Stigmatization and Dishonesty: How Doctors Communicate and Cope with Mental Issues among COVID-19 Patients in Indonesia

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Abstract

Background: The coronavirus (COVID-19) outbreak has caused public fear alongside social stigma and discrimination. As a result, people hide the illness to avoid discrimination. This study focuses on investigating doctor-patient communication, their challenges when diagnosing suspected COVID-19 patients, and how the physicians communicated with patients' mental issues. **Methods:** A mixed-methods approach examined this phenomenon and an online survey was conducted among 221 Indonesian doctors. The following were quantitatively examined: theme of Covid stigma and patient openness, patient/physician interaction and communication, and information and stigmatization of Covid. Qualitatively, two Focus Group Discussions (FGD) were conducted with five physicians and four COVID-19 survivors or their family members. Thereafter, interviews were set up with the selected four persons. **Results:** 74.2% of respondents encountered

patients with lack of honesty or openness, while 55% of physicians claimed that 1-2 patients out of every 10 patients covered up about their illness. 27% of physicians indicated that 3-5 of 10 patients did not tell the truth. Majority of respondents opined that the media/social media played a large role in the promotion of stigma for those who had COVID-19. **Conclusion:** Study results affirmed belief in a link between the stigma of COVID-19 and patients' dishonesty. Results indicated that many individuals are reluctant to disclose their true positions for fear of stigmatization by the people around them. This is linked to the stigma of COVID-19 and patient reluctance to be honest about their health/illness per impact of COVID-19. This research concluded that doctors need to find creative ways to communicate with their patients so as to increase patient honesty about illness.

Keywords: COVID-19, social stigma, physician-patient relation, mass media/social media/communications media impact

Introduction

The continuing COVID-19 and variant outbreaks have provoked social stigma and discriminatory behaviors against people contracting or in contact with the virus (Grover et al., 2020; Nature, 2021; Wang et al., 2020; WHO, 2020). The continuance of the pandemic crisis is evidenced by the response with the recent Omicron variant and lack of global collaboration that extenuates timely resolution (Nature, 2021). As defined by WHO, social stigma in the context of health is the negative association between a person or group of people who share certain characteristics and a specific disease. "In an outbreak, this may mean people are labelled, stereotyped, discriminated against, treated separately, and/or experience loss of status because of a perceived link with a disease" (WHO, 2020). This treatment, via stigma and discrimination, may have negative impacts on COVID patients, their families, friends, special groups of people, and the caregivers and frontline workers supporting them through health and social institutions (Grover et al., 2020; Ramaci et al., 2020).

Background

Despite global focus on vaccination, there is still social stigma among communities due to COVID-19. In Indonesia, the stigmatization haunts patients and families due to protocols with deaths where they cannot carry out normal funeral ceremonies and corpses often cannot be buried in public cemeteries (Assegaff, 2020; Marcoes, 2020; Sulistiadi et al., 2020; Syakriah, 2020). A survivor in Jakarta reported feeling like an outcast who was ostracized because her colleagues accused her of infecting other employees

and declined having lunch together (Syakriah, 2020). Hence, COVID-19 stigma, for some Indonesians, is worse than the disease.

COVID-19 is not the first major health crisis to produce impact of stigma on patients and their society. In comparison, a similar case occurred decades ago when HIV/AIDS had a significant impact on the American public as described by Thompson et al. (2003, p.290). According to the scholars, no illness has riveted the attention of the American people more than HIV/AIDS during the past 20 years. HIV/AIDS became the most stigmatizing disease in modern times due to its enormity and the reach of its connotations, which made it the public's top health concern. As with the COVID-19 stigma for some Indonesians, those who initially had AIDS also experienced stigma perhaps worse than the disease of HIV/AIDS, itself. The impact is suggested by more than 810,000 cases identified and 467,000 deaths attributed to AIDS by the end of 2001 (As reported by Centers for Disease Control and Prevention (CDC), 2001). Health care expenses as well as social, psychological, emotional, and economic repercussions on spouses, family, friends, co-workers, neighbors, students, and healthcare professionals are all included in the impact's size.

