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Authors

Chang, Jamie
Dubbin, Leslie
Shim, Janet

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Negotiating substance use stigma: the role of cultural health capital in provider–patient interactions

Jamie Chang, **Leslie Dubbin**, and **Janet Shim**

Social and Behavioral Sciences, University of California San Francisco, USA

Abstract

Diverse aspects of life and lifestyles, including stigmatised attributes and behaviors are revealed as providers and patients discuss health. In this article, we examine how the stigma associated with substance use issues shapes clinical interactions. We use the theoretical framework of cultural health capital (CHC) to explain how substance use stigma is created, reinforced and sometimes negotiated as providers and patients engage in health interactions. We present two main findings using examples. First, two theoretical concepts – habitus and field – set the social position and expectations of providers and patients in ways that facilitate the stigmatisation of substance use. Second, we found both providers and patients actively exchanged CHC as a key strategy to reduce the negative effects of stigma. In some clinical encounters, patients possessed and activated CHC, providers acknowledged patient's CHC and CHC was successfully exchanged. These interactions were productive and mutually satisfying, even when patients were actively using substances. However, when CHC was not activated, acknowledged and exchanged, stigma was unchallenged and dominated the interaction. The CHC theoretical framework allows us to examine how the stigma process is operationalized and potentially even counteracted in clinical interactions.

Keywords

drug use; substance abuse; Bourdieu; doctor–patient communication and interaction; grounded theory; stigma

Introduction: substance use and cultural health capital

In the USA today almost 21 million people have been diagnosed with drug and alcohol abuse and dependence (Substance Abuse and Mental Health Services Administration, 2012). People with substance use issues often have complex and challenging healthcare needs (Single *et al.* 1999, Volkow and Li 2005) and worse health outcomes. Substance use (tobacco, alcohol and illicit drug use) is cited as among the leading causes of death in the USA (Mokdad *et al.* 2004).

There is growing recognition that substance use issues can be effectively addressed in hospital settings, for example, through brief interventions (Madras *et al.* 2009). However, the success of brief interventions is hinged on routine, open, safe conversations about substance

Address for correspondence: Jamie Chang, University of California San Francisco, San Francisco General Hospital, 1001 Potrero Avenue, Building 20, Suite 2100, San Francisco, CA 94110, USA. jamie.chang@ucsf.edu.

use between providers and patients. Provider–patient discussions about substance use are often fraught with challenges (Merrill *et al.* 2002). In a national survey, 32% of primary care physicians and psychiatrists reported they do not ask patients about illicit drug use; and when physicians were aware of patients' drug use, referrals to substance use treatment programmes were not routine (Friedmann *et al.* 2001). In another study, 45% of patients reported that their provider did not know about their substance use (Saitz *et al.* 1997). Moreover, when active substance use is a factor in clinical interactions, both providers and patients often display mutual distrust (Merrill *et al.* 2002). In these ways, substance use is the proverbial elephant in the examination room. It is common and highly consequential to health, but often avoided or minimised by providers and by patients.

One reason substance use is challenging to discuss is that some providers have negative attitudes about patients who use drugs and alcohol (Lindberg *et al.* 2006, Miller *et al.* 2001). A recent meta-analysis of healthcare professionals has shown that negative attitudes toward patients with substance use disorders is common, and leads to less optimal care for these patients (van Boekel *et al.* 2013). They are often perceived as difficult patients (Hahn *et al.* 1996).

One way sociologists have conceptualised negative attitudes is stigma. The stigma concept goes beyond simply having a negative attitude, however, to emphasise the social processes and structures that underlie the development of these attitudes. This is best exemplified by Link and Phelan's (2001) definition of stigma as not simply a discrediting individual characteristic, but rather as a social process involving labelling, stereotyping, status loss and discrimination that unfolds when unequal power dynamics exist. Stigma affects health through the barriers it creates in clinical interactions, adding to social stress and increasing discrimination (Link and Phelan 2006). In this conceptualisation, the stigma of substance use is based on broad social inequalities but also developed or reinforced through interpersonal experiences, like the provider–patient interaction. Research has shown that structural factors, such as physician shortages and efficiency requirements, are also linked to the stigmatization of patients who use substances (Paterson *et al.* 2013).

In this article, we offer the concept of cultural health capital (CHC) (Shim 2010) as a theoretical tool to dissect how substance use stigma unfolds in and through provider-patient interactions. CHC is a specific form of cultural capital that is valued and exchanged between providers and patients as they interact. We present two main findings. Firstly, we argue that two theoretical concepts – habitus and field – set the social position and expectations of providers and patients in ways that exacerbate the formation of stigmatising behaviour. That is, the social and institutional dynamics of the clinical encounter can facilitate the stigmatising process. Secondly, we argue that both providers and patients actively exchange CHC as a key strategy to find common ground and reduce stigma. Interactions where providers and patients activated, recognised and exchanged CHC resulted in more productive and mutually satisfying interactions, even in spite of a patient's substance use. However, when CHC was not mobilised, recognised and exchanged, stigma was unchallenged and dominated the interaction.

Methods

The data we analysed for this project came from a subset ($n = 15$; six providers, nine patients) of the participants recruited for a broader study ($n = 23$; six providers, 17 patients) on CHC. For the main study we recruited six providers from three safety net healthcare sites in the San Francisco Bay Area – five specialised in cardiology and one in internal medicine. Four of the providers were women and two were men. Four described their race/ethnicity as white, one as black and one as biracial. All the provider participants of the study were medical doctors. However, we refer to the doctors as providers because in the USA other types of healthcare providers often have a direct primary care role, such as nurse practitioners and physician assistants.

For each provider participant, we then recruited two to three patients who had a diagnosis of coronary heart disease or type 2 diabetes ($n = 17$). We were interested in these specific health concerns because they are chronic diseases that require active disease management and ongoing contact with healthcare providers and institutions. Of the patient participants, twelve were men and five were women. Their average age was 56 years. In total, eleven patients described their race/ethnicity as black, three white, two Asian/Pacific Islander and one Hispanic/Latino. All patients in the sample had a low income (individual income less than $15,000 per year).

We audio-recorded one clinic visit between each provider and patient. In the following 2–8 weeks we interviewed patients and providers separately using semi-structured interview guides focused on the conversation and interactional dynamics in the clinical visit. The interviews lasted between 1–2 hours. The patients were interviewed in their homes and the providers in their offices. We asked the participants about their expectations and perceptions of the interaction; their ideas about what constitutes good health and health behaviour; the actions they took to promote health; and specific moments in the interactions. We played audio-recorded segments of the clinical interaction to prompt discussion during the interviews.

All audio-recorded material was transcribed verbatim. The transcripts were then uploaded into the qualitative analysis software Atlas.TI. Data was coded and analysed using the grounded theory method (Charmaz 2006). The coding scheme was developed through an iterative process. First we developed an initial set of codes that derived from our theoretical understanding of CHC. We supplemented these deductively derived codes with a set of inductive codes that emerged from our analysis of the data. Each researcher independently coded a small number of transcripts first. The provider interviews and patient interviews were coded separately. We met regularly to resolve differences in interpretations of the deductive codes and to discuss respective inductive codes. Through successive iterations of independent coding of transcripts and meetings to discuss evolving understanding of codes, we settled on a set of 24 codes for the provider interviews and 36 codes for the patient interviews. Using Atlas.TI, each interview was coded by at least two researchers using the coding scheme. When the data were coded, software tools like thematic family trees were used to inform what related sets of concepts were most germane to the interactions.

