Reviewer's report

Title: The Stigmatization Dilemma in Public Health Policy - The Case of MRSA in Denmark

Version: 2 Date: 25 April 2015

Reviewer: Arne von Delft

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- Major Compulsory Revisions

1. Distinction between use of intentional stigmatisation as a public health tool vs. stigmatisation as an unintended consequence of public health interventions.

In the provided “author’s response”:

“We consider the ethics of stigmatization as an instrument for public health interventions…”

The authors cite smoking policies in the USA as an example of intentional stigmatisation as a potentially effective public health tool. It is worth interrogating the strength of the referenced evidence, since this example of intentional stigmatisation as a public health instrument is used repeatedly in the paper:

Ploug et al: Effects of Stigmatization – Theory and Evidence: paragraph 2

“Both studies conclude that creating further stigmatization or social unacceptability of smoking would be an effective public health tool.”

As far as I could see neither of the two referenced papers (3 Kim & 4 Alamar) propose that stigmatisation was, or should intentionally be pursued as an effective and potentially justifiable public health policy:

Alamar and Glantz focus on social unacceptability and the word ‘stigma’ (or ‘stigmatization’) is not used once in the paper. Alamar 2006: Discussion: “Our results indicate that increasing the social unacceptability of smoking is a highly effective policy tool in reducing consumption. Tobacco control programs should stress the dangers of environmental tobacco smoke and reinforce the nonsmoking norm.”

Based on the definition put forward by Ploug et al (adapted from 2 Link 2001), social unacceptability meets some, but not all of the criteria for stigmatisation. Specifically the concept of differential power is not explored sufficiently.

In the paper by Kim the authors use regression models to explore the possible associations between public sentiment and smoking behaviour, however, there are various methodological concerns, many of which are highlighted in their discussion: “…at best a crude and approximate measurement of public sentiment toward cigarette smoking.” (Kim 2003)
(Refer to Appendix 1 for more details, please). Their comparison also fails to interrogate the proposed definition of stigmatisation properly. A case supporting intentional stigmatisation as justifiable policy is not made either:

Kim 2003: Discussion: “This study demonstrated the process by which changing social norms and public sentiment may have an impact on individual behaviors, especially health-related behaviors.

One of the concerns about this process is the creation of a social atmosphere in which unhealthy behaviors are defined as socially unacceptable and accordingly stigmatized as deviant behaviors.”

In summary:

Substantial portions of the paper, and a major line of reasoning, focus on the merits (or lack thereof) of stigmatization as an instrument for public health interventions. Based on my reading, the referenced papers fail to support the assertion that intentional stigmatisation of individuals is justifiable in certain situations and intentionally pursued by public health policy makers. I suggest that the authors should either strengthen the evidence supporting intentional stigmatisation or alternatively focus their core arguments more on stigmatization as an unintended consequence of some public health policies.

Please refer to Appendix 1 for more comments on references made to intentional stigmatization.

2. “DISCUSSION
The Ethics of Stigmatization and Public Health Intervention – three perspectives

...However, three main perspectives are developed and discussed in the literature”

Please provide references for these three perspectives, particularly the ‘legitimacy’ of the controversial Utility-perspective, the maximization and optimization criteria and the state-sanctioned paternalism interpretation.

3. The Stigmatization Dilemma:
Paragraph 3:

“In extension, if the MRSA situation worsens, the patient might not have the right to equal treatment.”

Is there evidence suggesting such potential rights infringements?

Also refer to the apparent contradiction in paragraph 4:

“As already mentioned, it is very clear in the guidelines from the authorities that there is to be no difference in the care offered to carriers and non-carriers”

In general people have the right to equal treatment for the same condition. The nature of that condition may require that such individuals are managed differently than individuals without the condition (especially relevant with contagious diseases, e.g. infection control measures), but all individuals with the same condition should be entitled to the same level of care.
4. “The ethics of choosing whom to stigmatize”
I find the ‘choice’ terminology to be somewhat misleading and would suggest that you clarify in the heading and subsequent discussion that Public Health decisions are based on various benefit-risk considerations: potential stigma represents an unintended and unwanted risk that warrants careful assessment.