Stigmatization of COVID-19 and its negative social impacts have affected many countries. Dye et al. (2020) noted that with COVID-19, bullying, harassment, and stigma occurred among health workers in many countries. Bhattacharya et al. (2020) focused their work on social stigma of COVID-19 and consequences in India. Cassiani-Miranda et al. (2020) also evaluated stigmatization associated with COVID-19 in Columbia. A Chinese psychologist cited a study of 1,000 COVID-19 patients suffering from depression and anxiety long after recovery (The Economist, 2021). This psychologist indicated that research continues into the precise role played by social stigma and discrimination.

Social, Political, Cultural and Economic Context of Indonesia

The social, political, cultural, and economic contexts of countries around the world have some consistent variety, yet some global commonality as well. Global commonality is shared through reference to previous applicable research. A helpful insight to these factors with Indonesia specifically is shared by Wahyuni and Fitrah (2022) in their qualitative analysis with the eight most accessed online media outlets in Indonesia. They found an emphasis on political context of the pandemic over the health and economic context (p.84). The authors noted ensuing problems from this choice of contextual emphasis by online media. One example was the pressure for governmental policies by the media at the cost of information from health experts such as epidemiologists. Another example was delay in mitigation of problems per conflict between the central government and local

governments. A final example was the occurrence of information overload as the pandemic continued. Wahyuni and Fitrah noted that complexity of information and overload could have issues of accuracy and promotion of distrust by a readership.

Rela et al. (2022) addressed the presence of community resilience for Indonesia in the experience of COVID-19. This encompassed social, political, cultural, and economic contexts in the local environments where Indonesians lived out their daily life with impact of COVID-19. Rela et al. also noted the economic impact of the pandemic resulting to unemployment and underemployment, loss in tourism and external investment into the country, and limitations on travelling outside the home to support daily needs. Some social unrest and increase in crime rates occurred occasionally in the form of street demonstrations, looting, or other violence with demands for governmental supply for their needs. Furthermore, Rela et al. indicated the availability of only enough COVID-19 vaccines to support 24.8 percent of the Indonesian population. All of these challenges exacerbated the struggle to maintain community and individual resilience through the course of the pandemic.

Labelling and Stigmatization of COVID-19

Concepts of labelling, stigma, and stigmatization, including recent association with COVID-19, were examined per Erving Goffman's (1963) sociology theory (e.g., Cassiani-Miranda et al., 2020; Kusow, 2004; Roberto, Johnson & Rauhaus, 2020; Tyler & Slater, 2018). According to Goffman's concept, a stigma is a characteristic that makes a person in a social category different from others, with reduction of the individual to a tainted or discounted status. Stigma consideration as a handicap shows the difference between the perceived identity and the holder of the stigma's real identity. Goffman implies that a person with a stigma is not quite human by social standard. On this premise, individuals practice forms of discrimination that restrict the stigmatized individual's life chances. This stigma-theory is a philosophy designed to justify the inferiority of an individual, account for the risk of a person, or rationalize hostility based on other factors (Goffman, in Davis, 2017).

Physicians and Imprecise COVID-19 Patients and their Connections with Social Media

Social stigma toward COVID-19 patients can prevent individual honesty about their illness condition. Prolonged stress, anxiety, and lack of sleep may have a significant adverse impact on the immune system (Grover et al., 2020; Shneider et al., 2020; Wang et al., 2020). Good doctor-patient communication is an important part of patient-centered treatment, which

leads to positive health results (Grover et al., 2020; Dalma et al., 2020). However, poor doctor-patient communication can cause patients to overestimate their prognosis and misinterpret treatment options (Breitbart & Alici, 2014, p.143). With COVID-19, Biss (2020) noted the important and therapeutic value of communication.

Oh et al. (2020) studied the 2015 Middle East Respiratory Syndrome Coronavirus (MERS-CoV– a viral respiratory disease which is also caused by Coronavirus family) outbreak in South Korea. It was noted that social media exposure is related to the two self-relevant emotions, i.e., fear and anger, which mediate the relationships between social media exposure and personal-level risk perception as well as preventive behaviors related to MERS. The authors suggested that social media exposure during an infectious disease outbreak can prompt strong self- relevant emotions and raise personal-level risk perception and preventive behaviors. The current study affirmed results that accompanied an uncertain and uncontrollable event for the public. This supports Oh et al's conclusion of social media usage as both presentation of factual information and the more emotion-filled communication regarding crises in public health and response to those.