As we examined the data, substance use was a pivotal theme that shaped many of the clinic interactions. Investigating substance use was not a part of the main CHC project study design but we believe it warranted targeted analysis because it affected all six providers as they interacted with patients with major substance use histories ($n = 9$). The data collected from this sub-sample of interactions involving substance use comprised the bulk of data analysis related to substance use, but broader theoretical concepts (CHC, habitus and field) were developed using the entire data sample ($n = 23$).

One major challenge in exploring substance use is defining terms like substances and problematic substance use (Turner and McLellan 2009). These concepts have been defined in different ways by researchers, policymakers and providers. To begin, the term substances can indicate illicit drugs such as cocaine or methamphetamines as well as legal substances like alcohol or tobacco. In the USA substances like cannabis and prescription opioids occupy a grey area between medicinal versus illicit use, leading to a range of clinical attitudes about these substances (Kondrad and Reid 2013). The terms use or abuse can indicate a spectrum of behaviour, ranging from past use, current occasional or recreational use, medicinal use, habituated use, dependency, abuse and addiction.

Because we analysed the concept of substance use and stigma retrospectively we did not have the opportunity to do a full assessment of each patient's substance use history. In this study, therefore, we defined substance use as any use of drugs (prescribed or illegal) or alcohol, current or historical, that emerged as a problematic health concern in the clinical interactions or interviews we recorded. In the sample we observed, five of the nine patients who used substances reported a major use of cocaine (powder, crack-cocaine and injected cocaine). The other four patients reported a major use of alcohol ($n = 3$) or cannabis ($n = 1$). Several patients also described tobacco use in addition to other substance use. All types of substance use are somewhat stigmatised in healthcare settings, but it was also evident that specific types of substances and consumption patterns were perceived as more problematic than others.

The relatively high percentage of patients reporting substance use (53%) in our sample is likely to be due to two factors. First, we recruited participants with cardiovascular diseases and type 2 diabetes for which substance use can be a risk and complicating factor (Kotseva *et al.* 2009). Also, the sites where participants were recruited were safety net healthcare settings. People who have chronic substance use issues are less likely to have health insurance (French *et al.* 2000) and disproportionately rely on safety net institutions for medical care.

Theoretical frameworks for examining stigma in clinical interactions

To understand how substance use impacts interactional dynamics between providers and patients, we used Pierre Bourdieu's (1986, 1990) concepts of habitus, field and cultural capital for theoretical guidance. First, Bourdieu argued that '[t]he conditions associated with a particular class of conditions of existence produce habitus, systems of durable, transposable, dispositions … principles which generate and organise practices and representations' (Bourdieu 1990: 53). Habitus is an actively debated theoretical concept. It is

broadly thought of as the attitudes and dispositions we acquire through the historical, biographic and social experiences provided to us by our social position. These form to become the lens through which we understand our world and the general principles of action we use to engage with it. Because our experiences are situated by our position in the social structure (as defined by race, gender and class), habitus echoes this social position. Bourdieu described habitus as transposable because it travels with us and forms the basis of our point of view as we move through different places, interactions and time. Habitus is also durable: it is structured, in that it is linked to our place in society; but it is also structuring, because it informs and guides our actions that in turn often reinforce our social position. However, as Bourdieu insisted, 'Habitus is not a fate; it is not a destiny' (Bourdieu 2005; see also Bourdieu 1993: 133). Habitus shapes our actions because it guides and structures our behaviour, but it is not determinant, because individuals still possess agency to act in ways that are not always consistent with their habitus.

Second, fields are arenas where social relations and power struggles between people are organised. Fields can be broad, like an economic field, or more specific, such as an art or educational field. They develop their own distinctive norms and rules, but they reflect the social structures and power relations of the people in the field. A person's experience in and capacity to navigate a field depends on her status and position in these structures and relations (Bourdieu 1993). We argue that health care is a field in the Bourdieusian sense because it is a site of social action and power struggles over capitals with specific norms and rules, where broader social structures are objectified.

Third, cultural capital is a way in which Bourdieu conceptualised habitus and field to operate in society. Cultural capital consists of the skills, dispositions, possessions, achievements and experiences we accumulate over time through our biographical and social experience. Like economic capital, cultural capital can be used and exchanged in social interactions to improve one's social status. In different types of fields – arenas of social action where participants struggle for social distinction – different types of cultural capital are recognised, transferable and rewarded as assets. Thus, each field is characterised by different forms of cultural (as well as social and economic) capital and different rules that set the terms of exchange. In institutional fields such as schools, workplaces and hospitals, the cultural capital that is valued necessitates familiarity with the dominant culture in a society. For example, knowledge of information relevant to the field and ways of speaking and comporting one self can influence how others perceive one's intelligence and sophistication. In these ways, cultural capital functions symbolically, cueing others as to one's social status or authority.

However, Bourdieu argued that cultural capital is not equally distributed. Those without the cultural resources, skills and dispositions that are recognised and valued in a specific field are disadvantaged in the struggle for social status and privilege. The acquisition, production, deployment and distribution of cultural capital – structured as it is by habitus and field – is integral to understanding the exercise of power and the production and reproduction of inequality.

Shim (2010) argued that CHC is a specific form of cultural capital that is valued and exchanged in the field of health care, particularly in healthcare interactions. Like cultural capital, the presentation of CHC is sometimes strategic and deliberate, but it is also deeply embodied and habitual. Thus the mobilisation of CHC may be conscious strategies of action (Swidler 1986) or more tacit styles and habits of action. Shim's conceptualisation focused on the CHC elements that providers seek out in patients as they work to navigate and access care in today's healthcare field. In this article, we expand on this perspective using our data to argue that not only patients, but also providers, use similar but distinct sets of CHC elements to promote positive health interactions. For both providers and patients, possessing good communication skills, sensitivity to interpersonal dynamics and the ability to adapt one's interactional style are key elements that promote the exchange of CHC. Providers value additional characteristics in their patients, such as their knowledge of medical topics and language, the active presentation of markers of social and economic status (for example, physical appearance, educated, middle class or relatable interests) and proactive, health savvy behaviour and attitudes (Shim 2010). The CHC elements that patients value in providers include medical expertise, along with more interactional factors like understanding the personal context of illness and approaching sensitive topics non-judgmentally (Dubbin *et al.* 2013). These elements of CHC are forms of capital that can be exchanged by patient and provider for positive health interactions and ideally better health outcomes.

CHC is particularly relevant in today's healthcare system, where personal and social barriers are common in interactions, yet patients are increasingly expected to play an active, consumer-like role (Clarke *et al.* 2003) and be partners throughout the healthcare process (Davis *et al.* 2005). In what follows, we explore how CHC together with substance use – and the attendant potential for stigma – operate to shape the clinical interactions between patients and providers.

