



# Healthcare Educational Practices on Stigmatism of Chronic Illness: A Qualitative Narrative Study

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## Abstract

The problem is the identified stigma related to certain diseases affecting the quality of care provided by healthcare workers. Somatic diseases or those with vague signs and symptoms are subject to various stigmas. Due to the lack of a known cause of fibromyalgia, the disease is subject to stigma. The purpose of this qualitative narrative study was to bring awareness to healthcare educators about the potential impact of stigma. Educators may transfer stigma to their students, which may affect the quality of care. The research question guiding this study was, "How might healthcare educators' perceptions of chronic illness transfer to their students?" The detailed analysis of 20 interviews with medical educators and students identified the perceptions and experiences of each. The results of this study emerged from in-depth examination of the 20 participants' perceptions from the viewpoints of how they participated in the medical education, either as a student or as an educator. Five main themes emerged from the data: experiences, subjective information, effort, education, and environment. According to the findings of the study, healthcare educators and caregivers passed on stigma perceptions to the students. The healthcare educators were unaware of the transference and many stated they took precautions to avoid such transference. The students identified a vector of stigma and offered the opportunity to alert the healthcare community of a change necessary from within. Identification of several areas suggested how changes in the educational delivery system could address the subtle stigma transference and meet academic needs of the students.

## Introduction

Statistics showed that almost half of all Americans live with a diagnosis of chronic illness. Estimates suggested 60% of Americans diagnosed with chronic illness were between the ages of 18 and 64, which happened to be the typical working age range in the United States [1]. Patients with unexplained chronic illness endured demeaning behaviors and experienced stigma from the members of the general society as well as from their own healthcare providers [2] described stigma as unfair treatment due to preconceived notions that may be detrimental to another's wellbeing [2]. The outcomes of stigma include experiences of discrimination, negative perceptions towards those affected with a stigma related issue, or self or internalized stigma [3]. The internalized feelings of stigma can result in feelings of emotional sorrow, and externally, those stigmatized show reduced healthiness, a lower level of accomplishment, and increased unemployment rates than do peers without stigma. The objective of the study was to add to the literature by exploring the perceptions of 10-15 healthcare educators and students from medical, nursing, clinical, and academic backgrounds about chronic illness; specifically, about

fibromyalgia. The use of semi-structured interviews assisted in exploring how the educators conveyed their perceptions of chronic illness to the students. The intent of the study was to discover the perceptions of 20 healthcare educators and students from medical, nursing, clinical, and academic backgrounds about chronic illness and to explore how the educators conveyed their perceptions to the students, possibly creating stigmas and ultimately affecting the quality of care patients received.

## Problem Statement

The general problem is the identified stigma related to certain diseases affecting the quality of care provided by healthcare workers [4]. Somatic diseases or those with vague signs and symptoms are subject to various stigmas [5]. Due to the lack of a known cause of fibromyalgia, the disease is subject to stigma. The stigma of fibromyalgia may have perpetuation within the healthcare educational system, affecting the quality of care the healthcare workers provide to fibromyalgia patients. Scholars do not know why certain diseases such as chronic neurological

illness carry stigmas, while other diseases such as chronic pain do not carry a stigma [5]. Stigmatized patients do not believe they get quality care at all times and often believe healthcare workers negate them [6].