Uncertainty and Communication

Harrington (2015), quoting Babrow and colleagues, identified sources of patients' uncertainty such as complexity of the illness, quality of information, and structure of information which play great roles in dealing with their disease. Harrington noted that patient uncertainty is an uncomfortable state for humans, with the assumption that uncertainty is always a bad thing. Harrington also maintained that, "effective communication about illness can help patients to feel more certain about their diagnosis, treatment, and social aspects of their disease, which may lead them to better deal with the challenge of their illness." (p.184). More so, humans will experience uncertainty about a variety of life experiences (including illness). Therefore, they often strive to manage uncertainty through interpersonal communication with family, friends, and healthcare providers.

Thompson et al. (2003) provided further clarity with management of uncertainty while noting the centrality of it within an experience of illness and the role that expectations play in facets of illness. Thompson et al. also noted uncertainty in communication management that stems from the basic need for information-seeking with illness and the fact that patients cope with their uncertainty in the face of illness within the framework of their values.

This study observed a tendency for patients to conceal the truth of their disease or health conditions during an interview, and also looked at how doctors deal with these issues. As many individuals fail to disclose the truth for fear of being stigmatized by the people around them, there has been

exacerbation of the country's persistent struggles with containment, testing, and tracing of the virus. Thus, many cases in the country remain undetected (Syakriah, 2020). Many doctors encountered patients who concealed their experience or lied about feelings and actions before coming to the hospitals. Similar to Dewa and Kilkenny (2020), mental health stigma is a significant barrier to treatment seeking and hampers receipt of a proper diagnosis.

Information regarding COVID-19 has spread quickly, continuously, and massively through the Internet and social media platforms (Ali et al., 2021). This may contribute to stigmatization and trigger excessive fear, which ultimately worsens the patient's physical and mental condition. Ahmed and Bates (2013) noted the role of mass media in shaping understanding of the experience of illness and health outcomes. In recent months, new cases of hospitalized COVID-19 patients in Indonesia have increased significantly (Amindoni, 2021) As these numbers increase, doctors and healthcare workers in the country become overwhelmed handling COVID-19 patients, due to many patient deaths (Rizal & Nugroho, 2020).

Pavlova and Berkers (2020) examined doctor-patient communication and its relationship to the stigmatization of COVID-19. This study casts a broader net of assessing the general public's (i.e., patients') understanding of social stigma, reasons they conceal truthful information, and the impact of uncertainty within provider-patient communication.

Aim and Objectives of Study

The aim of this study was to understand how doctors communicate and cope with their patient dishonesty during an outbreak such as COVID-19. This is important since doctors can make an effective and accurate diagnosis only if their patients and or their relatives are being open and honest about their illness. This study had the following research questions:

RQ1: How are doctors communicating and coping with mental health issues, i.e., stigma, because of COVID-19?

RQ2: Can the stigma of COVID-19 prevent patients and survivors from being open and honest about their illness?

RQ3: How do physicians improve the quality of their communication with patients related to the stigma of COVID-19?

RQ4: Does fake information trigger the stigmatization of COVID-19 and how are doctors trying to neutralize it?

Methods

In order to answer the above research questions, a mixed-methods approach was used to integrate the strengths of qualitative and quantitative data and reduce the constraints of both approaches (Creswell, 2018). As noted by Shorten and Smith (2017, p.74), the mixed-methods approach

allows the researchers to seek a more comprehensive understanding of the study area by examining occurrences from many angles and through various research lenses. In this study, an explanatory sequential method was used as a research design in which quantitative data was first acquired and evaluated, then qualitative data was obtained and analyzed to further elucidate the quantitative data. All the study participants gave their consent to participate in writing and they submitted it in a prepared answer format.

Quantitatively, online surveys (N = 221 with the respondent's characteristics in Table 1) were circulated using a frequency distribution table with central tendencies (mean, median, mode and sum) and a Likert scale that has five-option answer: strongly agree, agree, doubtful, disagree, and strongly disagree. A number of multiple-choice questions were also provided in order to find out the respondents' opinions (with three-option answer: in favor of, opposed, and no opinion). The surveys were conducted from August 31, 2020 to September 5, 2020 using the social media platform, Whatsapp Group (WAG), by providing informed consent through the knowledge and permission of the group administrators for ethical considerations. WAGs include membership of general practitioners, specialists, or a mixture of both. Inclusion criteria were men and women aged over 23 years (+23). Doctors who had or are still actively treating COVID-19 patients also participated voluntarily in this research project. The questionnaire had three question themes which were presented at the same time during the distribution of the questionnaire (see Table 3).