Results

Habitus, field and the perpetuation of stigma

Ideally, patients and providers work in partnership to achieve a patient's healthcare goals. Despite the popularity of the health partnership rhetoric, however, the reality is that partnerships are challenging when substance use is involved. As he reflected about his patients who use crack cocaine, one of the provider participants, an attending whom we call Dr Barberry, acknowledged:

> Biases – everybody has them. And I think it would be silly to suggest that we don't. So I'm sure there are things that I make and form impressions about immediately, that I shouldn't.

Dr Barberry told us about his experiences struggling to balance the health needs of patients who use substances with those of other non-substance-using patients, especially within an environment with limited time and resources:

> When I get those patients [who use substances], you kinda spin your wheels … you're really not doing good for anybody and you may be just taking time away from other people who really you could be helpful with. There's definitely patients

> that I've seen once or twice who, I wonder why I'm seeing them, because there's nothing that I'm doing for them necessarily. Except they come in and I remind them not to smoke crack anymore. And they choose to smoke crack anyway. They don't necessarily take their medications, it may not necessarily be safe to give them medications if they're smoking crack … We have a very long backlog to see patients and time that I spend with someone like that is time that I could spend with somebody who I can help out … It's an opportunity cost thing.

In the context of the health resource scarcity Dr Barberry perceived to be prevalent in the USA healthcare system, he grappled with the deservingness of substance-using patients.

Dr Barberry was not alone in conveying negative impressions about patients who use substances. A second provider participant, Dr Clary, described her perception that patients were unlikely to change the substance use behaviour that may have contributed to or exacerbated their health problems. She did not typically view patients with substance use issues as good candidates for specialised medical or surgical treatments:

> [Substance users] go back to the same friends that they had trouble with in the first place and then they start back up. What's the use of trying all these exotic medications if it's still the drug that's the problem? [Healthcare institutions] don't want some IV drug abusing scum ball, just to be plain about it … We have to save the resources for people who want to take care of themselves so what's the point of doing this massive operation if the person is just going to destroy his body again?

A third provider, Dr Aster, declined to see patients with substance use issues altogether, because she believed from her previous experiences that it was futile. Although patients with chronic substance use issues were common in the clinic, her assistants knew not to include them in her clinic schedule. She explained her rationale to us:

> Personally, I will not see substance abusers … The recidivism rate is extremely high among the substance abusers. And most do not, or have no wish to, discontinue drug use and it's a waste of both our times.

To be clear, we do not offer these quotes to point to individual providers' insensitivity to those who use substances or to individually held attitudes that stigmatise substance use and users. Rather, we treat these examples as sites in which the CHC framework can offer a more nuanced analysis of the situation, one that moves beyond merely implicating individual providers and individual patients. That is, we suggest that the quotes above are examples of how providers' habitus and the field of health care – both of which are socially structured and stratified – frequently operate together to produce or reinforce stigmatising attitudes about substance use. In the clinical interactions we analysed, the habitus-field dynamic was characterised by (i) meaningful inequalities between providers and patients who use substances and (ii) a lack of resources to address these inequalities.

Individual providers have a wide range of personal characteristics, attributes and approaches to patients, as we continue to show through the examples below. However, as a group, there are elements of habitus that providers shared in common. Again, habitus is the set of knowledge and dispositions acquired through the experiences provided to us through our

social position. In general, providers have higher socioeconomic status than their patients who receive care in the safety net. Their experiences working in public healthcare settings involved repeated interactions with poorer substance using patients, often in stressful health circumstances. Moreover, providers, like all Americans, are exposed to broad, negative messages about substance use in society, such as the stigmatizing representations of people who use substances and criminalising policies widely disseminated in the ongoing 'war on drugs' (Campbell 1994, Elwood 1994). These messages, which are imbued with moralistic undertones and often explicitly racialised and gendered, are woven into the habitus of providers as they are socialised as individuals and as healthcare professionals, as they undergo clinical training and as they continue to interact with their patients throughout their careers. We argue that these shared elements of habitus in turn influence providers' attitudes and actions toward patients who use substances.

Habitus and field are distinctive concepts but they operate together, influence one another and mutually influence the outcome of social interactions. The healthcare field is characterised by distinctive norms and rules that are also reflective of larger social patterns of stratification. We argue that some of the norms particular to this field are likely to exacerbate stigma. One is that in hospital settings, providers are in a position of more authority relative to their patients. This of course is in part because hierarchies are institutionally embedded into the healthcare infrastructure: providers have greater access to expert knowledge and information, they are positioned as gatekeepers to valued health-related resources and thus have more authority in clinical interactions. But institutional or medical authority also trickles down to more informal though no less tangible interactional authority. For example, providers often have expectations of what constitutes a good patient (Dubbin *et al.* 2013). These expectations, borne out of their habitus, are used to establish the norms, attitudes and behaviour valued in the examination room. The authority that providers have to determine and enforce norms (such as the degree of tolerance of substance use) is one key factor of the interaction that can exacerbate stigma.

A second factor of the field that contributes to stigma is that most healthcare settings do not provide the time or resources for providers and patients to untangle and address the complexities of substance use. The 15-minute visit is the norm in most safety net health settings throughout the USA, yet this short time is inadequate to address the complex health needs of disadvantaged patients (Fiscella and Epstein 2008). The providers told us they did not have time for meaningful, in-depth discussions about substance use; they did not feel adequately trained to address substance use head on and they were concerned about conserving limited healthcare resources, thus being reluctant to 'waste' resources on people they felt were not committed to their health. That is, in the hectic, resource-scarce culture of the clinical field, providers lacked the training, time and resources to adequately address substance use.

In sum, both habitus and the healthcare field frequently operate together to produce challenging interactions between providers and patients who use substances. We argue that the perception of substance-using patients as unworthy of the scarce time and resources resulted in interactional barriers with tangible and systematic consequences for patients. It affected all aspects of clinical encounters and their trajectories, including how much time

and energy the providers were willing to invest in the interaction, whether they would recommend a patient for additional health services, even whether they were willing to see a patient. In these ways, patients with known substance use histories had less access to many healthcare options, which may in part explain the persistence of poor health outcomes among these patients.

Providers and patients deflect the stigma process using CHC

Providers use CHC to reduce stigma—Although negative impressions about patients with major substance use histories were prevalent, we also found that most providers (to varying degrees) actively worked to challenge these impressions. To do so, these providers used several strategies, such as addressing patient's health behaviour in the context of their life circumstances, approaching their patients non-judgmentally and focusing on positive changes and tangible goals. We propose that these actions are components of provider CHC.

