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Reducing stigma triggered by assessing smoking status among patients diagnosed with lung cancer: De-stigmatizing do and don't lessons learned from qualitative interviews

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Abstract

Objective: To characterize lung cancer patients' reactions to cancer care providers' (CCPs) assessment of smoking behavior and to develop recommendations to reduce stigma and improve patient-clinician communication about smoking in the context of lung cancer care.

Methods: Semi-structured interviews with 56 lung cancer patients (Study 1) and focus groups with 11 lung cancer patients (Study 2) were conducted and analyzed using thematic content analysis.

Results: Three broad themes were identified: cursory questions about smoking history and current behavior; stigma triggered by assessment of smoking behavior; and recommended dos

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Human rights

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed consent

The research was reviewed and approved by the MSK Institutional Review Board. Informed consent was obtained from patient participants in Study 2.

Welfare of animals

This article does not contain any studies with animals.

Declaration of Competing Interest

Authors Drs. Ostroff, Banerjee, Shen, Haque, Hamann, Lynch, Williamson, and Park declare that they have no relevant conflicts of interest.

and don'ts for CCPs treating patients with lung cancer. CCP communication that contributed to patients' comfort included responding in an empathic manner and using supportive verbal and non-verbal communication skills. Blaming statements, doubting patients' self-reported smoking status, insinuating subpar care, nihilistic statements, and avoidant behaviors contributed to patients' discomfort.

Conclusions: Patients often experienced stigma in response to smoking-related discussions with their CCPs and identified several communication strategies that CCPs can use to improve patients' comfort within these clinical encounters.

Innovation: These patient perspectives advance the field by providing specific communication recommendations that CCPs can adopt to mitigate stigma and enhance lung cancer patients' comfort, particularly when taking a routine smoking history.

Keywords

Smoking; Lung cancer stigma; Empathic communication; Patient-provider communication

1. Introduction

Patients diagnosed with lung cancer frequently report feelings of stigma —the experience and internalization of negative appraisal and devaluation from others [1]. Lung cancer is stigmatized primarily because of its causal association with smoking, leading to the perception of lung cancer as self-inflicted [2]. Greater lung cancer stigma has been associated with negative psychosocial outcomes such as higher depressive symptoms [3,4], higher anxiety [5], and poor quality of life [6] as well as worse patient-clinician communication appraisals [7,8]. Notably, a substantial proportion (48%) of patients report experiencing stigma from their cancer care providers (CCPs) [1] often triggered by taking a smoking history during routine clinical encounters [1]. Better understanding lung cancer patients' reactions to CCPs conducting a smoking assessment may inform clinician-focused recommendations to mitigate stigma during clinical encounters—a crucial step towards developing effective interventions to reduce lung cancer stigma [9] and promoting evidence-based tobacco assessment and treatment in lung cancer care.

Persistent smoking following a cancer diagnosis is associated with reduced treatment efficacy and higher morbidity and mortality [10]. However, patients report that in the context of cancer care discussions about smoking are sensitive topics that may trigger feelings stigma [1,11]. Patients report that discussions about tobacco are often very brief or sometimes do not occur at all [11] and others report experiences of being blamed for their smoking behavior or wrongly assumed to have smoking history [12,13]. Although most CCPs report conducting tobacco assessments with their patients [14,15] patients and CCPs acknowledge that assessing tobacco use may prompt feelings of stigma and discourage discussion of tobacco use [11]. Yet, many patients express an interest in having discussions about smoking cessation if the topic were to be approached sensitively [11].

Taken together, these findings underscore the need for recommendations for how CCPs can mitigate stigma and initiate smoking-related discussions sensitively during clinical

encounters with lung cancer patients. To this end, the goals of the current study were to conduct semi-structured interviews (Study 1) and focus groups (Study 2) to characterize lung cancer patients' stigmatized reactions to their CCPs' assessment of tobacco use and to elicit patient perspectives on specific dos and don'ts recommendations intended to reduce stigma and improve patient-clinician communication.