## Literature Review

The beginnings of stigma date back to the early Greek culture, when authorities would physically mark a person with a burn or a scar to denote the person as a criminal or a slave [7]. As society aged, the Christians perpetuated the use of stigma by adding physical malformations as well as skin blemishes. [7] Posited that the term began to appear more broadly and related more to the disgrace itself, than to the physical manifestation [8]. [9] Supported the view of Goffman by researching a population of people with disabilities and maintaining when society sets a stigma upon an individual, others continually recognized the individual by the stigma. Today, social interactions perpetuate stigma [8,9]. Stigmas are a way to identify people by certain characteristics and can lead to alienation [10]. While in early civilizations, stigma formed because of an offense, in today's society, the stigma is the offense [9]. Yet both societies considered those with the stigma to have them to blame. Reflection on the "why" of a certain role is necessary, followed by understanding of the unseen reasons for the need of stigma designation in our society [11]. Stigma is any psychological or corporeal mark or oddity assisting in classification or analysis of a state or a distinctive characteristic that seems to be or in fact is publicly or expressively detrimental [2]. Historically, one of the first and earliest written teachings about stigma began with the Holy Bible. Leviticus 13:2-4 (New King James Version) stated, "And the priest shall look on the plague in the skin of the flesh: and when the hair in the plague is turned white, and the plague in sight *be* deeper than the skin of his flesh, it *is* a plague of leprosy: and the priest shall look on him, and pronounce him unclean." Since this early time, stigma has been a part of society.

## Creation of stigma

Stigma creates a foundation of stereotypes grouping a person into a perceived classification and resulting in what can be a paralyzing disgrace to the individual [12]. Persons with chronic diseases such as fibromyalgia may not receive the quality of care they deserve due to stigma of suffering from a perceived make-believe disease [13] placed on them by healthcare providers. Medical healthcare educators may unintentionally pass on this stigma to students in the educational healthcare process. Educators can create the stigma during a discussion of patients, and the negatively perceived behaviors may influence the healthcare providers' treatment of people. Such discussions can influence students' learning and pass on false interpretations of chronic disease. The findings of the study helped to discover the perceptions of healthcare educators about chronic illness and to explore how the educators conveyed their understandings to the students.

## Stigma in relation to chronic illness

The study of stigma falls into five categories: the understanding of unfairness due to stigma, the positions towards citizens affected by the stigma, the perceived stigma, identified stigma, and inequitable practices [14]. The outcomes of stigma include experiences of discrimination, negative perceptions towards those affected with a stigma related issue, or self or internalized stigma. The internalized feelings of stigma can result in feelings of emotional sorrow, and externally, stigmatized individuals show reduced healthiness, a lower level of accomplishment, and higher unemployment rates than do peers without stigma [15]. The outcomes of stigma are very similar, regardless of the type of illness or etiology of the stigma, within a society or healthcare program [14], allowing the research focus of outcomes of one disease to be indicative of the outcomes of another.

## Implications of stigma in relation to chronic illness

Some chronic diseases such as fibromyalgia do not have one definitive diagnostic criterion, which results in only the management of the patient's symptoms rather than a cure. This behavior can cause disaffection and frustration between the care provider and the patient. Without being able to definitively provide a specific etiology for the disease, care providers start to view the disease as psychosomatic [16]. Psychosomatic identified disorders lead physicians to seek the socio-cultural and psychiatric causations for the patients' symptoms, which are also areas associated with stigmas. The psychiatric focus has led care providers to view such patients as psychogenic/psychosomatic in the attempt to escape work tasks [16]. The result is the psychogenic/psychosomatic focus produces a label affixed to individuals as being difficult patients: Herein lies the creation and future consequence of the stigma. Stigmatized patients believe physicians minimize the symptoms the patients report. The patients themselves express distress from healthcare workers forcing a non-deserved depressive psychiatric diagnosis upon them [16]. The patients recognize they are in tune with their bodies and do not feel depressed, thus promoting feelings suggesting the doctors were not as up-to-date on current literature as they should be [16] and resulting in the patients' awareness they have not received the quality of care they deserved.

## Role of educators

Research indicated, historically, the role of the educator was to educate the students with facts and not bias; however, over time, the role evolved to become more of a guide rather than an autocrat [17]. The educator is no longer simply a provider of facts, but must also encourage students to increase their critical thinking skills, problem solve, and generate awareness to profit both the pupils and humanity as a whole [18], allowing the students to develop a secure working relationship with the educator. The medical educators maintain this relationship in both the academic forum

and the clinical arena. One goal of this study was to discover the impact of the relationships between medical educators and students in cultivating stigma.

