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Andrea Miranda-Mendizábal, MD, MPH, Health Services Research Group, Institut Hospital del Mar d'Investigacions Mèdiques (IMIM), Barcelona, and Department of Health and Experimental Sciences, Pompeu Fabra University (UPF), Barcelona, Spain; **Jordi Alonso**, MD, PhD, Health Services Research Group, Institut Hospital del Mar d'Investigacions Mèdiques (IMIM), Barcelona, Department of Health and Experimental Sciences, Pompeu Fabra University (UPF), Barcelona, and Centro de Investigación Biomédica en Red de Epidemiología y Salud Pública (CIBERESP), Barcelona, Spain. Email: Jalonso@IMIM.ES

doi: 10.1192/bjp.211.6.399a

The medical profession and stigma against people who use drugs

Corrigan *et al*[1] argue that stigma against people who use drugs is 'in some ways socially, politically, and/or legally sanctioned' and discuss this with reference to the criminal justice system, the workplace and health promotion strategies. How the medical profession, medical diagnosis, medical language and medical models of addiction might be propagating stigma is not discussed and we offer some examples.

First, terms widely used by the medical profession to describe people who use drugs are apparently neutral and objective, but in fact convey negative attributes. For instance, 'drug abuse' can be taken to imply that people who use drugs do so to deliberately inflict harm upon themselves. The use of this term also implies that there is a universally recognised standard for the 'proper use' of a given substance, when there is not.

Second, medical diagnosis is normative. The ICD-10 and DSM-5 define addiction by identifying normative standards of behaviour that people with drug dependency fail to achieve. For instance, one DSM criterion identifies drug use 'resulting in failure to fulfil major role obligations at work, school, or home'. As Matthews *et al*[2] put it: 'to be diagnosed with addiction under these systems [. . .] is to be classified as morally compromised or deficient'.

Third, medical models of understanding cast people who use and/or are dependent on drugs in a negative light. The cause of dependent drug use is contentious. Is it the result of moral choice, a disease, or normal brain changes that result from habit acquisition? The 'moral model' of drug use holds drug use as a choice, and has a critical stance against this choice, legitimising stigma. The 'disease model' sees dependent drug use as a result of neurobiology. This model underpins the medical approach to dependent drug use, where a diagnosis, based on symptoms and history, leads to prescribed treatment. Although this approach absolves responsibility, and therefore the potential for stigma via blame, it nevertheless influences stigma by casting dependent drug users as helpless victims.[3]

Fourth, healthcare professionals are unsympathetic to people who use drugs. There is evidence that negative attitudes of healthcare professionals towards patients who use drugs are widespread.[4] This may affect drug users' self-stigma. Gilchrist *et al*[5] found that healthcare professionals appear to attach lower standing to working with people who use drugs than to work other patient groups. Since healthcare professionals are influential, these negative attitudes may engender stigma elsewhere.

Fifth, there is the matter of doctors and drug policy reform. As Corrigan *et al* point out, criminalisation fuels stigmatisation. Criminalisation is also responsible for many of the harms associated with drug use, for instance violence associated with the black market in drugs, and adulterated supply. Doctors are in a position to influence drug policy away from blanket criminalisation towards a more nuanced approach which more closely correlates to the potential for harm. Some organisations representing doctors have called for changes but 'such calls are far from universal – and far from loud enough'.[6]

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Stephen K. Ginn, Psychiatrist, Camden and Islington NHS Foundation Trust, London. **Edward Clark**, London, UK. Email: stephen.ginn@candi.nhs.uk

doi: 10.1192/bjp.211.6.400

Authors' reply: In response to our editorial in the *BJPsych*,[1] Ginn & Clark note that medical professionals add to the stigma of substance use disorders. Sadly, their insights parallel the larger research on the stigma of mental illness and psychiatry: namely, psychiatric service providers tend to be among the most stigmatising of professions. This can be surprising because most providers would seem to pursue advanced degrees for reasons of altruism: to help people with behavioural health challenges. Research suggests, however, that patients and their families often describe mental health professionals as the source of stigma, with specific providers frequently focusing on the disease and ignoring the person.[3] As many as half of providers fail to endorse recovery as an outcome for serious mental illness. Psychiatrists, in particular, are often found to be more pessimistic about mental illness compared with other provider groups. Mental healthcare providers endorse stereotypes about mental illness, including perceptions of dangerousness, unpredictability and blame. Stigma undermines the provision of care.[3] Studies have shown that up to half of participating psychiatrists did not share a diagnosis of schizophrenia with the patient unless specifically asked or failed to engage patients in such real-life matters as finance, accommodation and leisure.

Unfortunately, the stigma shown by mental healthcare providers extends to healthcare providers in general, perhaps in even more sobering ways. Studies comparing patients with and without identified mental illness have shown that healthcare providers are less likely to refer patients with mental illness for mammography, hospital admission after diabetic crisis, or cardiac catheterisation.[2] To make sense of the direct relationship between stigma and healthcare decisions, one study examined views of primary care and psychiatric physicians and nurses towards people with mental illness.[4] Results showed that providers who endorsed stigmatising ideas about a patient with mental illness presenting for arthritic pain were less likely to refer the person for a consultation and less likely to refill their analgesic prescription. This relationship was

https://doi.org/10.1192/bjp.211.6.400a Published online by Cambridge University Press

demonstrated equally across primary care and mental healthcare providers. People with mental illness cannot obtain services when providers fail to offer them or do so contrary to practice standards.

Things seem to be getting better, with newly trained providers endorsing stigma less than more senior professionals. In part, this reflects the growing awareness that people with mental illness (and substance use disorders) recover and therefore should be hopeful about life goals. This corresponds to the degree to which people with mental illness and substance use disorders are provider platforms for sharing their stories of recovery.

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Patrick W. Corrigan, PsyD, Illinois Institute of Technology, Chicago, Illinois, USA. Email: corrigan@iit.edu

doi: 10.1192/bjp.211.6.400a

Corrections

Interaction between the *FTO* gene, body mass index and depression: meta-analysis of 13 701 individuals. *BJPsych*, **211**, 70–76. The published declaration of interest stated incorrectly that K.J.A. has received research grants from various companies including Lundbeck and GSK. The correct declaration is as follows: K.J.A. has been on the advisory board for Bristol-Myers Squibb and Otsuka Pharmaceutical and in addition received consultancy fees including payment for lectures and educational presentations. Also, the ninth author's name is Sarah Cohen-Woods (not Sara Cohen-Woods, as published).

doi: 10.1192/bjp.211.6.401

https://doi.org/10.1192/bjp.211.6.400a Published online by Cambridge University Press