Acknowledging stigma

We commend Dr Dubin and colleagues[1] for bringing attention to stigma as a barrier to patient care and for discussing some of the drivers of stigma within the Canadian health care system. It is widely acknowledged that the stigmatization process is complex, and considerable efforts have been expended to understand the different forms of stigma that exist and different factors that contribute to stigmatization.[2] As in Dubin and colleagues' commentary, stigma is often discussed in terms of overt acts of stereotyping or discrimination (enacted stigma); however, it is important to note that stigma can be experienced in a number of different, and often interrelated, ways. For instance, simply the awareness of negative societal attitudes or anticipating being stigmatized by service providers (perceived stigma) can act as a barrier to accessing care.[3] Stigma can also be internalized, such that individuals with a stigmatized condition accept negative views, beliefs, and feelings toward themselves based on the stigmatized groups they belong to, which has implications for seeking and adhering to treatment.[4,5] Furthermore, stigma can be enacted at the organizational level: structural stigma occurs through the implementation of stigmatizing policies and procedures, which can prevent individuals from accessing or engaging in health care.[6] Addressing stigma in health care means understanding and combating stigma at each of these levels, as well as accounting for the ways in which stigma intersects with other forms of social inequities (eg, racism, classism, heteronormativity) to exacerbate the barriers experienced by individuals.

A key group of patients who are often subjected to stigma in the health care system and who were not specifically mentioned in the article are people living with or vulnerable to sexually transmitted and blood-borne infections (STBBIs). Throughout the past 3 years, the Canadian Public Health Association (CPHA), in partnership with various experts and organizations, has developed numerous resources to help service providers build their capacity to reduce STBBI-related stigma in their practices and organizations. While these tools were specifically developed to address stigma related to STBBIs, sexual health, and substance use, the framework of stigma used within CPHA's materials and the relational approaches advocated for can be used as a starting point for addressing stigma related to other conditions (eg, mental health, obesity, lung conditions). These stigma-reduction resources are available for free on the CPHA's website, and include a discussion guide for service providers to enable safer, more inclusive, and more respectful dialogue with patients; guidelines on reducing stigma through protection of patient privacy and confidentiality; materials for 3 workshops focused on the effects and causes of stigma in health and social service settings, and strategies that can be used at the provider and organizational level to reduce stigma; a self-assessment tool for practitioners to reflect on their attitudes and values in relation to sexual health, substance use, and STBBIs; and an organizational assessment tool to identify ways in which organizations can reduce stigma experienced by their patients or clients.[7]

As stated by Dubin and colleagues,

> Encouraging greater compassion and nonjudgmental acceptance of our patients as individuals who live with chronic illnesses and need

our help will move us toward less stigmatization within both clinical and educational settings.[1]

This requires unlearning of many of the negative attitudes, values, and beliefs that are prevalent in society and developing an appreciation for the social determinants of health that affect vulnerability to stigmatized conditions—something the CPHA hopes to support through its ongoing efforts to reduce STBBI stigma. The article spoke to the importance of addressing stigma in both the formal and the hidden curriculum of medical education, owing to the sometimes apparent disconnect between formal instructional values and the behaviour modeled by instructors. The CPHA aims to provide opportunities for transformational learning, encouraging health care providers both to reflect on their personal attitudes, values, and practices, and to identify opportunities to reduce stigma through their organization's policies and procedures. Evaluation results of the CPHA's professional development initiatives show increased awareness of attitudes, values, and behaviour that perpetuate stigma and also increased knowledge of ways to decrease stigma among participants. Training for health professionals, including students preparing to enter the field, is a promising step toward improving patients' experiences and, ultimately, their health.

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Competing interests
None declared

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Correction

In the article "Diagnosis and treatment of pruritus," which appeared in the December issue of *Canadian Family Physician*,[1] there was an error in the byline. It should have read as follows:

Dominik A. Nowak MD Jensen Yeung MD FRCPC

Canadian Family Physician apologizes for this error and any confusion it might have caused.

Reference

1. Nowak D, Yeung J. Diagnosis and treatment of pruritus. *Can Fam Physician* 2017;63:918-24 (Eng), 925-31 (Fr).

Correction

Une erreur s'est glissée dans l'article intitulé « Diagnostique et traitement du prurit » publié dans le numéro de décembre du *Médecin de famille canadien*[1]. Les noms auraient dû se lire comme suit :

Dominik A. Nowak MD Jensen Yeung MD FRCPC

Le Médecin de famille canadien présente ses excuses pour cette erreur et toute confusion qu'elle aurait pu causer.

Référence

1. Nowak D, Yeung J. Diagnostique et traitement du prurit. *Can Fam Physician* 2017;63:918-24 (ang), 925-31 (fr).

Correction

In the article "Associations between sensory loss and social networks, participation, support, and loneliness. Analysis of the Canadian Longitudinal Study on Aging"[1] published in the January issue of *Canadian Family Physician*, an author was inadvertently omitted. The byline, biography, and contribution statement should have appeared as follows:

Paul Mick MD MPH Maksim Parfyonov MD Walter Wittich PhD
Natalie Phillips PhD Dawn Guthrie PhD
M. Kathleen Pichora-Fuller MSc PhD

Dr Guthrie is Professor in the Department of Kinesiology and Physical Education and the Department of Health Sciences at Wilfrid Laurier University in Waterloo, Ont.

Dr Guthrie interpreted the results and edited the manuscript.

Canadian Family Physician apologizes for this error and any confusion it might have caused.

Reference

1. Mick P, Parfyonov M, Wittich W, Phillips N, Pichora-Fuller MK. Associations between sensory loss and social networks, participation, support, and loneliness. Analysis of the Canadian Longitudinal Study on Aging. *Can Fam Physician* 2018;64:e33-41. Available from: **www.cfp.ca/content/64/1/e33**. Accessed 2018 Jan 23.

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