Acknowledging stigma

Its presence in patient care and medical education

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Elaine is a 48-year-old woman with chronic pain due to fibromyalgia and postsurgical pain, and she has been prescribed opioids for this pain for a number of years. Elaine works full-time and has followed all the recommendations made by her family physician. She exercises regularly and has participated in the Chronic Pain Self-Management Program. She has been honest with her family doctor that she uses small amounts of cannabis to help her sleep, but has exhibited no concerning behaviour. However, she missed her last appointment with her doctor as a result of the sudden unexpected death of her mother, and has now run out of her medication. She presents to the emergency department asking for a refill and is scolded by the emergency physician, who gives her a few days' supply of medications and tells her to see her own physician.

On her way out of the emergency department, Elaine overhears another staff member saying to the physician, "Another drug-seeking addict clogging up the system." When Elaine sees her family physician, she expresses how shamed she felt by this encounter.

Family physicians are generalists who care for all manner of patients with complex illnesses and life stories. Elaine is one of the more than 20% of Canadians who live with chronic illness—in this case pain, a condition which, without amputation, scars, deformities, or objective evidence seen on imaging, remains mostly invisible. Chronic pain frustrates mind-body dualism and is quintessentially subjective in nature.[1] Imaging rarely correlates with patients' physical complaints of widespread pain or altered sensations of burning or stabbing. Patients with chronic pain also experience emotional challenges: half are depressed, and one-third have suicidal thoughts.[2-4]

Patients like Elaine who live with pain have described being treated as if they are addicted to pain medication or are morally weak. Some family physicians even exclude patients with chronic pain from their practices or refuse to continue opioid prescriptions in inherited patients. An updated Canadian opioid guideline recommends lowering the watchful dose of opioids,[5] which might cause prescribers to rapidly reduce or discontinue these medications without taking into account the risks and benefits for the patient. Misplaced trust can lead to harm and undermine the doctor-patient relationship, or even lead to providers feeling "burned" by "cunning" patients.[6-8]

People living with chronic pain are not alone in being stigmatized in health care settings; patients with various medical conditions or with mental illness, those who are incarcerated or who use substances, refugees or immigrants, and even patients with poorly controlled diabetes can all be subjected to stigma.

It is common for people with certain medical conditions, personalities, behaviour patterns, or socioeconomic status to feel stigmatized by the health care system. The *Oxford* dictionary defines *stigma* as follows: "A mark branded on a slave, criminal etc, or an imputation attaching to a person's reputation; stain on one's good name."[9] Nielsen describes stigma as a socially discredited attribute that causes rejection or discrimination, and outlines stigma's elements as "labelling, stereotyping, separating, status loss, and discrimination."[10]

This article aims to discuss stigmatization's "hidden" yet ubiquitous role in the health care system and how it acts as a barrier to high-quality patient care and as a potential cause of health inequities.[11] We will also explore how stigma is addressed in the health care curriculum and the need for education to help overcome the natural human propensity to reject and marginalize that which might be threatening, poorly understood, or at odds with one's own beliefs.[1]

Stigma in patient care

Patients with lung conditions that are linked to smoking are a key group of patients subjected to stigma. People with chronic obstructive pulmonary disease (COPD) might be recognizable by their visible bodily changes (sometimes described colloquially in medical rounds as "pink puffers" or "blue bloaters"), as well as their use of inhalers or portable oxygen. Because smoking is a leading cause of many lung conditions, the patient might be held accountable and the disease might be perceived as the patient's fault. A study of patients with COPD revealed a feeling of being exiled from the world of the healthy owing to self-blame and society's stigmatization of COPD as a self-inflicted disease.[12]

Stigmatization might reduce patients' self-esteem and their social supports, leading to isolation. Affected individuals might feel guilty and avoid seeking health care services. Even when doing so, their care might be affected by the stigmatizing behaviour of health care

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professionals. Our failure to provide nicotine replacement therapy during a hospitalization for COPD is one poignant manifestation of stigma in action. Patients' socioeconomic status can also lead to stigmatization in the health care system. There is a relationship between disease severity and lower levels of household income.[13] Patients with limited financial resources have more hospitalizations and exacerbations.[14] Most patients with COPD are elderly,[15] which adds the additional stigma of ageism. This adds a layer of complexity for the health care provider who needs to be aware of how these layers of stigma can affect both care and the patient experience.