### **Effects on students**

When students begin to shadow medical professionals, they may witness unintended responses by the practitioners often resulting in uncomfortable situations, and if the educators do not teach students how to handle the situation ethically, the event can be detrimental to the patient relationship. Indications include lack of communication, lack of respect, and lack of empathy. Such issues arise when the practitioner views the patient as an object rather than as an individual human being with thoughts and feelings [19]. The delicate balance of the human psyche insists both rationality and emotion need to be present when forming relationships with patients. Because the students learn in school, through the teachings of the sciences, to distance themselves and to see truth objectively, seeing the patient as a person becomes a challenge [20]. To learn about the disease processes and diagnosis, the students develop a sense of good and bad patients based on their ability to categorize the signs and symptoms of illness. Such classification requires tangible verification, as corporeal evidence is equivalent to intellectual legitimacy [21] to envision specific diseases. Eventually students will work with patients, which is why the need is crucial for them to learn about emotional feedback and perceptions in patients and caregivers. Students and educators need to stop classifying patients as good or bad [21].

### **Effects on patients**

The research of [22] indicated women diagnosed with chronic fatigue syndrome and fibromyalgia often experienced stigma in their lives, particularly in the many areas of their lives outside of the home. The women experienced stigma at work, when peers questioned their morality because of the number of missed days of work and believed they looked healthy. The women also experienced stigma in their relationships with physicians, and based on these interactions, believed the physicians viewed them as being psychosomatic. Following establishment of a diagnosis, the women believed the diagnosis lacked legitimacy in the medical field [23] and they did not experience any emotional relief from the identification of the disease. To avoid the stigmas, many women withdrew from care providers, while others sought multiple care providers to avoid the label of a complainer; resulting in not receiving the cohesive care they required [22].

### **Other effects of chronic illness**

Statistics show almost half of all Americans live with the diagnosis of a chronic illness. Estimates indicate 60% of Americans diagnosed with chronic illness are between the ages of 18 and 64, the typical working age range in the United States [1]. Of those diagnosed with chronic illness, five million are diagnosed with fibromyalgia, with 89-90% of the diagnoses in women (Office on Women's Health, 2010). People diagnosed with

chronic illness experience a reduction in financial stability, an increased rate of unemployment, and a loss of financial solvency, as well as exhibiting many other psychological effects of stigma [23]. Because of the inequality of treatment and the failure to have signs and symptoms controlled adequately, those with chronic illness and chronic pain make up over half of the suicides in the United States [1]. Emotional situations affect the quality of health as well as the quality of family life at a time the person with illness most needs the family support, thus increasing the dissolution of families. Chronic illness also affects divorce rates, with 75% of those divorcing having a diagnosis of a chronic illness [1]. Stigma might also affect the large group of the population who already suffer.

### **Effects on fibromyalgia patients**

The study was important to the community of chronic fibromyalgia sufferers: as many as half the people diagnosed with fibromyalgia become disabled due to the illness [24] and require many years of medical treatment. Fibromyalgia is the most common chronic musculoskeletal/rheumatologic disorder among women between 35 and 65, with as many as 3.4% of all women affected and as many as 90% of all fibromyalgia cases in women. Fibromyalgia presents a high degree of disability with little to no relief of chronic symptoms [24]. The cause of the disease is unknown, it has no known cure, and little knowledge exists as to the types of interventions able to reduce the negative signs and symptoms of the disease. Several research organizations currently are working to find the cause. Treatment of fibromyalgia is on a per-symptom basis using both pharmacological and non-pharmacological interventions. While the disease has no known cure, it is not fatal [24]. No straightforward lab test exists to produce an effortless definitive diagnosis of fibromyalgia, and identification consists of ruling out other illnesses as a cause, followed by the need for a thorough physical exam of ambiguous physical signs and symptoms [24]. Healthcare workers may perceive the disease as psychosomatic in nature and may not treat the individual appropriately, focusing on a non-existent psychiatric illness rather than on a physical disorder.