Qualitatively, two separate Focus Group Discussions (FGDs) were conducted. The first FGD was organised in Jakarta on 24th January 2021 using Google meet application, which involved five physicians with different specializations and places of practice (Table 2). The physicians in the FGD have not participated in the quantitative survey. The FGD with four patients and/or their families was carried out the following day. All participants in the two FGD did not know each other, but the physicians were often interacting and treated patients with suspected COVID-19. The FGD was established in a semi-structured interview format where three of the researchers were medical doctors and the other two were communication experts. Questions for the group were per the three central themes of the survey questionnaires. In February 2021, another interview was conducted with four COVID-19 survivors or their family members. This small number (n=4) of interviews took place due to accessibility but was considered important to clarify and confirm information from the above FGD. All names of informants/participants who were interviewed individually or in the group discussion were anonymized for ethical consideration. Due to government regulations during the pandemic, both FGDs and interviews were organized through Zoom. After conducting the FGD with four patients and/or their

families, they were interviewed separately the following week in February 2021 in order to clarify and confirm details from the particular FGD.

Table 1. Characteristics of Respondents (n = 221)

Characteristics of the Physician		N	%
Sex	Male	85	38.5
	Female	136	61.5
Age	<24 years	5	2.0
	25 – 29 years	34	15.4
	30 – 39	46	20.8
	40 – 59 years	103	46.6
	60+ years	33	14.9
Plc of Practice	Public Hospital	158	71.5
	Private Clinics	28	12.7
	Others (Univ. etc.)	35	15.8

Table 2. Characteristics of the FGD Participants (n = 5)

Panellist	Sex	Age	Specialization	Place of Practice
Informant 1	Male	38	Cardiologist	Public Hospital
Informant 2	Male	34	Internist	Private Hospital
Informant 3	Female	27	General Practitioner	ER in Public Hospital; Private Clinic
Informant 4	Male	29	General Practitioner	Public Health Centre
Informant 5	Female	26	General Practitioner	Inpatient Ward in Public Hospital

Table 3. The Questionnaires and Thematic Results

No.	Questions	Answers	
Theme #1: COVID-19 stigma and the patient's openness			
1	During anamnesis, I have encountered patients who aren't transparent/dishonest about their medical records	● Strongly agree: 14% ● Agree: 60.2%; ● Doubtful: 9%	● Disagree: 15.4% ● Strongly Disagree: 1.4%
2	Can you state from every 10 patients you encounter, how many of them do you think aren't open or dishonest?	● 1-2 patients: 55.2% ● 3-5 patients: 27.1%	● 6-8 patients: 10.9% ● None: 3.6%

3	Usually a patient's lack of transparency (being uncertain/ vague) happens because they might be experiencing a certain disease. What do you think those diseases are? (you can choose more than one option)	● Chronic diseases, e.g., diabetes, hepatitis, etc.:38 ● Diseases related to sexual behavior: HIV/AIDS, etc.: 195	● Diseases with a stigma, e.g., TBC, COVID-19: 160 ● Pandemic diseases, e.g., COVID-19: 121 ● Others: 32
Theme #2: Patient-physician Interaction/Communication			
4	There are some assumptions that due to bad communication between doctors and patients, they might doubt the doctor's competencies and diagnosis.	● Strongly agree: 18.1% ● Agree: 70.1% ● Don't know: 3.7%	● Disagree: 8.1% ● Strongly Disagree: 0%
5	Do closed off or dishonest patients hinder your efforts in diagnosing them?	● Strongly agree: 57.9% ● Agree: 39.4%; ● Doubtful: 3%	● Disagree: 1% ● Strongly Disagree: 0%
6	What are the effects of a patient's dishonesty or lack of transparency to your diagnostic process?	● VVery difficult to make a correct diagnosis: 30.8% ● IIt's a bit difficult, can lead to a misdiagnosis 50.7%	No problem, I have other ways to get the right information:6% ● NNo problem, tools can help to get information: 14%
7	How do you think information can be passed on correctly to avoid scaring the patients? (you can choose more than one option).	● Explain what it is, according to the outlined SOP: 142 ● Due to limited time, it is enough to explain the principles and ask assistants or nurse to explain in detail: 28	● Listen more from patients and their families: 76 ● PPersuasive approaches, particularly those "patient centered": 173; Others: 27
8	Experts state that communication between doctors and patients needs to get rid of the uncertainty experienced by patients. Please select the cause of "uncertainty" that you think is important (there can be more than one choice)	● Disease complexity: 116 ● Quality of information obtained (from various parties): 154 ● MMisleading information from media/social media: 163	● The patient's disease prognosis: 70 ● OOthers, none of the abovementioned: 24
Theme #3: Information and Stigmatization of COVID-19			
9	If a patient receives correct information, they may change	● Strongly agree: 35.3%	● Disagree: 0.7%