Patients with lung cancer might feel blamed by both members of the public and the health care team because they were smokers and "should have known better."[16] Financial support of lung cancer research has been limited owing to the disease's connections with cigarette smoking.[17] Some patients have described that they were reluctant to apply for financial assistance owing to the guilt they felt. Men especially have reported feeling devalued as not being the strong male stereotype when they admit illness.[17] With chemotherapy and its visible sequelae of baldness and weight loss, both men and women report feeling poorly about themselves owing to these physical changes.[18]

Stigma in medical education

So where do physicians (and other health care providers) acquire stigmatizing behaviour? Learners experience the curriculum both explicitly and implicitly. The formal curriculum is explicit while the implicit curriculum is often referred to as the *hidden curriculum*. As described by Hafferty and Franks, the hidden curriculum is "more concerned with replicating the culture of medicine than with the teaching of knowledge and techniques."[19] While the formal curriculum is designed to avoid bias and stigma, the hidden curriculum might reflect content opposite to the formal curriculum.

Learners still see stigmatization in attitudes toward patients from physicians and other providers. Canadian medical students have recognized negative Canadian Aboriginal stereotypes present in medical schools.[20] Other groups are subject to stigma at the learner level. Only 26% of surveyed medical students indicated that they could have a fulfilling life with a severe cognitive disability.[21] Similarly negative stereotyping has been reported for patients who are obese,[22] have mental illness,[23,24] are elderly,[25] and use substances.[26] Learners report that articulated institutional values are different from what is role modeled, and that patient characteristics such as obesity, substance abuse, mental illness, and poverty are perceived by medical teachers as the result of personal choice rather than other more crucial contributing and causative factors.[27]

Efforts to address stigma as perceived and experienced by medical students have varied from training exposures of varying lengths[23,24,26] to single events conducted outside of the clinical setting.[22] While it is admirable and necessary to address stigma in the formal curriculum, the effect of the hidden curriculum needs specific consideration. Our learners can see the disconnect between articulated institutional values in the formal curriculum and role modeling as an expression of the hidden curriculum. Without confronting these hidden biases, stigma will be perpetuated into the next generation of physicians.

In addressing stigma, we must target both the formal and informal curricula during the entire learning continuum from undergraduate medical education to continuing professional development. While the formal curriculum is largely organized to mitigate stigma with teaching sessions to decrease stigma, faculty development sessions will be required to raise the awareness of the hidden curriculum and its deleterious effect on student learning. Practising physicians should be acutely aware to minimize stigma both from the perspective of teaching medical learners and in their everyday practices.

Conclusion

The process of stigmatization usually begins with the diagnosis of an illness, but a patient's circumstance is also a highly influential contributing factor. We need diagnoses to create a treatment plan and to facilitate accurate communication within the health care system. However, labels often lead to negative stereotypes such as beliefs that the illness is the patient's fault or that the illness might be infectious or otherwise dangerous. Stigma can also lead to discrimination that can result in a patient experiencing loss of status, rejection, exclusion, and avoidance of social interaction, as well as others exhibiting hostile behaviour toward them and withholding help.[28] Stigmatized illnesses might make a patient reluctant to both seek care and continue treatment.[28] Stigmatized conditions can be more debilitating and more difficult to overcome than the chronic illness itself.[29]

As family physicians we are well aware of patients like Elaine because we care for many people with similarly challenging circumstances. Solutions to combat stigma within the health system are multifactorial and beyond the scope of this short commentary. However, our awareness of stigma's presence within both patient care and medical education is important. The medical profession needs to reflect honestly on how we can minimize stigma in patient care and medical education. 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. This behavioural and cultural change will undoubtedly have a positive effect on patient and provider satisfaction and might even lead to considerable improvement in health outcomes.

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