5. Summary section:
“It is uncontroversial that some public health interventions cause particular groups and individuals to become stigmatized…The stigmatization may either be a deliberately chosen means to achieve a positive public health outcome”
As explained above I would argue that this statement is not without controversy, esp. the ‘deliberate’ component.

- Minor Essential Revisions
The author can be trusted to make these. For example, missing labels on figures, the wrong use of a term, spelling mistakes.

1. Abstract summary
Correct definition: MRSA = Methicillin-resistant Staphylococcus aureus
http://www.cdc.gov/mrsa/

2. The Ethics of MRSA Interventions – The Choice of whom to Stigmatize
4th paragraph:
“Thus the real question concerns whether scenario 1N may be justified…”
Should be 1S?

3. Paragraph 8 after “Ethics of MRSA interventions”:
“This is supported by several studies (24)”
Only one reference listed, though? Are there others that were omitted?

- Discretionary Revisions
1. Regarding differences in factors which result in possible stigmatisation:
Relating to “escaping stigma”: potentially possible if stigma is related to a potentially curable disease (MRSA) compared to circumstances which are more difficult to change, e.g. farming profession.
One could also expand on the argument presented that there is a difference between discrediting a voluntary action vs. an attribute or circumstance over which an individual has little or no control.

2. “Defining Stigmatization”
The definition put forward by Link and Phelan is informative. Using this framework to assess the potential for stigmatisation in the various MRSA
scenarios would add depth to the discussion. Also suggest adding the asymmetrical distribution of power to the list in the last paragraph of the “Defining Stigmatization” section.

3. Effects of Stigmatization – Theory and Evidence:
“Does stigmatization have effects that may be considered harmful to the individual?”
One could argue strongly yes, by the very definition presented in the previous section. And reinforced in the second paragraph of the autonomy-perspective.

4. Paragraph 3 after the dignity perspective:
“Although strongly contested, the precautionary principle…”
Could you consider clarifying what is contested and by whom, please?

5. Last paragraph of “The Ethics of Stigmatization and Public Health Intervention – three perspectives” section:
Is stigmatization really inevitable? Are there not alternative measures to minimize or even eliminate potential stigma? Any evidence of such measures in literature or own suggestions? (Also refer to comment 8, please)

6. The Ethics of MRSA Interventions – The Choice of whom to Stigmatize
4th paragraph:
“…the farmers that suffer stigmatization do not gain the health benefits”
Benefits could potentially extend beyond their own knowledge and practices, e.g. disclosure of the scope of the problem could help mobilise resources to tackle the problem and/or provide additional support for those affected.

7. Paragraph 8 after “Ethics of MRSA interventions”:
Are the authors confident that health benefits linked to awareness do not extend to the general public?

8. The Stigmatization Dilemma: paragraph 1
“Often the choice to be made in the public health context is not between stigmatization and no stigmatization, but rather between who or which group of people to stigmatize.”
The argument that stigmatisation is potentially an inevitable (and undesired) ‘side-effect’ of public health action (or conversely inaction), with potential trade-offs between vulnerable groups/populations, merits further discussion.
Paragraph 4: “we do not – so far – suggest that the Danish authorities’ precautionary measures are in any respect wrong”
Perhaps expand on the merits of the above precautionary measures by exploring proposed/potential Public Health options to mitigate inadvertent stigmatisation.

9. MRSA information sharing considerations:
In my professional and personal experiences dealing with HIV and drug-resistant tuberculosis, potentially deadly infectious diseases regularly elicit apprehension and even outright fear, which more frequently than not are aggravated by a lack of information and/or disclosure. Such fear, coupled with a power differential is a recipe for stigmatisation and discrimination, as the Ebola epidemic in West-Africa also showed in the past 12 months. Initial disclosure may appear more damaging (stigmatising) initially, but I would have liked to see a more thorough exploration of the medium to longer term impact on stigmatisation of disclosure vs. secrecy (brief mention is made of ‘escaping stigmatization’, but what if this is not possible?). As the authors point out, inaction could be more damaging to other groups (from the public health and stigma point of views), but it could also inadvertently serve to deepen stigma over the longer term amongst the group one was attempting to protect.

10. Many references are in Danish: are translations available?

**Level of interest:** An article whose findings are important to those with closely related research interests

**Quality of written English:** Acceptable

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**

I declare that I have no competing interests.