	their attitude. In turn, they will be more open to doctors.	● AAgree: 57%;	● SStrongly Disagree: 0% Don't know: 7%
10	If patients aren't open or dishonest to their doctors, what do you think might be the cause? (you can choose more than one option)	● Shame, fear of being ostracized by family, neighbor, friend: 175 ● Lack of correct information from doctors or hospitals: 85 ● Poor communication between doctors and patients: 67	● Many reports that the patient is often bullied, alienated by the environment: 146 ● The assumption that anyone who has the disease is considered a bad person: 129
11	The old media and social media play a role in extending information to the public. This results in the risk of misinformation when news is falsely reported, which in turn harms many people. What do you think should be done? (You can choose more than one option).	● It can mislead audiences: 128 ● It can lead to stigma and discrimination in society (e.g., COVID-19 disease): 150 ● Journalism ethics really need to be upheld: 102	● Doctors need to improve communication skills & media literacy: 148 ● Society needs to improve their media literacy: 112

Note: All the above questions are originally written in Indonesian

Results

The researchers examined a total of 221 medical doctors and interviewed four COVID-19 survivors or their family members. Table 1 reveals participant characteristics in sex, age, and setting of practice. Table 2 indicates the same characteristics with FGD participants. 46.6% of physician respondents were between 40 to 58 years old. All practice settings were in Jakarta area, with most study respondents living in Jakarta, the capital city and the epicenter of the COVID-19 outbreak in Indonesia.

Quantitative Findings

Table 3 illustrates response ranges for the eleven questions to participants according to three main themes per the research questions. Summary of those responses are outlined in narrative description, which is followed by summary in Table 4.

74% of respondents   encountered patients with lack of honesty or openness about their health condition. 55% stated that 1-2 patients out of every 10 patients lied or covered up about their illness, 27% physicians

indicated 3-5 of 10 patients not telling the truth, while 10.9% noted that 6-8 of 10 patients did not speak the truth about their illness condition. 195 doctors believed that some patients who have diseases related to sexual behaviour (e.g., HIV/AIDS) were untruthful about their condition.   38 respondents indicated patients may have chronic disease, e.g., diabetes and hepatitis. 195 respondents indicated patients' diseases with a stigma, e.g., tuberculosis and COVID-19, were untruthful about their disease condition. 121 physicians thought patients had pandemic diseases, including COVID-19.

Through physicians-patient communication/interaction, 88.2% affirmed that patients may doubt doctor's competence and diagnosis because of poor communication between doctor and patient. 97.3% presumed that dishonest patients may hinder the doctor's efforts in diagnosis of physical and mental conditions, which may interfere with the doctor's duties. 30.8% of respondents noted considerable difficulty for correct diagnosis because of this, while 50.7% indicated possible misdiagnosis and 6% stated that there was no communication problem.

With delivery of correct information to avoid patient fear, 173 use persuasive approaches. In addition, 142 doctors also explain from outlined Standard Operating Procedures (SOP). The results reveals that 76 doctors would listen more to patients and their families, while 28 respondents explain only the principal information and ask nurses or assistants to give details. Respondents considered "uncertainty" to stem from misleading information from media/social media (163), quality of information obtained from various parties (154), disease complexity (116 respondents), and patient's disease prognosis (70).

