



## Commentary on "Stigma"

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The commentary is in response to the reflective student narrative "Stigma" which is accessible at <http://rhime.in/ojs>

The student narrative, Stigma, is about revulsion and the fear of contracting disease experienced by a young medical student – the experience is one that every doctor is familiar with. These are feelings that will run through all medical students, to a lesser or greater degree, when they enter the wards in clinical years. I say this in response to the author of the narrative who expresses guilt and shame about his reaction – revulsion and fear are far more common than realized; I would, in fact, commend the courageous sharing of this event that allows for self-learning, as well as enhances learning in peers and other health professionals.

Before we join medicine we have a sanitized vision of ourselves as doctors; a gloved and gowned surgeon, or a consultant behind a desk, reviewing test results on a monitor. Anatomy is the first stomach-heaving experience that upturns

our view of medicine, and the next is the blood and gore of clinical years. The first open surgery, the first delivery, septic dressings, the maggot filled gangrenous foot, the dying child, the screams of burn victims; these can be life-changing experiences, and are not for the faint-hearted, no matter how well one is prepared for them.

There are two terms that I would like to expand on here because understanding them might help students and practitioners of medicine find a way to navigate the slippery slope of stigma. These terms are 'getting comfortable with' and 'being sensible about'.

There are many things about clinical practice that we have to get comfortable with: these are things that cannot be avoided, and things that are unjust. Gloves and masks need to be used in

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operation theatres, and in certain wards and emergency rooms. We must get comfortable with their use since they are primarily to protect the patient - the hospital environment is bound to have air and surface contamination with bacteria, viruses and fungi, despite protocols to control contamination and cross infection. But we do not wear gloves and masks all the time, especially since the human touch, for diagnosis or consolation, and facial expressions, are vital tools of medical care. We may have patients coughing in our faces, and we often confront their vomit, blood, pus, and odours, as well as the ugliness of disease and that of physical decay, yet we have to think and act logically even as others are fainting and recoiling all around us. These are the realities of our medical arena and we have to get comfortable with them.

How do we do that?

One way would be orientation of students before they enter the wards, before clinical years. This should preferably be done by a senior (experienced) faculty member – and could include a gentle reminder of what medical practice means, of how disease presents itself, and of the human being inside the patient. A good way is to ask students to imagine that it is their mother, or sister or child that is being examined or treated. This mind game also helps with developing respect for each person, regardless of their class, appearance or condition. Students can be reassured that the right attitude is the outcome of conscious practice, and that it can be achieved; teachers should constantly model the right attitude.

We must also get comfortable with injustices that may exist, especially in a country like ours. Patients in teaching hospitals have to endure multiple examinations because their choices are

limited. And while we feel sorry, we train to be doctors thanks to this unfair situation. We must humbly thank them. Patients may come with advanced disease only because they could not afford treatment. I am glad this student realised first hand that disease disables people - financially, emotionally, and physically - but it shouldn't affect their right to justice and equality. We are not aware of the reason why this man had multidrug resistant tuberculosis. Did he not have access to medicines, or was he denied access due to his circumstances? Getting comfortable with injustice does not mean that we do not advocate for change, or try in our own small ways to reduce disparities; but that is another discussion.

Most students are advised to be 'sensible' about infections during laboratory and clinical work. Wearing a mask in the ENT clinics, in chest clinics, and in infectious disease wards is easy to understand and be sensible about. But patients in other wards too may have infectious diseases, even though they are admitted for other reasons. Should we wear masks all the time when we know that facial expression is important in communication? What would be sensible is to consciously and universally adopt standard precautions like regular hand washing and the use of hand sanitizers, changing white coats (aprons) every day, eating regular, healthy meals, and sleeping well. Additionally, we must stop placing books and bags on ward beds and examination tables.

Another way of being sensible is to be informed. Residents and consultants can prevent unnecessary exposure of students to sick patients. In this narrative, surely the resident need not have exposed the student, especially as the latter already made a specific query about infection. Despite our busy schedules as doctors and

nurses, we have a duty to colleagues and other patients who can unnecessarily be exposed to harm by our thoughtlessness. Patients with multidrug resistant tuberculosis have symptoms and signs that can be elicited in other people with tuberculosis, so this case need not have been selected. For humane reasons, and in the best interest of both the patient and the students, highly infective, or extremely sick patients are best excluded for groups of students to examine. They should, instead, be discussed as case studies in the classroom.

Although it is encountered everywhere in society, stigma is a problem that is observed most painfully in medicine. We notice it right from childhood; the fat child, the slow learner, the 'mad' neighbor, the dirty street-kid, the ugly cousin. In later years we hear about gender identity issues, sex workers, drug addicts and alcoholics. Any of these persons can be our patient, and we must not add to their pain by expressing personal bias against their habits, their disease (leprosy, tuberculosis, HIV infection), or their way of life. A

professional approach requires that we consciously change such attitudes when dealing with our patients. Just as we train ourselves not to recoil, grimace or react to a smelling, open sore, or an amputated foot, we have to discipline our minds against prejudice. Patients have a right to be treated equally and justly. Patients are very sensitive to a doctor's response – to the slightest flinch or change of tone - and those who are struggling with stigma will be most grateful to you for treating them normally. A doctor's role is to be compassionate, and to care for every patient without discrimination, without judging her circumstances. This comes with practice, and can be mastered.

I wish to compliment the student for a well written narrative. As a form of writing, reflective narratives allow students to deal with emotional experiences during training, and provide an opportunity to move beyond disturbing incidents while learning from them. The emotional growth that ensues is important in the formation of an empathic and ethical doctor.