### **Methods**

All ethical and IRB considerations were obtained and approved. The Research design chosen was qualitative study as it allowed the ability to gain understanding of the perceptions of the educators' views on chronic illness; specifically, on fibromyalgia. The objective of the study was to explore, depict, and comprehensively understand the data collected to gain understanding of stigma creation for the purpose of identification and correction. The qualitative method allowed origination of theories in support of the data generated regarding the participants' experiences. Use of the narrative inquiry design enabled the exploration of the phenomenon of stigma through the educators'

and students' stories.

## Limitations

The current study contained limitations. The identified limitations were (a) lack of diversity within the participant groups, (b) methodological limitations, (c) use of self-reported data, and (d) lack of previous research on the role of the healthcare educator in stigma perception. Diversity was missing in the individual sub-groups in the study. The doctors were all males who had specialized practices. All but two of the nurses were female. The medical students were two males and one female and the nursing students were both female. The participants were all well-educated and, except for the students, performing in the role of an educator.

The second limitation of the study was the method used to collect the data. The data collection instrument was a semi-structured interview in which the participants told their personal stories related to a series of prepared questions. Because the researcher was new to interviewing, more purposeful and probing questions could have sparked additional data. One such question might have been, "What is your personal view of illness, and how does chronic illness fit into this belief?" Another could have been, "How do you identify and reassure a patient who may be worried about discrimination?" The third limitation touched on self-disclosure. The participants might have felt uncomfortable with self-reporting any bias they saw or felt. Participants might have answered questions in the way the participants thought the interviewer wanted them to answer [25]. Because the subject matter touched on a subject viewed by society with a stigma, the participants might have answered the questions so they, themselves, appeared positively [25].

The recruiting process for the study involved contacting a university and a private organization for collaboration, choosing a purposeful sample to allow for snowballing. The identified volunteers from each location received a letter or telephone call with an invitation to participate in the study. Approximately 30 prospective participants from the organizations produced 20 individuals who met the criteria and were willing to share their experiences during face-to-face interviews. The study participants consisted of medical and nursing educators as well as nursing and medical students. The educators had an average 15.6 years of experience and the students' level of education averaged 3 years in the respective programs. All of the participants had at least 1 year of experience in their chosen field. Of the 22 potential participants, twenty participants met inclusion criteria: five medical educators, 10 nursing educators, and five students. NF13 did not meet the criteria due to not having worked with any patients with fibromyalgia. The participant did not feel she knew enough about the disease to answer the questions fully. NF11 did not meet criteria because after initial agreement, she decided she did not want to complete the interview.

## Data Analysis

Data from the interview analysis gave rise to the expressed thoughts and feelings of medical educators and students about their views of chronic illness and the stigma accompanying it. A focus on healthcare educators' perceptions of chronic illness may transfer to students. Specifically, how educators view fibromyalgia may shape how the students perceive chronic illness. After the interviews were complete, transcription transformed the original recordings into written text. The participants were in three categories: medical educators, nursing educators, and students. The region in the United States, number of years in the respective fields, and any personal relationship with fibromyalgia patients created additional data categories influenced by the answers gained in the field test. The data formed five major themes and multiple sub-themes developed through analysis using *N Vivo* 10.

## Findings

The findings of this study indicated the students identified a stigma placed upon certain diseases, and professionals showed differences in the care provided to patients with the diseases. Sometimes the students felt the patients' embarrassment about the illness might have been an initial cause and the healthcare providers augmented the feeling of shame.

## Themes

**Theme 1:** Emerged with personal experiences that were important concerning the way faculty members taught and also the way in which students absorbed the material for 16 of the 20 participants. Depending on the types of experiences with faculty, the aspiring faculty may create a method of instruction based on a preferred method of previous instruction. The students found having a good rapport with a strict but supportive faculty member made the learning experience better by allowing them to openly ask questions and by creating a yearning for a challenge to become better students. The students in such cases then emulated the faculty and reported wanting to teach their students in a similar fashion. Students noted their interactive clinical experiences as important. Included in this were The ways in which the floor nurses and doctors interacted with each other as well as with the patients was a strong factor in how the students chose to interact with their patients.