Dr Datura, a white woman attending, was one provider who reported a deeply felt commitment to engage the topic of substance use and other stigmatised lifestyle factors that shape health. When we interviewed her she acknowledged that patients who used substances often presented difficult cases. Yet based on her experience, Dr Datura believed a punitive stance toward substance use inevitably pitted her against the patients she hoped to help:

> One of the rules that I have is I'm willing to see the people who are kind of struggling through substance abuse issues … They may not really identify [substance use] as something they want to change and you have to meet people where they are … You have these incredible personal conversations and it's interesting to learn how people build their life with the choices that they make. It's not all black and white … [Heart disease] is a lifestyle-aggravated disease. You don't have to have bad lifestyle issues to get cardiovascular disease but a lot of people do. We kind of have this punitive look towards it …. That is simplistic to think that people who have bad behaviour are either stupid or lazy or indifferent to their health.

Dr Datura's approach to her patients had three characteristics: she discussed substance use with patients within the specific contexts of their personal life circumstances; she recommended achievable health goals; and she used non-judgmental language and tone that reached patients. In this approach, she activated her own CHC as a bridge to reach out to her patients, acknowledge the CHC they possessed and work to improve on them gradually:

> You get into it with patients who have those challenges and you're not going to feel greatly successful leaving clinic with them every time. You've got to start finding success … Maybe they're trying to use less cocaine … You kind of have to meet those people where they live. It takes a different set of skills and you have to have different goals in a way. You have to understand that it's easy sometimes to explain complex concepts to someone when you speak the same language … What we do is going to take a bigger chunk of time.

Dr Datura's strategy involved exchanging her own CHC – the provider skills, dispositions and attitudes valued in health care – to reach out to her patients and cultivate their CHC. She

repeatedly stressed that meeting patients 'where they are' was central to working with patients who use substances. Importantly, she was not dismissive of or uninterested in substance use – rather, her goal was to engage substance use in-depth to learn how it affected patients' health decisions.

Although we cannot make general assessments about the efficacy of Dr Datura's approach, it is worth mentioning that she played an important role supporting one of her patients we met in his recovery from decades of struggling with alcohol. Mr Dodder is a white man and Dr Datura has been his cardiologist for 7 years. When they met, Dr Datura recognised that Mr Dodder possessed CHC, as subtle as it was while he was drinking heavily. She encouraged him to use these skills, resources and strengths in an effort to address his heart condition and his drinking. She routinely coached him on how to take steps towards better health, actively educating him or referring him to supportive people and resources. She therefore not only acknowledged but also cultivated and increased Mr Dodder's CHC. We noticed in their clinic visit that most of their conversation was not about cardiology per se, like heart disease medications, symptoms or heartbeats. Instead, they discussed broader lifestyle factors affecting health, like pain and stress management, stretching and yoga, diet, physical therapy and family support. When asked about this in the one-on-one interview, Dr Datura responded:

> I don't want to take sole credit for the fact that he is sober and kind of living the life that he enjoys … but the reason [Mr Dodder] is doing fine is because I was willing to talk to him and see him as a broader person back then. I'm not going to stop that now because I don't know that next year, or the year after, he's not going to have another problem with alcohol. I want him to know that I am committed to him and we're just a team … thick or thin kind of thing. Frankly, if I were working in a different health system where they wanted me to see people in 5 minutes, I wouldn't do well.

When we interviewed Mr Dodder, he told us he has been in recovery from alcohol for 3 years and 3 months. And, from his perspective, Dr Datura was pivotal to his current sobriety. Referring to Dr Datura and another doctor (his primary care provider), Mr Dodder summarised the way his providers were pivotal to his recovery:

> I have a better life now that I'm clean and sober. I could tell by the doctors that I had at the hospital that that was the way to go. They pressed it, but being an adult, it's always up to the person. There's no scolding but they knew [about my drinking] … I hold them in highest regards, Dr Datura, I really do … [they] were tremendous in my cleaning up and feeling better about myself and everything.

Dr Datura's recognition and cultivation of Mr Dodder's own sources of CHC – his goals, skills and capacities – and her commitment to him was effective in shaping Mr Dodder's health. Dr Datura leveraged her own sources of CHC to encourage and support him as he mobilised his CHC to begin and maintain his recovery. This was a reciprocal process – the exchange of patient and provider CHC built the trust and communication in the interaction and helped Mr Dodder work on lifestyle changes that yielded multiple positive benefits for his health over the course of their 7-year relationship. It also benefited Dr Datura because

Mr Dodder's increased engagement and investment in his health allowed future clinical encounters to be easier and more productive.

Patients use CHC to reduce stigma—Like providers, patients who used substances also had impressions about healthcare interactions based on their habitus. Patients described predominantly negative experiences with their providers when substance use was a factor in the interaction. Mr Balsam is a low-income white male patient who was in recovery from injection cocaine use. His provider is Dr Barberry, a white man of a similar age. Before they met Mr. Balsam recalled feeling stigmatised by a previous cardiologist for his drug history:

> My old cardiologist, every time I went there he accused me of doing cocaine …. He was just convinced that I was always doing cocaine because I made the mistake in telling him in our first meeting that I used to be an injection cocaine user, so that just stuck in his head and that's all he heard.

Another patient, Mr Cress, is a biracial man who is a patient of Dr Clary, a biracial woman provider. Mr Cress was also concerned that substance use was a litmus test for who receives care:

> They don't want to give people who are drug users certain types of drugs … That was a real shock to me … I guess it makes sense. It's logical but kind of bummed out since there are a lot of people in my position … It's horrible that they would pick and choose who they're going to give an amount of care to.

These quotes show that based on their interactions with healthcare providers and settings, patients with histories of substance use frequently entered clinical interactions expecting their substance use to be severely stigmatised. At the same time, the patients knew that the providers were the gatekeepers of their healthcare options. That is, they understood the tangible liability of substance use in clinical interactions.

In response to these impressions and attitudes, the patients frequently worked to negotiate or reshape their provider's negative impressions. This process is what stigma theories have called stigma management or impression management (Goffman 1963). The dynamics and consequences of impression management strategies used by patients can be explained within the context of the CHC framework. Patients actively deployed elements of CHC, such as communicating their medical knowledge, sophistication and engagement, to effect demonstrations of their worthiness and good patienthood. The patients emphasised their recovery or limited disclosure, gauging providers' reactions before sharing additional information about their substance use – strategies Goffman referred to as 'information control' (p. 41) – in an effort to shape their provider's perception of them. The activation of CHC was strategic, but it also stemmed from the habitus of patients – their engrained understanding of how to navigate the people and systems that might view them unfavourably. That is, patients mobilised CHC to manage providers' impressions of them, as the examples below illustrate.

Example 1: Mr Balsam and Dr Barberry

One of the patients we interviewed, Mr Balsam, exemplified how CHC was used to manage his provider's impressions. He told us in the one-on-one interview that he avoided disclosing his substance use issues and history because of the negative impression they left on his providers:

> Mr Balsam: I think about how I present myself, if for no other reason than because certain doctors, if they know that you either were a drug user or are a drug user, you become a nonentity. It's like you're not even human any more, they don't treat you like a human being. Other doctors don't care whether or not you were a drug addict or are a drug addict. So that definitely influenced how I present myself. If I feel the doctor is conservative or Christian or whatever and has issues with drug users, I usually don't talk about my drug history.
>
> Interviewer: Do you actually withhold that information?
>
> Mr Balsam: Sometimes … scoot around it more because it's not something that's active now.

