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Stigma

The need to challenge stigma, in relation to HIV or mental illness or issues of disability, is a recurring theme in the pronouncements of the leading organisations of the medical profession.

According to the Canadian sociologist Erving Goffman, the term 'stigma' describes the 'situation of the individual who is disqualified from full social acceptance'.[1] Taking a historical view of his subject, Goffman recognised that 'shifts have occurred in the kinds of disgrace that arouse concern'. Indeed, over recent decades there have been some remarkable shifts in relation to some of the areas of stigma discussed by Goffman.

For example, homosexuality, one of the categories of stigma featured prominently in Goffman's study, was once defined by doctors as a disease and by the police as a crime. Yet, in 1974 it was removed from the list of psychiatric disorders recognised in the US while the gay movement helped to transform a stigma into a politicised identity. By the 2000s, the emergence of popular television shows such as 'Queer Eye for the Straight Guy' implied that to be gay was not only socially acceptable but culturally superior.

This does not mean that prejudice has disappeared, or that gay people do not still experience discrimination or abuse. But it does mean that such behaviour no longer enjoys official approval. Indeed, police-sponsored campaigns against homophobia confirm that homosexuality has become an issue which the authorities can use to improve their relations with the public and bolster their legitimacy. Similar campaigns against racial and domestic violence (the sort of activities more or less openly endorsed by the police in the Goffman era), reflect parallel transformations of stigma into identity and opportunity.

The ascendancy of a culture of victimhood has encouraged people to embrace labels, that would once have been considered stigmatising, as badges of status and entitlement. Another category discussed by Goffman and the focus of current campaigns is that of mental illness.

Although it is true that few still willingly accept the 'spoiled identity' of 'schizophrenic', many seek the fashionable labels of 'bipolar disorder' or 'post-traumatic stress disorder', and even more embrace the identities of victim of 'work-stress' or sufferer from anxiety and depression. A flourishing literature refers to the acceptance of a diagnosis of ADHD or Asperger's syndrome, in adults as well as in children, as 'a gift'. In his account of 'why my autism is a gift', Luke Jackson explains that 'different is cool'.[2]

Our surgeries are currently full of patients who, far from regarding the label of 'disabled' as shameful or embarrassing, seek medical endorsement of this status so that they can claim privileges in relation to driving, parking, and bus transport. (I do not object that people with disabilities should receive such privileges, but simply observe that, by the time that the entire population has a disabled parking badge, then any privilege is negated.) 'Drug addicts' were another stigmatised group in Goffman's account. Now, so little stigma attaches to drug addiction that, according to a recent government report, some 50 000 people are currently claiming benefits under this diagnostic label.

Through all the shifts in stigma over the past half century, one category identified by Goffman has endured: the 'urban unrepentant poor', 'those members of the lower class who quite noticeably bear the mark of their status in their speech, appearance and manner'. Goffman found that 'in their relations to the public institutions of our society' they were 'second class citizens', and second class citizens they remain. Their disqualification from full social acceptance is closely associated with their persistence in smoking and tendency towards obesity, the twin stigmata of the contemporary underclass (entirely unrecognised in Goffman's seminal study).

While challenging stigma in areas where it is no longer a social force, the medical profession plays a leading role in promoting stigma where it continues to sanction discrimination and social exclusion.

REFERENCES

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2. Jackson L. *Geeks, freaks and Asperger syndrome*. London: Jessica Kingsley, 2003.

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Top Tips in 2 minutes

If a living worm is put into the hand of a child before he is baptised, and kept there until the worm is dead, that child will have power in afterlife to cure all diseases to which children are subject.[1] Not all of us will have had the foresight to do this so we need other systems to aid diagnosis and management of symptoms.

Pain, frequency, and symptoms of UTI are much easier when children can tell you, but the younger they are the more difficult it is to know … And what about when they can't communicate verbally at all and are non-specifically unwell?

NICE has issued new guidance on UTIs[2] and pyrexia[3] in children and it will affect how we manage and refer on. It's not exactly user-friendly when it comes to accessing information quickly in those bite-size consultations with ever increasingly complex content. Essential tips from the guidance that can be used quickly in practice are here with links to the relevant parts. NICE also has produced a parent's booklet — helpful to have up-to-date information to give to support the consultation.

NIPPAs (New Ideas in Paediatric Practice at Addenbrookes) is a group of Cambridge primary and secondary care clinicians working together to enhance pathways and provide leadership and knowledge dissemination.

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2. National Institute for Health and Clinical Excellence. Urinary tract infection in children: Quick reference guide. http://www.nice.org.uk/guidance/index.jsp?action=download&o=36030 (accessed 7 Mar 2008).
3. National Institute for Health and Clinical Excellence. Feverish illness in young children: Quick reference guide. http://www.nice.org.uk/ guidance/index.jsp?action=download&o=30524 (accessed 7 Mar 2008).

More top tips can be found at: http://www.addenbrookes-pgmc.org.uk/handouts.asp?key=135

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Top Tips in 2 minutes: Urinary tract infection in children.

NIPPA's

Why:

- NICE guideline
- Think urinary tract infection (UTI) if unexplained temp >38ºC >24 hours
- Refer and investigate the few who need it rather than all patients

How:

1. Risk factors to explore:
- known renal tract abnormality;
- positive family history;
- dysfunctional voiding; and
- constipation

2. Recurrence of UTI
- two or more urinary tract infections

3. Atypical UTI
- seriously ill;
- poor urine flow;
- abdominal mass;
- increased creatinine; and
- no response to treatment after 48 hours

What next and when:

- Carefully examine and check blood pressure in all children
- Send urine for culture for all children with exception of a first lower UTI
- Refer all seriously ill/children aged <3 months of age to hospital
- Assess response to treatment after 24–48 hours

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Lower UTI
- dysuria
- frequency
- urine positive (nitrite +/-)

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Treat for 3 days with oral antibiotic (cephalosporin, trimethoprim, co-amoxiclav)

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Upper UTI
- urine positive *and*
- fever >38ºC
- loin pain

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Treat for 7–10 days

Imaging
- Arrange ultrasound scan within 6 weeks if ***2*** (see above)• DMSA (Dimercaptosuccinic acid) in 4–6 months if ***2*** or ***3*** (see above)

Where else:

Treatment and advice following UTI
- No routine urine testing following an episode of UTI in children
- No routine prophylactic antibiotics
- No routine surgical management of reflux with or without UTI
- Encourage to drink an adequate amount
- Address dysfunctional elimination syndromes and constipation

Indications for referral to a paediatrician
- Only children with recurrent UTI or abnormalities on imaging

Patient information: NICE patient information
http://guidance.nice.org.uk/page.aspx?o=448751

Web links/references: NICE UTI in children August 2007. Algorithms can be found at http://www.nice.org.uk/guidance/CG54
BMJ 2007; **335**: 395–397. BP centile charts http://adc.bmj.com/cgi/reprint/92/4/298
Growth charts http://www.cdc.gov/nchs/about/major/nhanes/growthcharts/clinical_charts.htm

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