[26] Developed the theory of conformity and social influence, which addresses the conscious handling of opinion and suggests one person, could influence beliefs in another person, either intentionally or unintentionally. Because students viewed their faculty as experts in the field, they reported they were nervous to incorporate any new ideas or actions into their learning program, fearing the faculty member might find the method unacceptable. The study findings indicated one of the most important features of medical school was watching the faculty to learn appropriate

social skills, which students then carried throughout their future practices. Based on the findings in the [26] study, it suggested students often adopted the belief of the instructor, whether or not the belief was accurate. The adopted techniques included both positive and negative patient perceptions. Even if at first the student does not fully agree, the student apparently does not want to express a difference of opinion and may internalize the perception of stigma. A strong link exists between the student's clinical reasoning skills and the fluidity of communication between the students and the clinical faculty.

**Theme 2:** Reflects social cognitive learning. The faculty and students described the need to identify and interpret the massive amounts of subjective information when assessing a patient. Often, little objective information existed to back up the subjective information, making a diagnosis difficult [27]. Thirteen of the participants indicated a faculty member passed on negatively identified beliefs while telling of the experiences and identifying certain diseases from staff to staff or with staff to student interactions. In one case, a nurse mentioned a doctor telling the patient he had caused his own disease because of his actions. The perceived negative actions were either verbal or physical, in the manner of body language such as eye rolling when speaking about patients, supporting Albert's social learning theory, maintaining most people learn in three ways, by examination, replication, and comparing [28].

**Theme 3:** Belief and perseverance were part of Theme 3. Based on belief perseverance theory, overcoming initial beliefs is difficult. Half of the faculty identified the evolution of their thoughts and feelings since initial identification of fibromyalgia with making a conscious effort, though those initial beliefs still remained. The entire nursing faculty reported they did not receive information about fibromyalgia in the classroom and had to learn about the disease through self-guided research when they encountered a patient with the disease. The initial research consisted of asking questions of other medical personnel who could give those reports or watching interactions of other medical personnel with the patient. When the participant wanted more information, he or she researched the disease through peer-reviewed sources. Current faculty members described teaching about the disease, often linking it with the psychiatric/neurology lectures. The faculty members ensured the students understood the content by evaluating the interactions of the students with the patients and the level and quality of education given to the patient. The students, however, did not recognize this style of evaluation as a teaching method. The students often disclosed they did not feel the faculty evaluated them unless they took a formal test. The belief perseverance theory maintains when a person has a belief about an issue or topic, he or she will maintain the belief, even when faced with new evidence to the contrary [29] and may interweave the new evidence to support the original belief as was supported in this data.

**Theme 4:** The fourth theme identified was education for self and the patient. The concept of requiring an increase in individual knowledge for personal growth and development as well as adequate health was prominent with both faculty and students. Participants suggested the others' attitudes influenced their own behaviors. The students thought the attitudes were important, but focused on the viewpoint of the educator. If the educator was negative, the students noted the perception and the students felt less comfortable asking questions. All of the students mentioned negative influence by faculty. Theme 4 reflected unconscious thought theory, which suggests making a difference in the thought process is a challenge, even with time to process the information [30]. By the end of their training, the students had at least 2 years to habituate the behaviors and beliefs of their faculty and co-workers, making the behaviors very difficult to change, even in light of gathering and processing additional information and education. The theory makes reconciling the new thoughts with the old a challenge, especially when attempting to integrate patient feelings. The 16 faculty who identified unfair treatment of patients thought the treatment was directed to patients with either a "self-inflicted" illness, such as obesity, cirrhosis, or alcohol and drug addiction, or a chronic disease the medical personnel found difficult to treat. The four students who identified this situation thought the unfair treatment emerged with patients viewed as "weak" or self-destructive in society. The perception had a strong link to patient education, suggesting the medical personnel did not feel the patients had heeded the education given to them to prevent future flares of illness. All but one participant, NS1, said they believed the patients themselves felt they would suffer discrimination in the healthcare system because of lack of money or the type of illness they had.

