables us to study how and through which mechanisms frontline professionals in healthcare interpret their clients (van der Waal and de Koster 2015).

First, in this conceptualization, the distribution of economic and social resources is central. In Bourdieu's approach on capitals (Bourdieu 1984, Bourdieu 1987), professions could be hierarchically ranked based on their labor market value. Indicators of economic status are whether someone is employed, how well this job is paid and whether one has economic resources (Vrooman, Boelhouwer et al. 2023). Social status, on the other hand, is defined as the total of existing or potential resources resulting from the possession of a more or less institutionalized network of social relationships. Social networks are never given and fixed and there must be continual investment in relationships and networks to maintain them (Bourdieu 1984, Engbersen 2003). Second, cultural class, or people's lifestyles, including knowledge, cognitive capacities and education, that can be hierarchically ordered in terms of prestige. Cultural class can be used to obtain and maintain social privileges. A specific lifestyle is expected from people who belong to a certain cultural group (Weber 2009, van der Waal and de Koster 2015). The lifestyles of the higher cultural status group are shown, embraced and propagated by those belonging to higher cultural groups. These lifestyles are not internalized by lower cultural groups, even though they recognize them as 'how it should be', and as 'valuable and important' (Bourdieu 1984, Brinkgreve, van den Haak et al. 2011, van der Waal and de Koster 2015). Sociological literature argues that economic and cultural stratification are largely independent. However, educational level is used as an indicator for both cultural lifestyle as well as for someone's labor market or economic position (van der Waal and Houtman 2010, van der Waal and de Koster 2015). Following van der Waal and de Koster (2015), existing literature is not always explicit as to what socioeconomic status entails, which is especially problematic in stratification research. Our research includes the above discussed dimensions, which enables us to explore the mechanisms along which interpretation takes place among healthcare professionals. Below, we discuss research that takes into account these different dimensions, such as evaluations of culture, educational level and lifestyle.

2.2 Qualitative literature on interpretations of socioeconomic status of citizens

- This paragraph will serve as a review of the interpretations of signals to arrive at a decision. It focuses on reasoning and the process of assessing information.

- Qualitative research shows that socioeconomic status of citizens can be interpreted differently. This research shows diffuse patterns, as sometimes clients with higher socioeconomic status and sometimes those with lower socioeconomic status characteristics are being positively rated (Harrits and Møller 2013, Raaphorst 2018). There are indications that the same signals evoke different associations for people from different classes. Thus, there are different standards at play.

- In this study, reasoning means that frontline professionals must rely on salient social classifications and group reputations (Fording, Soss et al. 2011). Street level bureaucracy literature demonstrates how the use of stereotypes, personal values, and moral concerns is frequent among frontline professionals interacting regularly with citizens, such as doctors and pedagogues (Maynard-Moody, Musheno et al. 2003, Lipsky 2010).

- Research shows that there are different mechanisms along which socioeconomic status influences decision making. Harrits (2019) studied how perceptions of normality and social class stereotypes impact how frontline professionals categorize citizens. Raaphorst and colleagues (2018) studied whether educational level serves as a moderating context affecting a combination of cues in the evaluation of entrepreneurs during inspections. Moreover, experimental vignette research shows that race affects officials' evaluations of rule evaluations (Schram 2009). In these studies, socioeconomic status is only partially taken into account.

- Existing research concerns assessments. In the methods sections, we will elaborate on the evaluations we incorporate in this research, namely the establishment of a treatment plan. Moreover, assessment in our research also includes judgment, or the interpretation of signals to arrive at a decision. In existing research, the focus often lies on the final decision-making (Raaphorst 2018), but in our research, it revolves around the process instead of the final level of concern (Harrits 2019).

- Socioeconomic status cues have found to be especially relevant in circumstances where resources are scarce and tasks are goal-oriented (Ridgeway 2019), and social status assumptions

function as a tool to reduce the uncertainty of the information and situations characterizing frontline work (Harrits 2019). Thus, we may expect that among general practitioners, working in a resource scarce (high workload) and goal oriented environment (helping people with their health), status characteristics may serve as strong signals in interactions with and interpretations of patients. In our study, therefore, we aim to research how general practitioners reason about socioeconomic status cues when interpreting their patients' problems.

