Stigma is corrosive. It is capable of causing intense psychosocial harm. Even after controlling for every conceivable confounder, members of social groups persistently subjected to stigma get sicker and die quicker than their counterparts. Accordingly, many social epidemiologists regard stigma as an independent social determinant of health. Hatzenbuehler, Link, and Phelan have gone further, labeling stigma a true “fundamental cause of disease” justifying intensive social resources intended to alleviate stigma’s adverse health impact.\(^{1}\)

Stigma is therefore increasingly being regarded as a major population health concern by leading epidemiologists, physicians, and public health officials.\(^{2}\) Moreover, as stigma scholars note, the definition of stigma is inextricably linked to power structures, which means that stigma strongly tracks social inequalities: disadvantaged groups are more likely to be stigmatized than privileged groups.\(^{3}\) In turn, given what we know about health inequalities, this fact suggests that the least well-off groups in the US are most likely to have their disadvantage intensified by stigma.

Furthermore, stigma is social. Despite the understandable colloquialism, it is not correct to say that a disease or a health condition stigmatizes anyone. It is always people who stigmatize other people. And, unfortunately, although stigma can flow from a number of sources, there is ample evidence of the commonality with which health care providers, public health officials, and policymakers channel and intensify stigma against the least well-off. Therefore, stigma is not merely of interest to medical and public health stakeholders because of its health impact. Because stigma has historically and continues to be so commonly inflicted on vulnerable and disadvantaged communities specifically by health professionals — even when they do not intend to do so — it is of great ethical concern.

While it is true that commentators and scholars have not ignored the topic of stigma and health, there has been less sustained focus on the subject that overtly draws on legal, ethical, and policy expertise. This matters because law especially is an important channel through which stigma flows. Indeed, social scientists point out that stigma is structural and is codified in a variety of social institutions.\(^{4}\) Laws and policies consistently reflect stigmas against all manner of disadvantaged groups, and this is certainly true in context of health and illness.

This commentary will first offer a working definition of stigma, patterned closely on Bruce Link and Jo Phelan’s influential model of structural stigma.\(^{5}\) It will then flesh out some of the ethical, legal, and social implications of that definition, and will connect the empirical evidence regarding stigma to robust normative frameworks that justify granting stigma high priority in public health policy and practice. The commentary will conclude by surveying the contributions to this symposium issue in highlighting directions for future research and interventions regarding stigma and health.

A Working Definition of Stigma

A working definition of stigma is deceptively simple: difference plus deviance. Although Link and Phelan advance a model of stigma along 5 or 6 dimensions,\(^{6}\) the core criteria for stigma can be distilled into two

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main components without doing violence to the overall model. First, an in-group must mark an out-group as different on the basis of a shared demographic characteristic. This is often referred to as the “branding” or “marking” phase. Note that this criterion in and of itself is not stigma. Marking an out-group as different is not stigma absent an assignation of deviance (i.e., a negative judgment) associated with that shared demographic characteristic. In other words, the marking phase must be followed by the “deviance” phase for stigma to be present. Thus, disability rights and advocacy communities—who know a thing or two about stigma—have for decades utilized a simple slogan: “Difference without deviance.” While disabled people live with functionings and capabilities that differ from the able-bodied, the argument is that disabled people ought not be judged as deviant, less-than, or inferior on the basis of those differences.

One important question to ask here is how stakeholders might, as disability rights communities suggest, intervene to “stop the stigma train.” That is, even where in-groups mark out-groups as different on the basis of shared demographic characteristics, we could deploy interventions that arrest the process by which deviance is subsequently attributed. Unfortunately, the history of health stigma in the West does not inspire confidence in moral agents’ ability to halt processes of stigma before marking of difference leads to attribution of deviance. All too often, and especially in contexts of health and illness, branding an out-group as different seems, sooner or later, to lead to attribution of deviance and full-on stigma. (Imagine the difficulty of arresting the difference-deviance process in cases of epidemic disease outbreak, for example).