**Theme 5:** Environment. All participants in the study mentioned the environments they experienced as youth led them to choose a career in the healthcare field. This exposure was a key event influencing the participants' choices to enter the healthcare field. The environment was also a reflection of how the individuals currently practiced and managed their patients. The environments in which the participants worked were strong influences on interactions with patients, as well as directions for the flow of care given to the patient. All but two of the participants had experienced healthcare services at a young age. Many participants had family members who worked in the systems, and those without family members in the system had experiences on the patient side of the system; all had overall positive images of the healthcare environment. The early exposure was a key factor in their decision to work in the field. This same environment helped guide the students in the way they currently practiced medicine. According to the participants, the early idealistic image of medicine had morphed into a harsh reality of insurance issues, bureaucracy of an ever-changing network, and a general feeling indicating patients needed to be well educated about their own disease process and treatment to

ensure safe delivery in this new type of medical environment. The students indicated they had acquired stigmas from the healthcare providers and educators, but the participants did not believe they were participating in the problem. In contrast, many of the participants stated they were aware of the issue and tried to ensure they did not behave in a manner promoting negative thoughts. The students who identified this recognition might unconsciously incorporate stigma into their care without realizing it, extrapolated from the situation in which the practitioners were aware of stigma, but were not conscious of replicating it themselves.

### **The identified limitations**

(a) lack of diversity within the participant groups, (b) methodological limitations, (c) use of self-reported data, and (d) lack of previous research on the role of the healthcare educator in stigma perception. Diversity was missing in the individual sub-groups in the study, as a purposeful sample was used. The doctors were all males who had specialized practices. All but two of the nurses were female. The medical students were two males and one female and the nursing students were both female. The participants were all well-educated and, except for the students, performing in the role of an educator. The second limitation of the study was the method used to collect the data. The data collection instrument was a semi-structured interview in which the participants told their personal stories related to a series of prepared questions. Because the researcher was new to interviewing, more purposeful and probing questions could have sparked additional data. One such question might have been, "What is your personal view of illness, and how does chronic illness fit into this belief?" Another could have been, "How do you identify and reassure a patient who may be worried about discrimination?" Another type of design, such as phenomenological, could have been used to gain understanding of the lived experiences of the participants. The third limitation touched on self-disclosure. The participants might have felt uncomfortable with self-reporting any bias they saw or felt. Participants might have answered questions in the way the participants thought the interviewer wanted them to answer [25]. Because the subject matter touched on a subject viewed by society with a stigma, the participants might have answered the questions so they, themselves, appeared positively. The fourth limitation was the limited previous research on the role of the educator and stigma transference. A multitude of research is available on the subject of stigma related to certain illnesses. The effects of stigma and the quality of care also have a plentitude of research, but few researchers have studied the healthcare educator relationship.

### **Discussion**

According to the findings of the study, healthcare educators passed on stigma perceptions to the students. The healthcare

educators were unaware of the transference and many educators stated they took precautions to avoid such transference. The students identified a vector of stigma and have offered the opportunity to alert the healthcare community of a change necessary from within. In many cases, the students were able to identify specific times when they felt the faculty had passed a message to the students suggesting the patient suffered from a stigmatized disease. The transference was in the faculty's actions, words, and body language, as identified by the students. Stigma can be a sign of disgrace and may become a badge for detrimental interactions [31]. Huxley noted the experiences of stigma included isolation, silence, injustice, and accusation, several of which the students identified first-hand in the study.