With the influence of accurate and fake news towards stigmatization of COVID-19, 92% of respondents agree that a patient's attitude may be changed with more openness to doctors' receipt of correct information. 175 doctors stated reasons as patient embarrassment or possible ostracization from family, friends, and neighbours. On the other hand, 146 respondents noted that the patient is often bullied and alienated by the environment due to news reports from media/social media. 85 doctors perceived a lack of correct information from doctors or hospitals, with 67% perception of poor doctor-patient communication. 129 respondents noted an assumption per media/social media that anyone with the disease is considered a "bad person". The term "bad person" was closely related to certain negative feelings which originated from, or linked to, fear or resentment, or both.

Finally, respondents gave opinions regarding harm to people from false reporting of accurate news. 150 contended that it can lead to stigma and discrimination in society, e.g., COVID-19 disease. 148 stated that doctors need to improve their communication skills and media literacy. 128 indicated

that false reporting can mislead audiences. 112 doctors suggested society's improvement of media literacy and 102 respondents noted the need for journalism ethics to be upheld.

Table 4. Summary of Quantitative Findings

Finding	Description
Doctor's response on patient behaviour toward COVID-19 stigma	● 92% reported that patients lied, covered up, or did not tell truth about their illness condition. ● 74% reported patients' lack of honesty/openness about health conditions. ● Perceived issues for lack of honesty related to sexual behaviours, chronic disease, diseases with stigma such as tuberculosis or COVID-19, and presence of pandemic diseases such as COVID-19.
Doctor's response on physician-patient communication/interaction.	● 97.3% presumed patients' dishonesty could hinder diagnosis. ● 88.3% affirmed patients' doubt of doctor's competency/diagnosis due to poor communication. ● 50.7% reported possible misdiagnosis per poor communication. ● 30.8% noted considerable difficulty to correctly diagnose. ● 6% perceived no problem per communication.
Delivery of correct information to avoid patients' fear.	● 78.3% used persuasive approach while 64.2 % used referencing Standard Operating Procedures. ● 34.3% would listen more to patients and families. ● 12.7% would explain only the principal information and ask nurses/assistants to give details.
Perceived sources of uncertainty for patients	● 73.7% misleading information from media/social media. ● 69.7% quality of information from various parties. ● 52.5% per disease complexity ● 31.7% patient's disease prognosis

Influence of accurate and fake news towards stigmatization of COVID-19	● 92% patient attitude could be changed with more openness to doctors' receipt of correct information. ● 79.2% influence per patient embarrassment or possible ostracization from family, friends, and neighbours. ● 66.0% news reports of patient bullying and alienation by environment. ● 58.4% assumption per media/social media that anyone with COVID-19 is a "bad person" per negative feelings of fear and/or resentment. ● 38.5% lack of correct information from doctors or hospitals.
Perception of harm from false news reporting	● 67.9% can lead to stigma and discrimination in society. ● 67.0% doctors need to improve communication skills and media literacy. ● 58.0% false reporting can mislead audiences. ● 50.7% need for society to improve media literacy. ● 46.1% need for journalism ethics to be upheld.

Qualitative Findings

With patient behaviour towards COVID-19 stigma, 30–40 % of the participants noted lack of truth from patients. When patients first arrived, they covered up their illnesses. However, findings from lab tests such as lung X-rays or swab tests were COVID-19 positive. A respondent noted "Some consider it a disgusting disease with fear of being ostracized. Consequently, COVID-19 patients going to the hospital tend to cover up their illnesses."

One participant cited near respiratory failure for many patients where families stated uncertainty about the cause until further inquiry produced knowledge of positive COVID-19 status. The respondent noted possible causes from stigma - "the patients are treated at home, but when it becomes critical, he/she is taken to the hospital; but because it is too late, the patient finally dies." One respondent indicated 30% of his patients denied the reality of their condition and gave an example "*the patient said, 'I didn't have a fever, I had nothing.' Thus, he looked for justifications or looked for other causes to his complaints in the effort to escape from being diagnosed as COVID-19.*"

Based on physicians-patient communication, most participants confirmed difficulties with COVID-19 patients being untruthful or suppressing their disease condition. Informant 1 noted that patient concealment when diagnosed would prolong the examination process and raise potential for transmission to more people. Informants 2 and 5 noted difficulty in establishing differential diagnosis between upper respiratory tract infections, pneumonia, and COVID-19. Informant 4 indicated that stigmatized diseases such as COVID-19 require transparency, stating that: *"Since COVID-19 has become a pandemic case, it must become the first differential diagnosis every physician concludes in the earlier step of the diagnosing process, prior to making a definitive one*."