Moreover, one of the most important implications of Link and Phelan’s stigma model is that notions of power and social inequality inhere. For an in-group to successfully mark another social group as “out,” by definition, the former must be “in.” That is, the in-group must possess a certain quantum of social power sufficient to mark or brand a different group as “out” along the axis of whatever characteristic will be made the mark of stigma. Of course, social life is complex, and most people are simultaneously members of multiple in-groups and out-groups all at the same time (and of course there exist many in-groups even within larger out-groups). But for stigma to flow according to a shared characteristic (e.g., skin tone, disease status, weight, etc.), the group branded as different must belong to an “out” group, often by virtue of that demographic characteristic.

This fact means that stigma is irreducibly a function of power and inequality. This is the first key to understanding stigma from a structural perspective. The notion of stigma as socially structured is often confusing, especially because stigma frequently manifests in individual encounters. Thus, a person seeks health care services and is stigmatized by a provider, or a chronically ill person has a conversation with a family caregiver that stigmatizes the illness sufferer. But while stigma frequently, albeit not always, manifests in individual encounters, its foundations are firmly rooted in larger social structures.

Further evidence for this conceptualization flows from the idea of unequal out-group membership. That is, while most of us are members of multiple in-groups and out-groups, some people belong to many more out-groups than in-groups. These people are marginalized along multiple axes, and we would therefore predict greater familiarity with stigma as horizontal out-group membership increases. And, in fact, this is exactly what the weight of the evidence suggests. In health contexts, this means that before a person has even sought health services of any kind, where that person belongs to multiple out-groups, they are already more likely to experience the slings and arrows of stigma across a variety of social domains. They are subsequently, of course, at higher risk of experiencing stigma in health care and/or public health contexts, which is ethically important for reasons that will be discussed below.

There are additional implications that flow from conceptualizing stigma as structural. For example, Link and Phelan have recently developed the idea of stigma power. That is, where stigma is a creature of social power and inequality, the power to stigmatize implies the power to inflict a variety of adverse social consequences on the person or group being stigmatized. One of the tragedies of stigma, as Goffman famously noted, is the way in which it taints a person’s social identity, i.e., their very idea of themselves and their place in society. The stigmatized person carries this taint as they move through a variety of social worlds and contexts, which means that although we might choose to focus on specific manifestations of stigma (here in health contexts), the adverse consequences of stigma power are rarely isolated to a single social context.

The connection of stigma power to larger inequalities also suggests that the directionality of stigma is significant from an ethical and policy perspective. While members of marginalized groups may certainly assign notions of deviance to members of empowered groups, the former by definition lack the social power required to produce adverse social consequences that flow from such assignations. Thus, for example, in a recent commentary, Kitta and Goldberg argue that it is not clear whether attempts to shame
vaccine-hesitant and vaccine-skeptical parents qualify as stigma, because such parents are overwhelmingly White, affluent, and well-educated. Thus, in a sense, their social status insulates them from the adverse social consequences of negative assignations for their choices regarding vaccines. Indeed, it is not even clear that such negative assignations qualify as stigma at all if they flow from communities of out-groups or otherwise marginalized people.

The directionality of stigma and its relationship to shame are of course hardly the only puzzling features about stigma. Indeed, its commonality is itself difficult to understand.

The Stigma Enigma

In health contexts, robust quantitative evidence for the prevalence and severity of stigma is typically limited to sexually transmitted infections, especially stigma connected to HIV/AIDS, and also to weight stigma. However, qualitative evidence, which is critical in illuminating the phenomenology of health stigma, suggests that health stigma is distressingly common across a wide variety of health conditions. This presents something of a conundrum. Primates, humans among them, are among the most prosocial creatures on the planet. In point of fact, social isolation is corrosive and has significant adverse health impact. In a study with a nationally representative dataset, Pantell et al. compared the effects of major clinical risk factors (obesity, smoking, hypertension) with that of social isolation. The latter was correlated with greater morbidity and mortality than any other risk factor save smoking, hypertension) with that of social isolation. The latter was correlated with greater morbidity and mortality than any other risk factor save smoking, which it tied. Similarly, our sociality is such that solitary confinement is increasingly regarded across the globe as a form of torture.

In short, we generally fare poorly in isolation. Yet, we frequently stigmatize each other. This juxtaposition is discordant because stigma is at its core an experience of alienation and exclusion. Thus, we apparently require community and social cohesion at the same time we commonly inflict one of the most anti-social experiences of which we are capable. How can these tensions be resolved? Why is stigma such a seemingly typical part of social experience?

