

Virtual Mentor

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HIV/AIDS Stigma: Historical Perspectives on Sexually Transmitted Diseases

by Laura J. McGough, PhD

In 1728, the impoverished Flora Price applied to her local parish churchwardens in London for assistance. Charitable support was provided at local parishes to carefully screened applicants. During her interview, she admitted that she suffered from the “pox,” the common term for sexually transmitted diseases before physicians clinically distinguished between syphilis and gonorrhea. Instead of entering a hospital, she was sent to a workhouse, an institution created to correct “idleness,” which at the time was widely regarded as the root cause of poverty. At the workhouse, she received mercury treatments for her illness. Her male contemporaries, however, were far more likely than indigent females to be admitted to hospitals, which provided bed rest in addition to mercury treatment. Female patients suffering from this “foul disease” did not win the sympathy of churchwardens as easily as male patients did. All poor patients, male and female, had to suffer the indignity of publicly admitting their diagnosis. Meanwhile, wealthy patients could afford private, confidential treatment with minimal, if any, loss to their reputations [1].

Stigma and Health Care Systems

Historical cases about the “pox,” such as the above example, provide useful insights about how stigma is perpetuated for present-day clinicians who treat acquired immune deficiency syndrome (AIDS) patients. The pox was regarded as a curable disease after the mid-16th century [2]. Stigma nonetheless persisted and was reinforced in a variety of ways. As the case of Flora Price shows, the health care and social services systems themselves can contribute to stigma by offering different levels of care with varying standards of privacy, confidentiality, and comfort to patients. Since the wealthy can more successfully shield their disease while the poor rely on public resources, the association between disease and poverty becomes more closely linked. It is, in fact, a vicious, self-reinforcing circle, since poverty can also make people more vulnerable to disease. Stigma is embedded in these wider social processes of power and domination, inequality, and poverty [3].

The Problem of Treatment Failure

During the 17th century, physicians inadvertently perpetuated stigma by explaining cases of treatment failure as the result of the moral failings of the patient rather than of the limitations of the therapy [4]. Unfortunately, stigma thereby inadvertently impeded medical progress. Because they held patients responsible for treatment failure, physicians and the wider public had no reason to question the efficacy of available treatments. On the contrary, the 17th and 18th centuries were a lucrative

period for pharmacists and vendors of cures for the "pox" [1]. It was believed that medical therapies had only limited success in some categories of patients, such as prostitutes.

This historical case is also a reminder for physicians of today to be careful about how treatment failure for HIV/AIDS patients receiving antiretroviral therapy is explained to the wider public. Given the crucial importance of patient adherence to treatment for the success of highly active antiretroviral therapy (HAART), it is potentially tempting to explain treatment failure as the result of patients' irresponsibility, forgetfulness, or inability to lead a disciplined life. Aside from cost, 1 of the reasons cited by Andrew Natsios, the head of the United States Agency for International Development, for not providing HAART to Africans in 2001 was their alleged inability to understand and follow the treatment regimen [5]. After protests from AIDS activists in reaction to Natsios' comments, the Bush administration later reversed its stand and initiated its own treatment program focusing on 12 African (and 3 non-African) countries. The potential for discrimination still exists, however. Some physicians regard the poor as less capable of adhering to medication, although studies have shown that physicians are not successful at guessing which of their patients will comply with therapy [6]. When access to life-saving therapy depends on physicians' or public health officials' perceptions about whether an individual patient can successfully adhere to therapy, it becomes a crucially important ethical issue to separate assumptions about patients based on often clinically irrelevant issues from demonstrated evidence of patients' ability to adhere to treatment [7].

Stigma and Society

Stigma also persists and is reinforced through the wider society because it is linked to perceptions of a particular group's weaknesses and vulnerabilities. Disease is both a painful reality and a potent metaphor, widely used by writers, artists, and the everyday public [8]. In 15th- and 16th-century Venice, for example, the sexually transmitted disease that appeared in epidemic form was called the "French disease," named after the French army that had invaded and, to Italian observers, unleashed this new malady. Reactions to the disease were complicated by the subsequent loss of military and political power in the wake of this invasion. The disease itself became a symbol of military vulnerability, thereby increasing the stigma associated with it [9]. Reactions to HIV/AIDS are also complicated by a wider set of political and cultural associations: initially, with homosexuality and Haiti, then with Africa. Each of these associations brought significant cultural baggage, including the legacy of racism and colonialism [10]. As individuals, physicians can do little to change the wider context of stigma or the symbolic associations between diseases and colonized or persecuted peoples. Nonetheless, it is important for physicians to be aware of the wider context of HIV/AIDS stigma and to understand that stigma falls more heavily on some patients than others.

Conclusion

HIV/AIDS stigma is not easily "cured" through the introduction of effective therapies. In fact, stigma can be reinforced by the health care system itself when substantial inequalities exist in access to and quality of care. Treatment failure can

provide another means of reintroducing stigma by blaming patients who either fail to benefit from treatment or experience difficulty in following the treatment regimen. Finally, physicians should be aware that stigma is perpetuated by wider cultural associations between disease and social, political, or moral disorder, thereby presenting the patient with a heavy psychosocial burden in addition to the physical burdens of disease.

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Laura J. McGough, PhD, is a Johns Hopkins Fellow in infectious diseases and medical history at Johns Hopkins University School of Medicine, Baltimore, MD.

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