As progress in respiratory medicine approaches new horizons, Stephen ends with both hope and a note of caution—to no longer take our lungs for granted. While he underscores the value of personal actions such as avoiding smoking, ensuring the air quality of work and home environments, and engaging in exercise, he believes that only by collective action to protect the environment and fight climate change can we ensure our ability to continue breathing healthily. According to Stephen, the lungs hold the key not only to our origins as a species, but also to our future survival on this planet.

Jennifer Thorley

Stigma: an unmet public health priority in COPD

"Back then, we didn't know how harmful smoking is." "I have really been trying to quit doctor, but it is not easy." At least once in every respiratory clinic we hear such an uncomfortable, apologetic response by patients with chronic obstructive pulmonary disease (COPD) when questioned about their smoking history. These patients have been stigmatised due to their disease.

Stigma is a social construct that devalues a person based on a distinguishing characteristic. Stigmatised individuals feel spoiled or less human compared with their peers. This stigmatisation can lead to impaired mental well-being and poorer health outcomes. COPD fits all six dimensions of a stigma trait: unconcealable, progressive, disruptive to social interactions, aesthetically displeasing, of a (supposedly) self-inflicted origin, and something which others perceive to be harmful to them (eg, coughing may spread contagious diseases). It is important to understand why and how patients with COPD might be stigmatised, so that stigma in COPD can be eliminated.

The community, health professionals, and even patients themselves might blame the person with COPD for their condition, on the grounds that COPD is seen as a self-inflicted condition. Enforcing this idea might be an unintended consequence of anti-tobacco public health campaigns, which place an onus on smoking being the cause of chronic respiratory conditions. However, there is a fallacy to this notion as the cause of COPD is multifactorial and about one in five patients have never smoked. Moreover, there is substantial heritability to nicotine addiction, the tobacco industry has spent billions on marketing over the last few decades, and tobacco use disorder is classified as a medical condition in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) document.

The use of outdated and derogatory terms when referring to these patients might also precipitate stigma. Characteristically, the terms "blue bloater" and "pink puffer" are still taught in undergraduate clinical training, are very accessible to patients and their peers through the internet and are even used in clinical practice. Even the choice of the term "rehabilitation", describing one of the most effective treatments for these patients, was unfortunate, as it can carry negative connotations. There are very few other medical conditions where such labels are used in clinical practice and medical literature or are taught to health-care students when their judgement of patients is easily pliable.

The presence of noticeable respiratory symptoms that are considered by the public to signify a communicable disease, such as cough, expectoration, and wheeze, undoubtedly adds to the problem. This issue is given a whole new dimension in a post-COVID world, where displaying respiratory symptoms in public more often attracts negative attention from others. For example, other passengers on a bus or train might choose to move away from a person with COPD, and while one can empathise with this behaviour to an extent, it reinforces the belief among people with COPD that they are social outcasts.

Stigma might also be precipitated by people letting a patient's COPD diagnosis dominate their judgement of and behaviour towards that person. For example, they may worry whether the patient's symptoms and disability will disrupt their own day-to-day professional, social, or leisure activities.

Stigmatisation by health-care professionals has a detrimental impact on the care of patients. Firstly, off-putting clinical interactions reduce the patient's trust in their doctor. In parallel, stigma might lead to unconscious, or even conscious bias against patients with COPD. For example, patients with COPD are very rarely offered an admission to the intensive care unit or intubation in the UK, despite it having been demonstrated that survivors would choose similar intensive care, again under similar circumstances. Similarly, it is a common practice, at least in the UK, to deny current smokers with COPD the potentially life-saving administration of domiciliary oxygen for fire safety reasons, when simple advice to avoid smoking in the same room could solve the problem. Bias against patients with COPD might also explain why COPD research remains chronically under-funded compared with other conditions that are less stigmatised. In 2019, COPD received 96% less funding than cancer from the National Institutes of Health, despite accounting for 64% more lost disability-adjusted life-years in the USA.

Unconscious stigmatisation by the public poses an additional burden to patients with COPD, who are less

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likely than other people of a similar age to have partners or receive much-needed social and emotional support from others. Loss of their social cycle is a problem for patients with COPD who cannot participate in all the leisure activities of their peers, or who are unable to leave their homes for long periods, due to exacerbations. Loss of their social lives is a crucial catalyst diminishing the physical and mental health of patients with COPD, limiting their motivation to self-manage their disease and take care of themselves.

Finally, patients with COPD also suffer from self-stigma. Patients can perceive themselves as different from others. As a result, they might be self-conscious and hypervigilant about their symptoms and appearance in public places. They might also feel embarrassed to use their inhalers or supplemental oxygen in public spaces, and so are less likely to receive these necessary treatments. They might subsequently avoid leaving their homes altogether. In parallel, self-blame is associated with depression and self-neglect.

There are several ways in which the medical community can eliminate stigma in COPD. Public health campaigns could raise awareness about the features and management of COPD, so that non-COPD members of the public can empathise with patients. Without diminishing the importance of smoking as a risk factor, undergraduate medical curricula should also emphasise that COPD can have other causes, and that tobacco dependence is a recognised medical condition. Championing patient organisations would strengthen peer-to-peer support in the COPD community. Furthermore, psychological support and opportunities to socialise should be provided during pulmonary rehabilitation programmes. Perhaps most importantly, clinicians should explore whether their patients self-stigmatise to extinguish these thoughts before they have a substantial effect on their mental health. Even the briefest of conversations about a patient's mental well-being can have a lasting impact.

We have no competing interests.

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