Scholars have submitted multiple possible answers to these questions. Some adopt Foucauldian critiques, emphasizing the power and domination dimensions of structural stigma. I have suggested a phenomenological explanation in Judeo-Western contexts that integrates religious theories of just desert into meanings of illness. Where we have strong reasons to link sin and suffering as a way of answering existential questions (i.e., “why is this happening to me?”), illness stigma becomes much more likely. This follows because the sin-suffering link implies responsibility for suffering. There is extensive evidence correlating beliefs about individual responsibility with stigma imposition. Furthermore, that we link sin and suffering in the West because it is a useful narrative for grappling with the problem of evil is obvious in the history of infectious disease, for example.

Others have advanced arguments drawn from evolutionary perspectives. While humans are prosocial, social life nevertheless poses all sorts of risks. Stigma may well be a mechanism by which people respond to those risks; paradigms of infectious disease present an obvious example of this argument. (While arguments about human behavior never follow just so from evolutionary explanations, this does not imply the immateriality of such explanations as part of a larger causal picture).

However, at the same time that stigma is common, it is also often invisible. Disease stigma, as Burris pointed out in his influential 2002 paper in this journal, is often hegemonic, “accepted as natural and sensible, without reflection —” akin to the background of a play. After a time, the audience often ceases to really see the background, as they are absorbed in the spectacle of plot, narrative, action, and character. Yet that background has enormous impact in setting the mood, tone, and even the reactions of the audience to the drama itself. Consider, for example, two studies pub-
lished in consecutive years that examined the stigma of type 2 diabetes in Australia. In 2013, Australian health care providers reported that type 2 diabetes is one of the least stigmatized diseases within the population. Then the investigators asked the patients. In two qualitative studies examining stigma connected to type 2 diabetes and type 1 diabetes respectively, 84% and 93% of the informants reported experiencing stigma.

Of course, one of the common experiences of stigma is that such reports are often doubted or rejected. Some commentators, present company included, have argued that this form of disbelief is best characterized as a form of epistemic injustice. Doubting the experiences of a marginalized group can, as Miranda Fricker explains, wrong a person in their capacity as a knower. The notion of testimonial injustice in particular resonates with Link and Phelan’s concept of stigma, as the assignation of a credibility deficit to a speaker is obviously a negative attribution that may result in adverse social and health consequences. Moreover, although testimonial injustice can manifest ad hoc, it also tracks well-worn patterns of domination and oppression, suggesting a conceptual link with stigma. Similarly, like stigma, epistemic injustice can be located on a structural level. Consider, for example, regulations governing the proof of disability that must be submitted to justify an entitlement to Social Security benefits. C.F.R. § 404.1508 (2013) expressly provides that “[y]our impairment must result from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques. A physical or mental impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings, not only by your statement of symptoms.”

This provision has particular implications for the class of people seeking disability benefits by virtue of chronic pain. Because many forms of chronic pain defy the objective armamentarium of Western medicine and health care, the population of claimants with chronic pain will likely have a much more difficult time drawing up the needed proof. This state of affairs is all the more problematic given that virtually every health professional modality charged with providing care for people in pain prioritize the patient’s subjective self-report. The American Pain Society’s formulation of this directive reads: “The patient’s self-report is the single most reliable indicator of pain. A clinician needs to accept and respect this self-report, absent clear reasons to doubt.” In contrast to this dictum, the Social Security regulations instanti-
structures is likely to have enduring and dramatic effect in reducing stigma.

**The Significance of History for Stigma and Health**

All of this suggests that stigma must be analyzed not simply using tools of law, policy, and ethics, but also from an historical perspective. Although history is commonly thought of as linear, its flow is more accurately understood as circular. The worlds we inhabit look the way they do because of events, ideas, and condition that happened in the past. Put simply, if different things had happened, the worlds we move through would look extremely different than they do to contemporary eyes. Thus, to paraphrase Galeano, the world is made anew everyday by the warp and weft of history.\(^{24}\) It is impossible to understand stigma and health in the present without comprehending how historical patterns shape and determine that stigma.