Mr Balsam was recently denied Medicaid due to unresolved legal circumstances from a past drug-related crime. Though he was a young man, he managed several major physical and mental health conditions uninsured. Being unable to work and living off a disability allowance, he did not have many resources and options for his health. Most immediately, Mr Balsam required a provider's note verifying that his medical conditions precluded his participation in a court-order drug treatment programme. Understanding that there was much at stake in the visit with Dr Barberry, Mr Balsam was determined to make a good impression. During the clinical interaction, Mr Balsam selectively reported his substance use, with the goal of managing how he was perceived:

> Mr Balsam: I got arrested for basically being a drug addict and stealing stuff to supply my drug habit.
>
> Dr Barberry: Are you still using drugs?
>
> Mr Balsam: No … I didn't know about [the cardiac illness] because if I had known, I would have stopped. I was actually an intravenous cocaine user. Of course, I'm lucky I didn't die.
>
> Dr Barberry: Oh, you're really lucky.
>
> Mr Balsam: I OD'd a couple times, I shot so much.
>
> Dr Barberry: I'm sort of amazed you're not dead.
>
> Mr Balsam: I'm not a violent criminal, never have been.
>
> Dr Barberry: You're not using anymore?
>
> Mr Balsam: No. The only drug I use occasionally is marijuana. I don't use any other street drugs. I can't.

Mr Balsam strategically deployed elements of CHC in this interaction to lessen the stigma associated with substance use, because he knew that stigma has consequences. He disclosed

his substance use history and current use, but couched it within a context of recovery and other positive attributes: he was never a violent criminal, no longer used any “street drugs” and acknowledged the impact of intravenous drug use on his heart condition. The emphasis on recovery evinced his willingness and ability to manage his health and change his lifestyle. He also arrived prepared for his appointment, with a stack of health and legal documents and a notebook listing questions and requests. According to Dr Barberry, Mr Balsam appeared professional and sophisticated, he communicated his health and legal circumstances clearly and he showed an enthusiastic, positive, serious attitude toward his own health. He also demonstrated he had social support by coming to the appointment with his partner, who herself activated a great deal of CHC and was tirelessly involved in the clinical interaction and Mr Balsam’s health more generally.

When Mr Balsam deploys CHC, he is acting with personal agency but there are limitations to his agency. He told us in his one-on-one interview that he ‘scoots around’ the topic of substance use because the label has been stigmatising in past interactions with providers. Thus, he was quite strategic in withholding information about his substance use in his interaction with Dr Barberry. However, we suggest that this individual agency – his ability to mobilise CHC – was also limited. It was restricted because people with substance use histories have access to only a few CHC strategies (for example, withholding information about their substance use, or covering or attempting to conceal or minimise their substance use) to overcome stigma. Moreover, it was limited by whether or not Dr Barberry was willing to accept Mr Balsam’s attempt at exchanging CHC through these strategies.

Mr Balsam’s impression management through mobilisation of his CHC was crucial to the interaction for reasons that go beyond simply facilitating informational exchange and medical treatment. His CHC was also symbolically important to Dr Barberry as an indicator of Mr Balsam’s likelihood to invest in his own health. In the end, Dr Barberry told us that he felt Mr Balsam was worthy of the time and medical attention despite his substance use history and current use:

> [Mr Balsam] has shown that he can achieve these lifestyle changes. He has a proven track record of stopping drugs – at least from what he’s telling me … He’s got his things together … He seemed like he’d made a lot of changes already; he was actively taking care of himself and it seemed like it was worth the time.

In this example, Mr Balsam mobilised his CHC in exchange for a less stigmatised relationship with Dr Barberry, and, in turn, tangible resources and time from their encounter. For example, Dr Barberry agreed to write him a letter supporting his Medicaid eligibility; he urged Mr Balsam to quit smoking and referred him to a smoking cessation programme; and he advocated that Mr Balsam should be transferred to a more specialised clinic for treatment, if necessary. Dr Barberry was more invested in Mr Balsam’s healthcare in ways that had tangible benefits for his future wellbeing.

Example 2: Mr Cress and Dr Clary

Mr Cress provides a second example of how CHC was used for impression management. Like Mr Balsam, Mr Cress had experiences with substance use and stigma. He had used substances, mainly crack cocaine, since he was a teenager and at times resorted to stealing to

pay for drugs. Just before he was incarcerated for the first time for burglary, he developed symptoms of heart failure.

The first time he met Dr Clary, Mr Cress was handcuffed, dressed in a bright orange state-issued jumpsuit and was being escorted from county jail by a police officer. Having started their relationship in that way, Mr Cress had a strong recognition of the role that substance use stigma (compounded by the additional stigma of having a criminal history) played in his health, healthcare options and interactions with providers. He struggled to access health care from jail. As he learned that providers 'pick and choose who they're going to give an amount of care to,' it became apparent to him that impressions and stigma matter. His concerns were valid. Dr Clary was clear in her conversations with both Mr Cress and us that she does not often consider people with his background (that is, substance use, criminal history and incarceration) as good candidates for costly medical treatments. During their second clinic visit together, Mr Cress frequently mobilised his CHC and practiced impression management:

> Dr Clary: Hello, nice to see you. Let's chat a little bit. I'm glad things worked out with regard to your social situation. Where are you living right now?
>
> Mr Cress: [Residential substance use treatment programme]. I got myself in.
>
> Dr Clary: Oh, good. I'm glad you did that. What's it like to live there?
>
> Mr Cress: It's a little uncomfortable. When I saw you last, I was going to the penitentiary, but that didn't end up happening. The day of our appointment, our last procedural appointment, … I got out [of county jail] … so now I'm on parole. I can't do drugs any more and I can't do the things I used to do, so I have to do something else. That's why I put myself [into the residential treatment programme].
>
> Dr Clary: How are you doing with the drugs?
>
> Mr Cress: I have 1 year not doing drugs. Last week I had a year. So – nothing at all. No cigarettes, no nothin.
>
> Dr Clary: That's great. It's not easy to do that and a lot of people are not successful, so I'm really proud that you did that … we gotta figure out how to get your health shaped up here again.
>
> Mr Cress: I don't eat meat any more, or eggs or anything … That's kind of hard [at the residential treatment program but] I don't eat any of that.

Mr Cress knew he needed to practice both disease management and impression management. Upon his release from jail, he enrolled in a residential substance use treatment programme and worked to be abstinent from drugs, alcohol and tobacco. He could no longer exercise rigorously due to heart failure, so he researched his conditions extensively and switched to a highly restricted diet (vegan, low-sodium) to manage his health and symptoms. During his interactions with Dr Clary, he proactively told her about these disease management strategies – not just because they were relevant to his health condition, but also because they improved her impressions of him. He arrived prepared and on time for appointments and repeatedly communicated his resoluteness to improving his health. In

these ways, Mr Cress used his agency to activate and deploy his CHC to counteract the stigma of substance use.

