Session 1: Language Matters – How to Communicate in Non-Judgmental Way

How Do You Ensure Communications with Your Clients Are Stigma-Free?

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How do you ensure communications with your clients are stigma-free? - Healthcare providers' Perspective

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DOI: None

“…how DO I ensure my communications are stigma-free?”

Is it even possible?

When did I last propagate stigma? When did you?

Discussion points

- A (very) brief overview of stigma theory
- Case example – healthcare-enacted stigma
- How we can overcome the burden of stigma-associated morbidities

What is stigma?

“An attribute that is deeply discrediting” (*Goffman, 1963)*

- Concealed/concealable or unconcealable

Occurs at all levels of society: macro/ global, regional, community, interpersonal, intrapersonal *ie affecting self-perception and self esteem*

Link & Phelan, 2001

Case study - Sally

- 11pm Sunday on-call – phone call from Emergency dept nurse practitioner
- “Hi Jo, glad you’re still here. Can you come and see this patient and send her home? She’s… *one of yours…*”

Details altered to protect patient confidentiality

Case study - Sally

- 34F, African descent, been in UK >20 years
- Perinatally acquired HIV
- Very inconsistent clinic engagement and ARV adherence
- Emergency dept 

- Last VL 180000, CD4 148 (14.4%)

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Case study - Sally

- Heavy burden of multimorbidity
- Previous PCP, prev infective endocarditis
- Episodes of drug-related psychosis and non-epileptic functional seizures
- Weight gain +++ on antipsychotics
- Frequent ED presentations for abdo pain and vomiting -> sometimes pancreatitis flare, sometimes NAD

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Case study - Sally

- Polydrug use inc. heavy cannabis, alcohol, opiates, occasional IVU
- Occasional sex work to pay for above
- Very unstable social background – ex partner is in a gang, history of intimate partner violence
- Only living family in the UK is younger brother, also perinatally acquired HIV, with chaotic social situation and poor physical and mental health

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So where does the stigma come in?

"Drug seeking"

"Frequent flyer"

"Personality disorder"

"*Functional* seizures"

"Difficult patient"

"My department is too busy for timewasters like this"

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So where does the stigma come in?

Compounded by:

- She’s black
- She’s a black woman
- She’s a fat black woman
- She’s a fat black woman, living in poverty, with poor educational attainment
- Judgemental societal concepts about PLWH
- Concepts around opiate IVUs, around sex workers, around mental illness, around obesity

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So what did I do?

"Thank f**k you're here Doctor Jo, these nurses are being f**king b*tches to me innit"

After checking she was safe enough to leave health-wise and had somewhere to go for the night –

Small pack of Ensure build-up juice *(she may be overweight but she still has significant food insecurity)*

Box of co-trimoxazole

Appointment with me in the Rapid Review Day Unit the following day for bloods review and chat about restarting her ARVs

(which she didn't turn up to, but I chased her and eventually got her in the following week)

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What's the moral of Sally's story?

- We have all been raised in a society that has cultural ideas about stigma attached to certain attributes
- These often fall along lines of social indices of deprivation – racialisation, poverty, chronic disease etc
- Healthcare settings are a **significant source of stigma** for marginalised patients – high risk of precipitating disengagement
- We in the HIV world are not immune!

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What can we do?

- Collaborative working and education for other specialties and teams
- **Trauma-informed,** practical, **harm reduction** approach
- We are here to help the whole patient, not just control the viraemia
- By being a little less “serious doctor”-y, we can reduce the paternalistic clinician-patient power differential

Thank you!