2. Methods

Our overall goal was to elicit patient recommendations for how CCPs can mitigate stigma and initiate smoking-related discussions sensitively during clinical encounters. For this paper, we aggregated data available from two complementary NCI-funded studies with the shared goal of gaining a better understanding of empathic communication and lung cancer stigma: Study 1 included 1:1 interviews conducted with patients immediately following the point of care within a single thoracic oncology cancer care setting; and Study 2 included several focus group interviews with patient volunteers nationwide who specifically responded to an email announcement eliciting sharing of stigmatizing clinical encounters. All procedures were reviewed and approved by the Institutional Review Board at Memorial Sloan Kettering Cancer Center (Study 1) and Weill Cornell Medicine (Study 2). Detailed information regarding study participants and procedures has been published elsewhere [8,16].

Both studies elicited stigmatizing interactions within different cancer care settings and allowed us to gather details about clinician-patient interactions at a Comprehensive Cancer Center and other cancer care settings. Our decision to combine the findings from these two studies was practical and intended to provide a rich narrative of relevant experiences. We also used the findings from the two studies to inform our clinician-targeted intervention on empathic communication skills training to reduce lung cancer stigma and the two studies provided for diverse viewpoints that were incorporated in the empathic communication skills training curriculum[17].

2.1. Study 1

We conducted semi-structured, individual interviews with lung cancer patients participating in a larger study examining lung cancer stigma in the context of cancer care. In brief, we recruited 56 lung cancer patients from Memorial Sloan Kettering Cancer Center. Patients were eligible if they a) were recently diagnosed with lung cancer (within 3 months); b) reported current or former smoking, c) spoke English; and d) were currently undergoing oncologic treatment with one of the physicians participating in the study. A research assistant completed a brief (15–20 min), semi-structured interview with each participant immediately following or within 3 days of their medical appointment. Participants were asked whether their CCPs assessed smoking behavior and about any stigma they may have experienced during the encounter. Interviews were audio-recorded and transcribed verbatim for subsequent coding [8].

2.2. Study 2

We also solicited input from a national panel of 14 lung cancer patient volunteers recruited by collaborators from the GO2 Foundation for Lung Cancer. Invitations were sent via an email to patient volunteers willing to help develop training materials for a planned communication skills training intervention for CCP treating patients with lung cancer. Eligibility criteria included patients: a) diagnosed and treated for lung cancer; b) who experienced a prior stigmatizing experience with a CCP; c) able and willing to participate in a conference call with other patients; and d) who currently smoking or formerly smoked at the time of their lung cancer diagnosis. Participants were asked if they ever felt judged (or guilty or blamed) for being diagnosed with lung cancer, and to describe that experience (if appropriate). They were also asked to describe their experiences discussing cigarette smoking with their physican and other CCP(s). Finally, participants were asked for their perspectives on dos and don'ts of taking a smoking history and discussing current smoking. The two focus group discussions were co-facilitated by the Principal Investigators (SB and JO) and audio-recorded and transcribed for thematic analysis.