It was apparent that Mr Cress's CHC was effective in reshaping Dr Clary's initial impression of him. Dr Clary told us:

> Mr Cress is like the ideal patient … He has come like clockwork to every single clinic and every single test we've scheduled for him. He's taking his medicine, he's in a rehab programme, he doesn't take drugs any more … He shocked me; he shocked everybody … He's gone from doing everything wrong, to doing everything that will ensure the success of his therapy.

Mr Cress' deployment of CHC generated a cascade of health services and resources. For example, Dr Clary assured him that she was willing to work aggressively to address his conditions. She agreed to monitor his progress through multiple tests to try to treat his conditions non-surgically, as he preferred. She also promised to advocate his admission to another hospital that could offer advanced surgical options for his condition. She told him: 'You're clean now. I'm proud of you. I'll get [those services] ordered up and we'll take it to the next level'.

Dr Clary was also clear, however, that she would fight for him only as long as he stayed abstinent from substances. As their clinic visit concluded, she explained, 'What's the use of trying all these exotic medications if it's still the drug that's the problem?' She is taking no chances – Mr Cress will routinely undergo urine toxicology screens for drugs. Dr Clary's authority illuminates a key limitation to patient's CHC. Mr Cress may be active in exchanging CHC to reduce substance use stigma, but the value of his CHC is ultimately determined by the provider. In clinical settings, providers have the interactional authority to accept or reject patient's CHC.

These examples show that although substance use is often stigmatised, the implications and outcome can sometimes be negotiated in clinical interactions. When providers and patients recognise the potential of CHC, this can soften substance use stigma and result in better health relationships.

Stigma is intensified when CHC is unrecognised

As the final finding of this article, we argue that when negative impressions went unchallenged in healthcare interactions, the stigma of substance use was reinforced and ultimately dominated the encounter. To illustrate this, we introduce Mr Bell, another patient of Dr Barberry's. Although Mr Bell had several valued elements of CHC he made little attempt to mobilise them towards the goal of impression management. In turn, the CHC Mr Bell did possess was not recognised, acknowledged or valued by Dr Barberry, who himself made no attempt to activate CHC toward bridging interactional barriers. In this clinical encounter, negative impressions were mutually all-encompassing, resulting in an unsatisfying clinic visit for both.

When we met Mr Bell, who is a black man, he actively used crack cocaine and alcohol. He managed several chronic conditions, including coronary heart disease, emphysema and

hypertension. Both Dr Barberry and Mr Bell informed us in their separate one-on-one interviews that their first meeting did not go well, particularly after Mr Bell disclosed his active use of crack cocaine. The interaction we recorded was their second meeting. That morning, Mr Bell arrived to his afternoon appointment yawning, lethargic and as Dr Barberry described, looking dishevelled. When Dr Barberry entered the room to find Mr Bell asleep on the examination table, he presumed Mr Bell was under the influence of substances or hung over. Within the first few moments of their interaction, Dr Barberry screened Mr Bell about his substance use:

> Dr Barberry: How's your drinking going and the crack? Are you still using crack?
>
> Mr Bell: Yeah.
>
> Dr Barberry: How much are you using?
>
> Mr Bell: I don't know.
>
> Dr Barberry: Every day?
>
> Mr Bell: Yeah.
>
> Dr Barberry: All right. Are you drinking alcohol?
>
> Mr Bell: The only thing I drink is just wine.
>
> Dr Barberry: Every day?
>
> Mr Bell: Yeah.
>
> Dr Barberry: The alcohol's not good for you … the cocaine's not good for you, though, either. You gotta quit that.

Early in the clinic visit, the tenor of the interaction was established. As is evident in the quote above, both Dr Barberry and Mr Bell were frank about substance use. During the 9-minute appointment, neither party made an effort to forge a connection with the other. Mr Bell, who was put off by their first interaction, made little effort at performing impression management. He did not attempt to conceal or downplay his active use of crack cocaine and alcohol. He was not secretive or apologetic about his substance use; instead, he was straightforward about it, as he was about other aspects of his health. He was responsive and candid with Dr Barberry, but communicated just the minimum.

Mr Bell's seeming lack of engagement was a barrier to Dr Barberry recognising his other aspects of CHC. Like many providers, Dr Barberry sought enthusiasm and engagement as a cue for how much to invest in the patient. Dr Barberry expressed in his interview with us that his impression of Mr Bell was poor, partly because of his substance use issues and partly because of the way Mr Bell presented himself, which Dr Barberry characterised as unsophisticated. Dr Barberry said he did not necessarily feel invested in Mr Bell as a patient. He wanted to help, but believed his efforts were futile due to his lack of training in addiction medicine and because of Mr Bell's attitude:

> My sense is, [Mr Bell] is one of these guys to who you say, 'You gotta stop the cocaine,' he goes, 'Okay'. And that's about all you can do. It's really – there's not much point in saying a whole lot more than that. He could have said, 'Yes, I want to

> stop the cocaine, what can I do?' And I'd talk to him for an hour if I needed to. I'm not gonna help 'em get off the cocaine. I can direct them towards the people who can help them, though.

When we interviewed Mr Bell separately, however, it was apparent that he was in fact invested in his health, but made little interactional effort to showcase these activities to Dr Barberry. Mr Bell informed us that he was actively 'trying to cut down on crack'. He also showed other efforts toward risk reduction, such as paying attention to his diet and salt intake. He was compliant with his complicated medication regimen, 'never missing a dose'. He was on time and prepared for his clinic visit, bringing Dr Barberry copies of his medication lists and pill bottles. This behaviour, in fact, is the kind of health-related habit that Dr Barberry told us he highly valued. But instead, these positive actions were not recognised by Dr Barberry nor were they actively mobilised by Mr Bell; thus, the stigma of substance use continued to dominate the interaction.

In this case, the failed exchange of CHC yielded results very different for Mr Bell than for other patients like Mr Balsam, Mr Cress and Mr Dodder. Unchallenged stigma impacted the types of healthcare options available to Mr Bell. There were no mutually agreed-upon goals in the conversation; rather, Dr Barberry informed Mr Bell that his current heart medication would harm his health and that he would not authorise an increased dosage until Mr Bell demonstrated he was no longer using crack cocaine. Mr Bell was frustrated by the interaction. In his follow-up interview, he told us:

> That was the second time I'd ever seen him … He was just like, 'hurry up and get outta here', or something like that … he didn't wanna hear nothin' … [He said] 'Well, see me next – 4 months from now;' some old shit. I said 'Alright'. Get the hell up out of here … he don't wanna deal with the crack thing, so he'll keep my medicine just like it is.

When comparing Dr Barberry's patients, Mr Balsam and Mr Bell, it is clear that while substance use is stigmatised, stigma can have different meanings and consequences. In both cases, the patients have severe substance use histories and continue to use substances today. Mr Balsam actively managed stigma through CHC and Dr Barberry recognised and rewarded this effort. For Mr Bell, however, the CHC elements he possessed did him little good and he left his clinic visit without Dr Barberry's support for the additional heart treatment he wanted. That is, the same provider reacted differently to substance use in each case based on how substance use stigma was negotiated in the interactions with the patients.