### **Conclusion**

The conclusion was based on the responses of the participants in this study, the conclusion indicated students were aware of their educators' perceptions of chronic illness during training and a perceived stigma toward certain forms of chronic illness was present in the educators. While the educators did not didactically educate the students on the stigma, the students discerned the educators treated certain chronic illnesses and groups of patients differently and offered different levels of care. It has been contended that stigmas are a way to identify people by certain characteristics, and sometimes the characteristics appeared in clinical teaching techniques. The faculty and students stated when the lack of objective signs and symptoms of some chronic illnesses made a definitive diagnosis difficult, the situation often led medical personnel to believe the patient fabricated some aspects. The students and healthcare providers in this study were able to identify times in which they felt the care given to stigmatized patients, while not always sub-standard, lacked the usual amounts of time and effort normally spent with a patient. Because of the lack of key objective diagnostic markers for fibromyalgia, faculty and students noted the disease was often in the psychiatric rotation of the medical programs. In the nursing programs, the students did not recall faculty teaching about fibromyalgia in the classrooms, though faculty stated they addressed the condition minimally. The teachers' perceptions seemed to have both positive and negative effects on information delivery methods. Students' perceptions of the classroom questioned the quantity as well as the quality of time spent on the subject [32]. Because educators spent little time on the topic, students had the idea it was not important. The nursing students and faculty first learned about the disease from other medical staff in the clinical areas, not in free literature, often just prior to meeting the patient with the disease. Students had to gather information not only from the patient's clinical presentation, but also from how the person's body and mannerisms reacted to the information relayed [33].

## Implications

Implications include the need for educators to be aware that they are passing along stigma and students are absorbing those perceptions. Research of existing literature highlighted the effects of stigma can be devastating to the individual. A patient's own perceptions of the disease may aid or hinder the healing process, suggesting people often actively represent the disease as they picture or understand it themselves. Such behavior reflects how the patient perceives the reaction of the disease process by others in the community [34]. The patient may take on the characteristics he or she believes depict the disease, not necessarily the signs and symptoms truly representative of the disease. Implementing changes to teaching process can adjust this. There is also a need to supplement the literature. The existing literature did not focus on this specific topic. Literature pertaining to stigma is available, as is literature about medical faculty perceptions, but limited literature was about faculty members' perceptions of chronic illness and transference of those perceptions to students. Findings from previous research addressed only the acknowledgement of stigma, with few narrative reports of the transference of stigma in the medical setting. Awareness can allow for change. The first and foremost recommendation is to educate the nurses and physicians. [35] Found increased education caused an affirmative transformation in the way nurses communicated with patients. A simple refresher class during annual training may be enough to remind faculty of their perceptions and potential for transference. Though medical school curriculum now includes cultural sensitivity classes, most are racial and ethnic in nature [36] with very few classes including disease sensitivity. Including information for students suggesting patients may not feel comfortable about living with their diagnosis is essential; informing students about certain diseases carrying a stigma is critical. Medical staff should receive the education to overcome such beliefs and help the patient to feel safe and secure with the quality of the treatment he or she receives. When evaluating the student, educators should know the importance of notifying the student of evaluations in progress [37]. In the present research, the students were often unaware an evaluation was in progress and they thought the faculty members did not ever evaluate them on their clinical communication behaviors, other than direct intervention with skills. The perceived lack of attention left the student feeling the faculty member was not interested in those aspects of care. Educators need to combine the formative and summative types of assessment and ensure the students understand both are equally important. If the student exhibits any negative reactions to the situations in the clinical setting, faculty need to address those behaviors in a timely fashion and remind the student the corrections are part of the evaluation process [37-40]. Continuing education is a beneficial consideration because news and information about diseases changes frequently. Because students noted many of the incidences of transference occurred in

the hospital, the hospitals might find benefit in offering incentives for the staff to continue learning. The continuing education would play a part in keeping the quality of the hospitals at cutting-edge. Replication of the study with the same scope but in a different area of the country or in another country would be beneficial. A review of the chronic illness literature of other countries would be beneficial to identify areas of stigmatism similar to or different from those in the United States. Different cultures have varying norms and identifying areas of stigma and areas of need as compared to the United States might be interesting.

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