Methods

The question into how professionals reason about clients with different socioeconomic status characteristics is best grasped by a qualitative within-person design. The data stem from qualitative vignette interviews as a method of data collection and data analysis (Harrits and Møller 2021).

3.1 Context and research focus

This study is set in The Hague, the third largest city in the Netherlands. The authors have used this setting as a strategic case because in this city, psychosocial problems are disproportionally common, particularly among low-income residents and there are substantial differences in the socioeconomic status of its population (Haaglanden 2021). The image exists that mainly people with lower social status characteristics suffer from combined problems and that they are less self- reliant (Van Eijk, Van der Vlegel-Brouwer et al. 2023), or that they may have specific preferences when it comes to treatment. To ensure internal validity, this study focuses on neighborhoods in which psychosocial problems are mostly apparent. General practice in The Hague is characterized by high workloads and there is a rapid movement from practice owners to general practitioners on a self-employed basis. This movement induces high variability and low continuity of general practitioners. These developments, in addition to high workload, add to the probability for general practitioners to use assumptions based on socioeconomic status in their work. Moreover, general practitioners increasingly have to deal with psychosocial problems, or a combination of physical, psychological and social problems, which are multiple, diffuse and can be seen as ambiguous. For example, citizens are often overburdened from all sides, teenagers live under tremendous pressure and experiencing burnout before turning thirty or

elderly experience melancholy due to difficulty coping with the transition to old age. This expansion of care places greater pressure on the general practitioner (Hadoks 2023) and these problems can often be interpreted differently and focused on various care domains. Importantly, general practitioners are often the fist frontline professionals to interpret patients' problems and to build a relationship with them. General practitioners are usually the first frontline professionals to interpret patients' problems and the first to build a relationship with patients when they express problems. We expect that this (first) point of contact is where we will observe differential assessment among general practitioners.

3.2 Methods and data

3.2.1 Approach of vignette study

In order to examine how and for which reasons the status characteristics of a patient with psychosocial problems plays a role in the interpretation of the problems by general practitioners, a qualitative vignette interview study was conducted with general practitioners to mimic real-life decision making (Cecchini and Harrits 2022). The authors use vignettes as stimulus material to start a conversation about attitudes, values, perceptions and judgements in decision- making processes. Vignettes refer to text, images or other forms of stimuli which are used to prompt responses to interview questions (Hughes and Huby 2002). Vignettes are hypothetical but realistic descriptions of situations that resemble daily experiences of respondents (Wilks 2004).

The vignettes are based on real interactions (see appendix A for vignettes) between general practitioners and patients observed during earlier studies by the first author (Autors., forthcoming), which strengthened the internal validity of the vignettes (Hughes and Huby 2004). These observations are used to create anonymous vignettes. Three vignettes are designed, each illustrating a patient with slightly different social status characteristics, but with the same expressed health problem. To further enhance the internal validity of the vignettes, they were tested in three pilot interviews with general practitioners and in conversations with general practitioner colleagues from the first author's department. The latter ensures that these vignettes create the types of response the authors are interested in and to make sure that participants are triggered by the cues that were purposefully put in the vignette.

In other words, the vignettes are plausible, authentic, engaging, and they produce vivid responses (Harrits and Møller 2021).

The respondents were asked to reflect on three vignettes, one with high socioeconomic status cues, one with low socioeconomic status cues and one with a combination of high and low cues to find out which cues would be dominant. The problem presented by all patients in the consultation described in the vignettes is chest pain. After consultation with professional experts the authors concluded that this type of problem can be interpreted in various ways and the level of concern and the development of a treatment plan can be directed at different aspects of the problem. In the used group of men between 40 and 50 years of age, chest pain can be a physical worry, but it can also be interpreted differently, for example as a problem related to stress. The descriptions of status characteristics may provoke the respondents to react to the presented problem in varying ways.