Consider, for example, an elegant 2015 study examining the effect of deeply-rooted, racialized beliefs about the experience of pain.\(^{25}\) Hoffman et al. developed a survey that included both true and false beliefs about “biological” differences between Black people and White people. Importantly, the false beliefs tracked relatively old and problematic views about pain sensibility along racial and ethnic lines, such as “Blacks' nerve endings are less sensitive than whites” “Blacks’ skin is thicker than whites.” These ideas about pain and race were particularly active in context of chattel slavery, advanced most explicitly and most notably by the infamous Louisiana physician Samuel Cartwright. Yet, ideas are social actors, and they can resonate in social structures long after they begin to circulate, akin to flour in finished cake.\(^{26}\) Hoffman et al. designed a clinical vignette that intentionally had a “correct” answer regarding treatment, and examined whether the probability of providing that answer correlated with the percentage of false beliefs participants affirmed about people in pain. The investigators repeated the experiment with a sample of White adults and a sample of medical students and residents at the University of Virginia. The investigators ultimately found just such a correlation. In other words, the more false racialized beliefs a participant held about people in pain, the less likely they were to affirm a clinical intervention that was very likely the best option for effectively managing pain.

The weight of this history for the scope of present and future anti-stigma work is simply staggering. The structures are old, deep, and by most accounts resistant to change. There are more arguments that can be developed to show the myriad ways in which history can and should inform public health policy.\(^{28}\) The central point for this paper is the ways in which fluency with historiography underscores the structural nature of stigma — and the difficulty of unsettling long years of entrenched violence and oppression.

Fortunately, even in the face of such reason for pessimism, there is still happier evidence.
INTRODUCTION

Stigma Reduction: What Works
That is, the difficulty of ameliorating stigma at the structural level should not be mistaken for nihilism about anti-stigma work and interventions in general. The happy answer to the question “what works in alleviating health stigma” is “almost everything.” That is, the evidence suggests that most interventions specifically designed and targeted at reducing stigma have at least some measurable effect in doing so. Education and training programs, specific anti-stigma laws and policies, and increased contact between marginalized and dominant groups have all demonstrated at least some capacity to reduce stigma. (However, there is a pressing need for more thorough reviews, especially given the heterogeneity of anti-stigma interventions).

Furthermore, while structural stigma will not be substantially ameliorated through individual encounters, it does not follow that successful stigma reduction

The twelve contributions to this Symposium delve deeply into stigma and health, and do so using a variety of knowledge modalities. Herein, readers will find deployment of expertise in law, public health, medicine, sociology, gender studies, economics, fat studies, disability studies, and history, among other approaches. Consistent with the diversity of approaches, the papers in the Symposium issue explore stigma and health through a variety of social domains.

in such encounters is morally insignificant. Especially in health care contexts where stigma seems relatively common (i.e., weight, chronic pain, sexually-transmitted infections, mental illness, etc.), an encounter where a person with multiple social disadvantages is validated, treated with respect and full inclusion, and is honored in their capacity as a knower, is, at the very minimum, a good encounter. And that goodness has at least some moral worth, even if it does not in and of itself substantially ameliorate structural stigma. In his 1992 book The Healer’s Power, Howard Brody points out that the Lazarus fantasy exerts tremendous social power in the West, particularly in the U.S. Healers, and especially physicians, are the social group marked with the power — and the responsibility — to relieve suffering. It is important to remember that members of marginalized groups are disproportionately likely to experience stigma, including in health contexts. This sparks all sorts of defensive and coping mechanisms on the part of the stigmatized person, many of which have been shown to be injurious to health. Reflect on the significance for a chronically ill, multiply-marginalized person that has likely endured health stigma to seek health care services and experience a positive, nourishing encounter. If made iterative, such achievements might even constitute an instance of what Szreter and Woodcock term “linking social capital” — the most difficult form to sustain given the social hierarchies that actors must traverse to preserve the links. Regardless, that such positive encounters can have marked impact on individual patients is unquestioned. There exists moral worth in such impact.

Synopsis of Contributions
The twelve contributions to this Symposium delve deeply into stigma and health, and do so using a variety of knowledge modalities. Herein, readers will find deployment of expertise in law, public health, medicine, sociology, gender studies, economics, fat studies, disability studies, and history, among other approaches. Consistent with the diversity of approaches, the papers in the Symposium issue explore stigma and health through a variety of social domains.