2.3. Qualitative data analysis

Interview and focus group transcripts were coded by an interdisciplinary coding team, consisting of a qualitative methodologist (KL), and several of the co-authors (JO, SB, MS, NH, and MR). The coders were trained by the qualitative methodologist on thematic content analysis, a rigorous methodological approach in qualitative health research [18–21]. Data from each study were coded/analyzed separately (2 codebooks, 1 for each data source). In the first stage of the analysis, the coders independently read each transcript to identify key narrative content, creating and assigning descriptive and interpretive codes specifically focused on discussion of tobacco history and patient perceptions of stigma. To develop a robust codebook, the coders held regular consensus meetings with one another to reach agreement on code names, definitions, and assignment to content. After establishment of the codebook, the study team applied the codes to all transcripts and then engaged in a secondary analysis, involving consensus meetings to review, synthesize, and interpret the narrative content, organizing the codes into categories to identify major themes. In the final phase of the analysis, the qualitative methodologist reviewed the completely coded dataset to identify and describe the most prominent and salient thematic findings that emerged. In this final phase, codes were merged to ensure that each category contained a comprehensive and discrete set of clusters, which were then ranked according to their frequency (assignment to text) and distribution (endorsement across participants) within the dataset. The full set of quotes (or fragments of narrative content associated with a code) for the highest-endorsed codes in each category were then reviewed for identification of key themes. A cluster analysis of code associations was also performed to facilitate pattern recognition in the data. These themes were solidified through consensus meetings between the principal investigator and the qualitative methodologist, then approved by the entire coding team. NVivo Pro v.12, a qualitative analysis software, was used to facilitate the analysis.

3. Results

Participants in Study 1 had a mean age of 67.95 years (SD = 9.06). Most participants identified as white (*n* = 43, 76.8%), female (*n* = 33, 58.9%) and formerly smoked (*n* = 47, 83.9%). Twenty-seven participants had early-stage lung cancer (48.2%), 21 had later stage disease (37.5%), and stage of disease was unknown for 8 participants (14.3%). The majority of participants in Study 2 identified as white (*n* = 10, 83.33%), female (*n* = 11, 91.67%) and formerly smoked (*n* = 12, 100%). Stage of disease was not assessed for Study 2 participants.

Below, we describe the combined findings of qualitative interviews conducted in Study 1 and Study 2. Three broad themes were identified: cursory tobacco use assessment (Theme 1); stigma prompted by routine assessment of smoking behavior (Theme 2); and recommended dos and don'ts for CCPs treating patients with lung cancer (Theme 3). Theme 1 was only identified through the interviews conducted in Study 1. Themes 2 and 3 were identified through the interviews in Study 1 and the focus groups in Study 2. Themes 2 and 3 were extracted from interviews with the subgroup of Study 1 patients who reported that their CCP had discussed smoking with them during their clinical encounter.

3.1. Theme 1: Cursory tobacco use assessment (Study 1 only)

In Study 1, 25 out of 54 patients indicated that there was little to no mention of their smoking history during their medical consultation, and four patients stated that they could not remember whether tobacco use was discussed. Among the 25 patients who reported some discussion of tobacco history, nine noted that the discussion was superficial, brief and experienced as perfunctory.

Patients generally interpreted a lack of attention to their smoking history to mean that smoking history was not seen as a clinical priority. As one patient remarked, "*I thought the doctor was just thinking about the reason why I was here, which is treating my recurrent cancer.*" Several patients noted that they had discussed their smoking history during a prior consultation with their CCP and interpreted this previous discussion as the reason for the lack of focus on tobacco use during the most recent consultation. Others speculated that the lack of discussion may have been because they had smoked "*a very long time ago.*" Generally speaking, patients were somewhat relieved when smoking was not raised and did not express concern over a cursory tobacco use assessment. In the words of one patient, "*I was anxious to hear what his opinion was in terms of my condition, not re-hashing my smoking history.*" On the other hand, the limited amount of time spent discussing smoking appeared to diminish patients' perception of its clinical importance. Avoidance of attention to smoking led some patients who reported current smoking to infer that their smoking history and current smoking behavior were not relevant to their clinical management.