In this study, judgement formation is thus based on the professionals' interpretation of signals to come to a decision about the patient. This research is thus about the process of the judgement of information. This judgement of information may lead to a certain level of concern for the patient. In our study, this means the level of worry a general practitioner has towards each patient and which aspects of the patient in the vignette they are most worried about. In other words: are they worried about the client in general or about specific aspects in or beyond the vignette and what kind of further decisions towards a specific treatment plan do these worries bring about. The level of concern helps to understand general practitioners reasoning regarding their judgement about the vignettes and thus their reasoning about applying assumptions in their work (Harrits 2019).

The respondents are also asked to react by developing a plan for treatment delivery (Covington, Chen et al. 2016). In the approach they choose, professionals may not only use knowledge embedded in policy regulations and administrative procedures, but they may have various assumptions about clients based on group membership, such as disease presentation and socioeconomic status (Maynard-Moody and Musheno 2012, Cecchini and Harrits 2022).

3.2.2 Data collection

The data collection took place in 2023. Prior to the vignette interview, the respondents are asked to tell a bit about themselves: How did they grow up and how would they describe their own social status? How do they see themselves as a professional, what do they find important in their work, how do they see their work context, why did they decide to work here as a GP? (see interview guide in appendix A). Then, the respondent is asked to read the different vignettes and the researcher poses open questions after each vignette. The interview finishes with reflective questions that will help to understand how the respondent reasons and compares their interpretation of the three vignettes. Why did they choose different strategies with varying patients? And how and why did their level of concern differ? These open questions help the respondent to think aloud and to talk freely about their interpretation of the vignettes from their own perspective.

All 15 interviews of between 45 and 90 minutes are audiotaped, transcribed verbatim, and coded by using thematic analysis including open, initial and closed coding (Braun and Clarke 2006, Charmaz 2006). We translated all quotes mentioned below from Dutch, and in doing so have tried to reflect the original wording as accurately as possible. We have used pseudonyms to protect the respondents' privacy and have omitted any reference to the neighborhoods where they work.

Respondents were recruited by contacting general practitioners that are part of the first author's network, which was build up during earlier research. Thereby, the method of snowball sampling was important to recruit more respondents. Moreover, a collaboration took place with a local general practitioners cooperative to recruit additional respondents.

3.3 Analysis

We adopt an abductive approach, moving back and forth between theories and data (Schwartz-Shea and Yanow 2013, Tavory and Timmermans 2014). We thus approach the empirical world with theory on frontline professionals and social status characteristics (Cecchini and Harrits 2022). We coded the interviews using constant comparison (Glaser and Strauss 2017) and sensitizing concepts relating to assumptions about socioeconomic status, treatment plans and levels of concern were used to identify relevant parts in the data. First, the first author looked at how stereotypes are visible in the respondents'

reasoning and what groups these stereotypes are based on. For instance, stereotypes based on medical conditions and/or dimensions of socioeconomic status. Second, the first author looked at how respondents talk about socioeconomic status and associated topics. Respondents may use status dimensions next to their professional expertise. Thirdly, the first author identified what respondents indicated they should explore and their perceptions of what is occurring beyond the vignette. The analysis does not focus on comparing responses to the various vignettes, but rather on their reasoning about the individual vignettes based on professional and cultural beliefs. This type of analysis is relevant in this context, because even though general practitioners are highly professionalized in the Netherlands, at the same time they use their intuition or gut feeling in their work with patients. We used our empirical insights to further explore the relevant literature and to refine our analysis accordingly.

4 Findings

5.1 General perceptions of the vignettes

Respondents generally first react to the vignettes by discussing various dimensions or their socioeconomic statuses. Most respondents however state that even though they are not very worried about the somatic problem of chest pain, they would first want to reassure the patient by ruling out the physical, often cardiac, problem in a certain manner. In doing so, they often differentiate between the vignettes. This means that most respondents would do more extensive physical and mental testing with patient with a lower and a higher socioeconomic status, as compared to the patient with the mixed vignette. In doing so, they argue that […].

5.2 First attitudes towards the vignettes

We see that professionals engage with various assumptions regarding group membership: medical conditions, educational level, profession, social network and lifestyle.