This is well-advised for multiple reasons. First, Goffman noted, and empirical evidence confirms, the ways in which the taint of stigma spoils social identity in different contexts. The stigmatized person carries the mark of such stigma through different social experiences (employment, school and education, family structures, health and health care services, etc.). Second, while the health (care) contexts are important spaces in which stigmas manifest, and are therefore significant as nodes for intervention, health exceptionalism is unwarranted. What makes stigma ethically problematic would exist even if stigma did not have adverse health impact, and even if stigma did not commonly unfold in health contexts. People will often trade measures of health in the pursuit of other social goods. Thus while health is important both in its own right and as to stigma because it is a historically active axis for the experience, clear thinking about stigma and health should explore social contexts and structures which implicate stigma beyond narrow health care encounters.

Third, such an approach is helpful because it undermines the tendency to view the importance of stigma
to health primarily in context of impediments to access to health care services. That stigma does act as a barrier to such access, and that this kind of obstruction can have serious health consequences, is undisputed. Nevertheless, just as the evidence demonstrates that health care services are a relatively minor determinant of health and its distribution in human population, so too does a deeper understanding of stigma demonstrate its adverse health impact far beyond impeding access to needed health care. As noted above, stigma corrodes health in a variety of ways that have little to do with access, and full comprehension of stigma and health requires stakeholders move well beyond cramped thinking that is limited to considerations of access.

Collectively, the contributions to the symposium speak to the fluidity of stigma’s taint, easily traversing different social contexts. Beavers and Halabi analyze the role of stigma in the federal legal structure that regulates prosecution of sexual violence. While this is morally problematic in its own right, it also has significant implications for major social determinants that disproportionately impact women’s health. Again working beyond narrow corridors of health care delivery, Tobin-Tyler and Brockman survey the health implications of stigma attached to the carceral state and subsequent reentry. Like a stigmata itself, the perceived taint of incarceration marks the bearer, intersecting with racial stigma, and causing devastating social consequences. Tobin-Tyler and Brockman then offer policy recommendations intended to reduce the impact of incarceration and stigma on health.

The reference to stigmata again underscores the important of visibility in thinking about stigma and health. Along such a line, Konradi’s paper pioneers new work addressing the stigmas commonly endured by people living with illnesses that distort the bones of the face and skull. The paper surveys the existing literature, evaluates anti-stigma interventions, and proposes policies rooted in human rights law to mitigate the effect of connected stigma.

The visibility of fatness also marks fat people with a kind of stigmata, rendering them easily susceptible to weight stigma, an experience that is one of the more common forms experienced in the U.S., at least. Hence two contributions addressing stigma connected to weight and body size. Pausé surveys the literature, highlighting key insights and integrating them into her developing work on public health ethics and fat stigma. Munro’s paper links the experience of weight stigma to emergent scholarship in microaggressions, evaluating the extent to which the latter framework illuminates key aspects of the experience of weight stigma.

No symposium on stigma and health published in JLME would be complete without full consideration of law as an object for analysis (drawing on methods and approaches connected to public health law research and legal epidemiology). A variety of contributions center such tools in their analysis. See et al. explain a novel method incorporating health law, performativity theory, policy analysis, and stigma studies. They use this method to analyze law’s capacity to mediate stigma and then apply that method to analysis of Australian laws regulating alcohol and other drugs (“AOD”).

Buchman et al. take a similarly interdisciplinary approach to conceptualizing stigma connected to addiction and the opioid overuse epidemic in North America. They argue that understanding addiction and opioid stigma as parallel social processes is mistaken given the moral and regulatory history of the contemporary epidemic. Rather, they contend, seeing stigma and the epidemic as coeval and co-constructed reveals their enduring symbiotic relationship, and produces important insights for anti-stigma interventions. Regarding stigma as a “biopolitical-bioethical phenomenon,” Buchman et al. conclude with recommendations for addressing addiction and opioid stigma that may disrupt the co-construction of the opioid epidemic and its related stigmas.