Certainly, there were other factors involved that may have shaped the trajectory of the interactions. Mr Balsam was a younger man than Mr Bell and he was in recovery from intravenous drug use, whereas Mr Bell continued to use crack cocaine; he and Dr Barberry are both white, while Mr Bell is black; Mr Balsam appeared professional to Dr Barberry, that is, of relatable social status, while Mr Bell was instead seen as dishevelled. These distinctions are important, as research has shown that providers perceive black and low-income patients negatively compared to upper-income whites (van Ryn and Burke 2000). Since the CHC framework rests on the structuring forces of race, class, gender and age, differences along these lines may shape the likelihood that negative impressions are resisted.

Also, social and clinical attitudes towards different substances vary, with specific substances having been imbued with more stigma than others. The precise substances that were considered most problematic for the providers in the study; namely, crack cocaine and injection drug use, are more stigmatised and criminalised than other substance use like tobacco or alcohol (Ahern *et al.* 2007). In Mr Bell's instance, his lack of impression management, his continued use of a racialised and highly stigmatised drug and Dr Barberry's judgment of these attributes, all worked to impede the exchange of CHC and produce a very brief, mutually unsatisfying and stressful encounter.

Conclusion

In sum, we used CHC as a theoretical framework to examine healthcare settings as a specific type of social field where social inequalities and power relations are objectified and operationalised, in part through interactions between providers and patients. This approach was useful for analysing how stigmatised attributes and behaviour, such as substance use, unfold in and affect clinical interactions. In the results, background details about the patients and providers give context and offer a glimpse of their habitus as it relates to their interactional style or their attitudes about substance use. But we stress that beyond individual attitudes, experiences and styles, the way structural inequalities (as conceptualised through habitus, field and CHC) affected the interaction offers better explanatory power for why patients who use substances face stigma. According to Bourdieu, habitus comes from individual experiences, but since individual experiences are structured by our social position, one cannot separate habitus from an individual's structured experiences as a member of various social groups. That is, our everyday actions today are shaped, though not determined, by our structured, stratified pasts. And in the field of health care, where differences and inequalities are worked out in clinical interactions situated by specific norms and rules, substance use stigma is produced, exacerbated and negotiated.

We have shown that people who used substances were routinely stigmatised, some to a greater degree than the others. Most commonly, providers perceived patients who used substances to be a waste of time and resources. Yet providers and patients also used CHC (to different degrees) to challenge the potential harm of stigma. When CHC was actively mobilised by patients (for example, Mr Balsam and Mr Cress) or cultivated by providers (for example, Dr Datura), it mitigated the interactional thorn of stigma, even resulting in a variety of health advantages. At the same time, there were circumstances (for example, in the case of Mr Bell) where stigma affected the interaction so profoundly that CHC was barely even recognised. CHC is unequally distributed in society, as our examples show, but the extent to which providers and patients were willing to recognise, engage and exchange CHC with one another was more predictive of productive interactions around substance use.

There were several limitations to this study. First, the small sample size warrants caution against over-interpretation of the results of the study. Second, since the topic of substance use was not part of the original CHC study design, a full clinical assessment of patients' substance use history was not conducted. Instead, problematic substance use was determined by self-report in the clinical interactions or the one-on-one interviews. Third, we recruited mainly providers specialising in cardiology. We expect that providers' attitudes towards

patients who use substances would vary by individual, but also by clinical training, as well as by exposure to and experience with patients who use substances (van Boekel 2014, Ding *et al.* 2005). With a larger sample size, future research can investigate questions that this study was not able to address, such as the effectiveness of CHC or its weight relative to the structural barriers of stigma. However, our data provide a close and in-depth view of healthcare interactions as they unfold and the possibility of analysing the interaction through each of the participants' eyes in the form of our one-on-one interviews with them. Therefore, we feel our study supports three implications for understanding the potential effect of stigma on health and health disparities.

First, under the current norms and rules of most healthcare fields, patients were worried about disclosing substance use to their providers due to the stigma and potential penalties involved. This can adversely affect health in two ways. In cases like Mr Bell, his disclosure of substance use was directly linked to his failure to receive many healthcare options. This may in part explain health disparities. On the other hand, when patients withhold information about their substance use due to their realistic concerns about the effects of stigma, this can independently lead to, or exacerbate, health disparities for those with substance use issues. Undisclosed substance use can complicate existing medical issues, treatments or medications, which can pose health risks to the patient. This underscores the clinical importance of reconceptualising how substance use and stigma are addressed in clinical settings.

Second, our study suggests that stigma can result in missed healthcare opportunities. Because patients often hold their provider's opinions in high regard, providers have great potential to help patients address their substance use issues. However, in the interactions we observed, the opportunity was rarely seized, largely due, we argue, to the effect stigma had on interactions. We also showed, however, that there were concrete strategies that providers could use to shift the stigma dynamic and promote CHC: addressing substance use, rather than ignoring it; creating a non-judgmental clinical atmosphere; being open to mutual and realistic goal setting; and learning about the patient's lifestyle and environment to contextualise and understand substance use. We suggest that promoting de-stigmatising interactional factors like these could be the basis of training for providers in addiction medicine. For example, training providers in structural competency, which shifts the medical lens from the individuals to the social structures that construct stigmatised health issues (Metzl and Hansen 2014), may promote mutual understanding and help ease difficult conversations. While stigma is known to create health barriers, relatively minor interactional adjustments may potentially reduce its effects.

Third, stigma is a process that does not occur, and therefore cannot be solved, at the individual level alone. As we have shown, institutional, structural and ideological factors shape the field on which stigma must be negotiated and the potential for CHC to be exchanged in ways that benefit both patient and provider. Thus, addressing stigma requires multiple levels of intervention. On an institutional level, providers must have access to time, resources and training. In particular, time is needed to discuss and contextualise substance use, including the role it plays in patients' lives. The current 15-minute visit norm is inadequate to address the complexities of substance use, in addition to other health issues.

Illicit drug use has increased in the USA (Substance Abuse and Mental Health Services Administration 2010) and the issue of substance use in clinical settings has intensified since the Affordable Care Act has called for substance use (and mental health) to be treated at parity with other health issues (Buck 2011). By providing an in-depth, theoretically informed analysis of the real-life substance use stigma process in clinical settings, we hope to have opened areas of future investigation and intervention.

References

Ahern J, Stuber J, Galea S. Stigma, discrimination and the health of illicit drug users. Drug and Alcohol Dependence. 2007; 88(2):188–96. [PubMed: 17118578]

van Boekel LC, Brouwers EPM, Van Weeghel J, Garretsen HFL. Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: systematic review. Drug and Alcohol Dependence. 2013; 131(1):23–35. [PubMed: 23490450]

van Boekel LC, Brouwers EPM, van Weeghel J, Garretsen HFL. Healthcare professionals' regard towards working with patients with substance use disorders: Comparison of primary care, general psychiatry and specialist addiction services. Drug and Alcohol Dependence. 2014; 134:92–8. [PubMed: 24099970]

Bourdieu, P. The forms of capital. In: Richardson, J., editor. Handbook of Theory and Research for the Sociology of Education. New York: Greenwood Press; 1986.