Additional reasons for patients' concealment of condition were stigma, dread of isolation and loneliness, or perhaps a natural introverted patient personality. Informant responses included patients seeking second physician opinions to find desired answer, fear of declaration as a COVID-19 patient and resultant disgrace or embarrassment, fear of death from COVID-19 per the current burial protocol, and need for a clear story from the patient and family with a trusting doctor-patient relationship.

Participant opinions varied on misinformation and fake news about stigmatization of COVID-19. Opinions included perception of hoaxes circulating through social media, difficulty from media channels with disseminating information, need for doctors to educate the public about COVID-19, and for government agencies to conduct more frequent blasting of information related to hoax news on COVID-19.

The four patient/family interviews included additional insight with two informants seeming to hide their health conditions and two apparently unafraid to tell the truth to doctors and healthcare workers.

- One survivor said "*COVID-19 is real even though the symptoms are different and contagious, and until now the disease is scary but not as frightening as in previous months*". This informant revealed that the experience of exposure to COVID-19 in early December 2020 was very unpleasant. She experienced negative social treatment in her neighbourhood after returning home, even though she was cured.
- A second informant stated that his symptoms were not severe but prolonged, i.e., "*it took the whole month for his body to return to normal*." The attitude and views of co-workers were very uncomfortable when the informant was still positive for COVID-19 even though results of his smears were negative.
- The third informant indicated sadness because her mother died in the emergency room due to lack of treatment place as many hospitals were fully occupied. In regard to stigma, she reported that colleagues in her office stated that COVID-19 was a disease of many sinners.

● The last informant had a child with COVID-19. With initial exposure, this child experienced cough and fever. Physician examination revealed positive results from a throat and anal swab test. At first, the informant was very shocked with confirmation of her child having COVID-19 but did not consider it a shameful disease - "*I consciously shared all my child's symptoms with the doctor because I wanted a quick diagnosis so that the doctor could give the right medication.*"

Representative responses from qualitative data collection are presented below in Table 5.

Table 5. Summary of Qualitative Findings

Finding	Representative Responses
Response on patient behaviour toward COVID-19 stigma	● Illness is covered up due to the perception of it as a disgusting disease with possible ostracization. ● Near respiratory failure for many patients with initial family uncertainty about cause. ● Families just keep patient in at-home treatment until critical, then go to hospital when it is too late and the patient dies. ● Patients claimed other causes for symptoms to escape COVID-19 diagnosis.
Response on physician-patient communication/interaction.	● Patient concealment prolonged diagnostic process and raised potential for transmission to more people. ● Difficulty with differential diagnosis between upper respiratory tract infections, pneumonia, and COVID-19. ● Stigmatized diseases such as COVID-19 require transparency. Therefore, it should be the first differential diagnosis before making a definitive diagnosis.
Additional reasons for patients' concealment of condition	● Stigma, disgrace, or embarrassment per a COVID-19 diagnosis ● Dread of isolation or loneliness ● Natural introvert patient personality ● Patients seeking a second physician opinion ● Fear of death due to the current burial protocol ● Need for clear story from the patient and family with a trusting doctor-patient relationship.

`	●73.7% misleading information from media/social media ● 69.7% quality of information from various parties ● 52.5% per disease complexity ● 31.7% patient's disease prognosis.
Influence of accurate and fake news toward stigmatization of COVID-19	● Perceptions varied on misinformation and fake news about stigmatization of COVID-19. ● Opinions included - Perception of hoaxes circulating through social media - Difficulty with media channel dissemination of information - Need for doctors to educate the public about COVID-19. - More dissemination of information from government agencies about possible hoax news.
Input from patient/family interviews	● Disease was more frightening to recipients during early months due to more negative social treatment upon returning home, even after been cured. ● Symptoms not severe but prolonged – a whole month for the body to return to normal. ● Avoidance attitude by co-workers, with some stating that COVID-19 was a disease of many sinners. ● Sadness per death of a mother in an emergency room due to lack of treatment space and full hospital occupancy. ● Shock upon learning that respondent's child had covid. The respondent consciously shared all symptoms with doctor to get quick diagnosis and treatment per cough and fever of the child.

