Stigma in Clinical Oncology

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BACKGROUND: Health-related stigma, including cancer-related stigma, can lead to discrimination that contributes to health inequities and poor health-related outcomes.

OBJECTIVES: This article provides a scholarly foundation to acknowledge and address health-related stigma in clinical oncology care.

METHODS: This comprehensive clinical literature review is based on peer-reviewed articles identified through targeted searches in CINAHL®, PubMed®, and Google Scholar™ databases.

FINDINGS: This review provides an updated scholarly foundation about stigma in clinical oncology practice. The review highlights stigma in clinical oncology research, identifies a framework for examining multilevel health-related stigma and discrimination, examines stigma measurement instruments, and reviews stigma reduction interventions.

KEYWORDS
stigma; discrimination; cancer; literature review; person-centered care

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STIGMA IS A POWERFUL, MULTIFACETED SOCIAL PHENOMENON. Health-related stigma can be associated with specific medical conditions, behaviors, and characteristics considered undesirable, such as HIV, substance use, obesity, and mental illness, which are then linked to negative stereotypes (Akin-Odanye & Husman, 2021; Phelan et al., 2023). Stereotyping and labeling can lead to systemic discrimination and inequity for individuals affected by health factors, contributing to adverse events and, ultimately, poor outcomes (Phelan et al., 2023). Across the patient's cancer continuum, cancer-related stigma can be a significant barrier to seeking and receiving clinical care. People experiencing or anticipating cancer-related stigma are more likely to hide their diagnosis and delay care in anticipation of negative judgments about their physical appearance, poor prognosis, or blame for their disease (Akin-Odanye & Husman, 2021). Stigma may facilitate distress and isolation, and may adversely affect cancer treatment, mental health, and social functioning (Huang et al., 2021).

Background

Sociologist Erving Goffman (1963) first described stigma as an attribute that profoundly discredits an individual or a group from being whole, causing them to be viewed as less desirable, harmful, or weak. This perception leads individuals who are stigmatized to feel as though they are flawed or handicapped, and that they have failed and are considered different from others (Goffman, 1963). Stigmatization occurs on a spectrum, going beyond characteristics and emphasizing the relationship between normal and contaminated identities. Goffman (1963) described three types of stigmas that are aimed toward an individual's (a) physical body, (b) character, or (c) tribe (referring to race, nation, or religion).

Goffman's (1963) work inspired additional research, improvements, and applications in countless situations. MacDonald (2003) used Goffman's (1963) stigma framework to conceptualize the "difficult" patient through a critical review of nursing research. Labeling a patient as difficult is really about the social interaction (i.e., relationship) between nurses and patients. Of note, no nursing theory has supported these conceptualizations. The article concluded with implications for nursing research, such as considering qualitative methods to better understand attitudes and perspectives (MacDonald, 2003). In clinical practice, nurses could consider alternative explanations for behavior.

Shortcomings in Goffman's (1963) conveyance of stigma, primarily related to variability and vagueness, led to the reconceptualization of stigma. *Conceptualizing Stigma* (Link & Phelan, 2001) expanded the definition from a different individual factor to the convergence of multiple interrelated differences, including cultural beliefs that link the differences to undesirable characteristics and stereotype formation (Link & Phelan,