Bourdieu, P. The Logic of Practice. Redwood City: Stanford University Press; 1990.

Bourdieu, P. The Field of Cultural Production: Essays on Art and Literature. Johnson, R., editor. New York: Columbia University Press; 1993.

Bourdieu, P. Habitus. In: Hillier, J.; Rooksby, E., editors. Habitus: A Sense of Place. Farnham: Ashgate; 2005.

Buck JA. The looming expansion and transformation of public substance abuse treatment under the Affordable Care Act. Health Affairs. 2011; 30(8):1402–10. [PubMed: 21821557]

Campbell, R. Cracked Coverage: Television News, the Anti-Cocaine Crusade, and the Reagan Legacy. Durham: Duke University Press; 1994.

Charmaz, K. Constructing Grounded Theory: A Practical Guide through Qualitative Analysis. Thousand Oaks: Sage; 2006.

Clarke A, Shim J, Mamo L, Fosket JR, et al. Biomedicalization: technoscientific transformations of health, illness, and US biomedicine. American Sociological Review. 2003; 68(2):161–94.

Davis K, Schoenbaum S, Audet A-M. A 2020 vision of patient-centered primary care. Journal of General Internal Medicine. 2005; 20(10):953–7. [PubMed: 16191145]

Ding L, Landon BE, Wilson IB, Wong MD, et al. Predictors and consequences of negative physician attitudes toward HIV-infected injection drug users. Archives of Internal Medicine. 2005; 165(6): 618–23. [PubMed: 15795336]

Dubbin L, Chang J, Shim J. Cultural health capital and the interactional dynamics of patient-centered care. Social Science & Medicine. 2013; 93:113–20. [PubMed: 23906128]

Kondrad E, Reid A. Colorado family physicians' attitudes toward medical marijuana. Journal of the American Board of Family Medicine. 2013; 26(1):52–60. [PubMed: 23288281]

Elwood, WN. Rhetoric in the War on Drugs: The Triumphs and Tragedies of Public Relations. Westport: Greenwood; 1994.

Fiscella K, Epstein RM. So much to do, so little time: care for the socially disadvantaged and the 15-minute visit. Archives of Internal Medicine. 2008; 168(17):1843–52. [PubMed: 18809810]

French M, McGeary KA, Chitwood D, McCoy C. Chronic illicit drug use, health services utilization and the cost of medical care. Social Science & Medicine. 2000; 50(12):1703–13. [PubMed: 10798326]

Friedmann P, McCullough D, Saitz R. Screening and intervention for illicit drug abuse: a national survey of primary care physicians and psychiatrists. Archives of Internal Medicine. 2001; 161(2): 248–51. [PubMed: 11176739]

Goffman, E. Stigma: Notes on the Management of Spoiled Identity. New York: Touchstone; 2009 [1963].

Hahn S, Kroenke K, Spitzer R, Brody D, et al. The difficult patient: prevalence, psychopathology, and functional impairment. Journal of General Internal Medicine. 1996; 11(1):1–8. [PubMed: 8691281]

Kondrad E, Reid A. Colorado family physicians' attitudes toward medical marijuana. Journal of the American Board of Family Medicine. 2013; 26(1):52–60. [PubMed: 23288281]

Kotseva K, Wood D, DeBacker G, DeBacquer D, et al. Cardiovascular prevention guidelines in daily practice: a comparison of EUROASPIRE I, II, and III surveys in eight European countries. The Lancet. 2009; 373(9667):929–40.

Lindberg M, Vergara C, Wild-Wesley R, Gruman C. Physicians-in-training attitudes toward caring for and working with patients with alcohol and drug abuse diagnoses. Southern Medical Journal. 2006; 99(1):28–35. [PubMed: 16466119]

Link B, Phelan J. Conceptualizing stigma. Annual Review of Sociology. 2001; 27:363–85.

Link B, Phelan J. Stigma and its public health consequences. The Lancet. 2006; 367(9509):528–9.

Madras B, Compton W, Avula D, Stegbauer T, et al. Screening, brief interventions, referral to treatment (SBIRT) for illicit drug and alcohol use at multiple healthcare sites: comparison at intake and 6 months later. Drug and Alcohol Dependence. 2009; 99(1):280–95. [PubMed: 18929451]

Merrill JO, Rhodes LA, Deyo RA, Marlatt GA, et al. Mutual mistrust in the medical care of drug users. Journal of General Internal Medicine. 2002; 17(5):327–33. [PubMed: 12047728]

Metzl JM, Hansen H. Structural competency: theorizing a new medical engagement with stigma and inequality. Social Science & Medicine. 2014; 103:126–33. [PubMed: 24507917]

Miller N, Sheppard LM, Colenda CC, Magen J. Why physicians are unprepared to treat patients who have alcohol- and drug-related disorders. Academic Medicine. 2001; 76(5):410–18. [PubMed: 11346513]

Mokdad A, Marks J, Stroup D, Gerberding J. Actual causes of death in the United States, 2000. Journal of the American Medical Association. 2004; 291(10):1238–45. [PubMed: 15010446]

Paterson B, Hirsch G, Andres K. Structural factors that promote stigmatization of drug users with hepatitis C in hospital emergency departments. International Journal of Drug Policy. 2013; 24(5): 471–8. [PubMed: 23453299]

Saitz R, Mulvey K, Plough A, Samet J. Physician unawareness of serious substance abuse. American Journal of Drug and Alcohol Abuse. 1997; 23(3):343–54. [PubMed: 9261484]

SAMHSA. Results from the 2011 National Survey on Drug Use and Health: Summary of National Findings. Rockville: Substance Abuse and Mental Health Services Administration; 2012. NSDUH Series H-44, HHS Publication No. SMA 12–4713

Shim J. Cultural health capital: a theoretical approach to understanding health care interactions and the dynamics of unequal treatment. Journal of Health and Social Behavior. 2010; 51(1):1–15. [PubMed: 20420291]

Single E, Robson L, Rehm J, Xi X. Morbidity and mortality attributable to alcohol, tobacco, and illicit drug use in Canada. American Journal of Public Health. 1999; 89(3):385–390. [PubMed: 10076491]

Substance Abuse and Mental Health Services Administration (SAMHSA). The DAWN Report: Highlights of the 2009 Drug Abuse Warning Network (DAWN). Findings on Drug-Related Emergency Department Visits. Rockville: Center for Behavioral Health Statistics and Quality; 2010.

Swidler A. Culture in action: symbols and strategies. American Sociological Review. 1986; 51(2):273–86.

Turner BJ, McLellan AT. Methodological challenges and limitations of research on alcohol consumption and effect on common clinical conditions: evidence from six systematic reviews. Journal of General Internal Medicine. 2009; 24(10):1156–60. [PubMed: 19672662]

Van Ryn M, Burke J. The effect of patient race and socio-economic status on physicians' perceptions of patients. Social Science & Medicine. 2000; 50(6):813–28. [PubMed: 10695979]

Volkow N, Li TK. Drugs and alcohol: treating and preventing abuse, addiction and their medical consequences. Pharmacology and Therapeutics. 2005; 108(1):3–17. [PubMed: 16098597]