Silverman and Wiley situate U.S. vaccination laws and policies as the desideratum. They ask an intriguing question: whether the design and implementation of such laws and policies can reinforce dominant social norms that regard vaccines as low-cost, effective care? The paper also surveys important moral and political issues connecting to shaming vaccine refusal, evaluating the extent to which law’s hand in supporting shaming vaccine-refusing parents comports with ethical and epidemiologic norms.

Similarly, Stanton and Smith’s contribution analyzes anti-stigma legal interventions, arguing that they tend to focus merely on easily-perceptible personal attributes. The authors assert that the phenomenology of stigma, i.e., the ways in which people live the experience of stigma, is of greater importance in crafting anti-stigma laws and policies in context of health. Insufficient attention to such experiences is likely to render subsequent legal and policy interventions less effective in alleviating health stigma.

Picking up on the common pathway by which public health laws and policies manifest existing stigmas, Roberts and Weeks document the extent to which stigma-related social policy can be “healthist.” Healthism, or discrimination on the basis of health status, is problematic inasmuch as it offends principles of health equality and health justice. The paper carefully defines and defends these values, and
explores the ways in which even well-intentioned laws and policies can perpetuate healthism. Roberts and Weeks conclude, therefore, that stigma should not be the foundation for any sound health law or policy, an important possibility for stigma scholars and stakeholders to weigh.

The relationship between structural stigma and social norms is complex. While formal norms play an important role, there is overwhelming evidence that informal norms also operate to mediate and focus stigma against certain groups. Carson’s article utilizes an economics-based explanation for the ways in which informal norms connected to condom use changed perceptions of risks and benefits related to HIV. While scholars have not ignored the role of informal norms, there has been little explanation of why informal norms are more or less prevalent in different social contexts, nor how and why some norms seem to encourage or discourage preventative health behavior. Carson concludes with some observations regarding the legitimate role of government action in monitoring and enforcing informal norms regarding behaviors relevant to HIV transmission in gay communities.

Last, but certainly not least, Jaipreet Virdi’s analysis of the medicalization of deafness in the first quarter of the 20th century goes some lengths to explaining the deep historical roots of stigmatization of hearing loss and deafness, including the ways in which deaf people internalized such stigma (“self-stigma”). Virdi’s paper is an important reminder that there is only weak evidence suggesting that medicalization and “biologization” of health conditions is an effective anti-stigma mechanism. In fact, the evidence suggests that in at least some contexts, such medicalization may have a tendency to intensify stigma, perhaps in part because of the tendency to see illness experiences as wholly embodied by the person experiencing them (and hence fundamentally inextricable from social identity).

Stigma is something of an odd creature in applied ethics, because, unlike many other problems in the field, it is relatively uncontroversial. Few bioethicists, health law scholars, and/or health professionals seem especially eager to stand up and trumpet health stigma as a social good that ought to be deployed whenever possible. There is virtual consensus that such stigma is usually, albeit perhaps not categorically, unjustified and ethically impermissible. And yet, the weight of the evidence suggests that stigma is common, especially in health contexts. Understanding the deep roots of stigma in social structures is key to proposing and evaluating interventions intended to alleviate it. The symposium issue hopefully contributes to such ends.

Note
The author has no conflict of interest to declare.

References
3. Hatzenbuehler, Phelan, and Link, supra note 1.
6. Id.
8. And, of course, that stigma “marks” is a product of the philology of the term itself, referring “stigmata.” It is no coincidence, therefore, that the father of stigma studies, Erving Goffman, spent a significant portion of his seminal 1963 text discussing the significance of socially “visible” conditions in creating stigma (with important implications for experiences that remain invisible, such as invisible chronic illnesses or impairments). See E. Goffman, Stigma; Notes on the Management of Spoiled Identity (Englewood Cliffs, N.J.: Prentice-Hall, 1963).
15. This analogy is chosen intentionally, as Goffman was actually a performance theorist; see also S. Burris, “Disease Stigma in U.S. Public Health Law,” The Journal of Law, Medicine & Ethics 30, no. 2 (2002): 179-190.
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22. There is, of course, a large literature discussing the extent to which law can antecede or presage widespread cultural and social change. My view is that while this can happen, for a variety of reasons, law and policy is much more likely to follow such change than to precipitate it.