- Reasoning about patients' (possible) medical conditions:

  '*He is busy and feels restless and he doesn't sleep well. It could be ADHD, but you should also look if he doesn't have a heavier mental health diagnosis. I would want to inquire more thoroughly about the mental health aspect. […] Look, it's been going on*

for a while, and there isn't a direct alarm signal, but this is something I would like to follow up on in the short term. […] I would say especially that part about the hyperactivity and not sleeping. I want to make sure that the man is not becoming manic because if that's the case, it could be troublesome.' (respondent 3)

'*He is certainly not in balance either. He overburdens himself, probably because he can do less after recovery from his burnout, which is somewhat common. Because a burnout doesn't happen because that active level was good for you. I think this man is one I would […] considering certain patterns of complaints – given his age and prolonged stress from various sources- I would send him to the hear clinic for a day. Then he comes back with something or nothing. In the meantime, you can always pick up later on: how is the rest? If nothing comes out, he is also immediately reassured'*(respondent 10)

- Reasoning about patients' lifestyle:

  '*That a man at the age of 46, which is relatively young, has been putting the brakes on his entire life for chest pain, I find that intense, especially his social life, as it seems from the description. That's I think we need to do something about that. […] I would want to talk to him about it, about what that chest pain means to him and what he is so afraid of. […] I think the pain comes from his fear, he is afraid of getting another burnout and the fear of it being something physical*.' (respondent 3)

The patient in the mixed vignette sometimes smokes joints with his friends so he can sleep better, '*so maybe he also uses other drugs, which could be the problem.*'

- Reasoning about patients' social networks:

- Reasoning about patients' profession:

  'My fist impression? Well, very recognizable. We see a lot of these construction workers, contractors, self-employed individuals who work very hard, but, in the meantime, completely overlook themselves. That's what I think. Somewhere, a bell rings, could it be ADHD, I wonder. But maybe that's a hasty conclusion. I would

explore a bit more about that hyperactivity and… But it could also be that he's just a bit overloaded. […] This population here, they often have to keep going because it's their income. They can't be sick. They just keep going. […] I often hear from people in this situation that it's just a lot and many balls in the air. […] I would also wonder if he used any drugs to keep going, maybe coke of ADHD medication? […] if you're thinking about mania, […] they might spend a lot of money, engage in excessive sexual activity, gamble excessively, or exhibit unrestrained behavior. So, I would like to inquire about that. If that's the case, I would consult with a psychiatrist for a short term assessment' (respondent 3)

- Reasoning about patients' educational level

  '*Based on the number and type of questions he asks I think that it is mostly a problem in his head. He thinks a lot. […] This seems to be a slower process, not currently at a tipping point where it is becoming a major problem. And it's someone you think will come back if it suddenly gets worse. […] Or at least, that's my expectation with highly educated people. On the other hand, you also convey this with all the problems that are not resolved yet. If the problem gets worse, you should raise the alarm earlier.*' (respondent 10)

[5.3 Zoom in on specific attitudes

5.4 The use of different types of reasoning per vignette/ socioeconomic status

5.5 Constructing the professional role/ target group/ client group/ what do they see as real clients/ patients? Who is worthy of their time?

5.6 Empowering groups]

Reflections on whom to empower and how the socioeconomic status of the professional may play a role in this.

One respondents has mostly worked in neighborhoods with higher socioeconomic status. This general practitioner is more worried about the patient with a higher socioeconomic status. She recognized herself in him and thinks it is '*not okay that he can't do what he wants to do anymore'*. She feels sorry

for the patient with lower economic status, but does feel overwhelmed by the idea of helping him herself, because this would be a lot of work.

Another respondent who recognizes herself in patients with a lower socioeconomic status is more worried about the patient with a lower (and mixed) socioeconomic status and she feels sorry for him and she wants to help him. [do they also reason differently about them?]

5 Discussion

- Reflect on findings with literature on logics (citizen and professional agency) when these come up in our findings more inductively (Cecchini and Harrits 2022). Maybe I see that respondents reason from different categories with patients from different socioeconomic classes. For example, maybe they use experiential knowledge with patients with a higher socioeconomic status patients and other types of knowledge with patients with a lower socioeconomic status. The distinction between the logics presented by Cecchini and Harrits (ibid.) is not entirely clear.
- Reflect on findings using Harrits' (2018) research on stereotype activation.
- Reflect on findings using double standards literature.

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Appendix A. The vignette interview and questions