Discussion

This study provided answers to each of the research questions as indicated by further discussion below.

RQ1: How are doctors communicating and coping with mental health issues, i.e., stigma, because of COVID-19?

Research indicates that most doctors understand patient embarrassment and fear of ostracization by family, neighbours, and friends.

146 doctors associated the stigma with media/social media, which results to patients being bullied or alienated by their environment. 129 physicians related this to media/social media assumptions that anyone with the disease was a "bad person". 85 respondents indicated lack of correct information from doctors or hospitals, and 67 respondents identified poor communication between doctors and patients.

RQ2: Can the stigma of COVID-19 prevent patients and survivors from being open and honest about their illness?

This research has shown a tendency for patients to hide the truth of their signs of disease or health conditions during interviews with doctors. Both quantitative and qualitative data reveal that many individuals are reluctant to disclose their true positions for fear of being stigmatized by the people around them. Findings indicate that doctors agree that stigmatization of COVID-19 prevents patients and survivors from being candid and honest about their illness. Thompson et al. (2003) noted the tendency for people to assume that communication to others is true. Hence, there is a tendency for health care providers to conceal some truth from patients to avoid the harmful impact of "bad news."

RQ3: How do physicians improve the quality of their communication with patients related to the stigma of COVID-19?

Health care providers can improve the efficacy of provider-patient communication through self-disclosure on their part. Deering (1999) in Thompson et al. (2003) discussed the positive impact of provider self-disclosure to promote patient self-disclosure. Examples given were patient education and support for patients who require emotional catharsis. This support was especially beneficial in the context of delivery of bad news.

RQ4: Does fake information trigger the stigmatization of COVID-19 and how are doctors trying to neutralize it?

With the FGD and patient/family interviews, most doctors confirmed survey results of difficulty examining COVID-19 patients who hid their disease condition. One doctor noted hindrance in differentiation between similar symptoms with other illnesses such as usual upper respiratory tract infections, pneumonia, and COVID-19. Doctors communicate differently with such cases, such as emphasizing the need for a trusting doctor-patient relationship. This would help the doctor know everything with a clear story from the patient and family. More so, the patients can be guided about wrong medication or mistreatment, which could endanger the patient or prolong the treatment.

Limitations of Study

First, the research was only among physicians in Jakarta and did not cover the experience and perspectives of medical doctors from outside the

capital city. Second, the authors only delved into answers from doctors and have not sufficiently integrated the lens of patients. The survey was carried out among patients with 283 respondents. Nonetheless, the information has not been comprehensively included in this study, but rather provides a foundation for further research.

Recommendations for Further Research

The continuance of Covid problems per additional variants indicates the need to continue research into prevention efforts, efficacy of interventions already employed, or implications for additional interventions beyond these. Global impact of the pandemic indicates more opportunity for further research.

Conclusion

A prolonged crisis, such as the COVID-19 pandemic, threatens the lives of many people. However, this can provide opportunities to clarify and uncover creative ways for doctors to overcome challenges in communication with their patients. Literature highlights show the importance of openness in doctor-patient interaction. Synthesis of quantitative and qualitative data in this study shows strong relationship between stigma (based on Goffman's theory), interpersonal doctor-patient communication, and integration of a closed attitude of people stigmatized because of shame, anxiety, and fear. New empirical evidence outlines social effects of COVID-19 stigma. Firstly, social stigma creates a tendency for patients to hide their illness and be untruthful with their doctors, even with possible fear of death. Secondly, social stigma built up through mainstream media/social media can increase patient fear and anxiety about the negative effects of stigmatization. Overall, a number of COVID-19 patients and survivors have hidden their disease conditions with increased potential of danger for the patients themselves and those around them, such as families.

Based on the research questions and the purpose of this study, it can be concluded that during a crisis such as a pandemic, when patients are often socially stigmatized, it is imperative for doctors to find creative ways in communicating with their patients so as to enhance honesty and openness about their illnesses. By doing so, the result will not only comfort patients' mental condition but also help the physicians in producing effective and accurate diagnoses which, in turn, is also important to prevent further spread of the disease to their surroundings.

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