3.2. Theme 2: Stigma prompted by routine assessment of smoking behavior (Studies 1 and 2)

In Study 1, although most participants denied experiencing stigma from their CCP, some patients who discussed smoking history reported feelings of guilt, shame, or perceived stigma. While participants expressed that their CCP was generally non-judgmental and

comforting during the consultation, feelings of stigma arose from the discussion about smoking (even in the absence of stigmatizing interactions with CCP). According to one patient, ""*He [my doctor] really wants me to stop. I agree with him… I mean I'm an outcast. Smokers [are] outcasts.*" Another patient expressed guilt about the duration of her prior smoking during discussion with her CCP: "*I had a little bit of mild guilt, I always do, because of the fact that when I was smoking I knew there was a risk of serious problems down the road, and yet I didn't quit until about 10 years ago.*" Some participants also expressed guilt about their perceived inability to quit, despite their CCP's recommendation. In the words of one participant: "*I felt guilty because they've been telling me to stop smoking for a while, but I just can't seem to stop.*"

In Study 2, participants described their experiences with stigma triggered by discussions about smoking with CCPs. The most frequently described example of stigma was when participants reported negative statements of judgment or blame. For instance, one patient said, "…*if you've got a doctor saying, 'You know, if you hadn't smoked, you wouldn't be here and you probably wouldn't have to go through all this…*'" Some participants also described perceiving harsh condemnation because of their smoking history. One patient described both verbal and non-verbal communication behaviors that signaled a demeaning attitude of CCPs towards lung cancer patients, "…*When I learned it was lung cancer, they said, 'Well, you smoked, you know?' And they even had the same nonverbal response where they would shrug their shoulders, turn their hands palms up, and they didn't even need to say 'Well, what did you expect?'*"

3.3. Theme 3: Recommended dos and don'ts for CCPs treating patients with lung cancer (Studies 1 & 2)

Participants readily described several observations regarding verbal and nonverbal communication that contributed to their comfort during clinical encounters with CCPs. They also highlighted communication styles that intensified perceptions of blame and judgment. Table 1 presents exemplar themes and subthemes (with illustrative quotes) describing communication patterns that contributed to comfort (dos) as well as patterns that prompted discomfort (don'ts).

Dos: Overall, four themes emerged describing comforting, engaging and non-judgmental communication styles: (1) Responding in an empathic manner (i.e., patients described empathic statements that they experienced or wished their CCPs had during discussions, e.g., "*I think they should just be warm. And empathic. And I think that it helps if an oncologist sits beside the patient rather than behind the desk. And if he touches the patient. I think that really is very meaningful*"); (2) Use of supportive communication skills (i.e., participants described that providing a rationale for assessing smoking can help create a comfortable welcoming environment for open, genuine communication about this challenging topic, e.g., "*And listening, explain that… 'Here's a list of questions that we ask all of our patients*'"); (3) Non-verbal communication skills such as maintaining good eye contact and active listening create a safe and supportive environment (e.g., "*He was sitting there and had good eye contact; not embarrassed for asking me, not embarrassed with my answers.*"); and (4) Participants made training suggestions to bolster empathic

communication (e.g., "*And the medical professionals that are coming in contact with patients need to be educated about what it means to a patient that has lung cancer to be confronted with that, whether they were a smoker, whether they weren't a smoker, if they're currently a smoker, if they're a former smoker, they need education.*").

Responding in an empathic manner was further broken down into four subthemes. First, participants noted appreciation for a direct approach to tobacco use assessment that includes providing clear rationale, normalizing the clinical importance of taking a smoking history and acknowledging that discussion of smoking history can be a sensitive topic. By introducing assessment of smoking history as standard clinical procedure without judgment, participants did not feel that they were being singled out or ostracized. Second, some participants requested acknowledgment that lung cancer has multiple risk factors (environmental exposure - e.g., radon, family history) and that some people who never smoked cigarettes can get lung cancer. Additionally, participants appreciated when their CCP was straight-forward and matter-of-fact about the dangers of smoking without adding moral commentary. Third, participants who reported current smoking wished that their CCPs would more fully acknowledge their longstanding struggles with nicotine addiction and stress-related quitting challenges. Several older participants noted that they began smoking at a time when smoking was common in the United States, and they appreciated CCPs who recognized the generational shift in smoking norms and attitudes. Fourth, participants expressed a desire for CCPs to respond empathically when they receive distressing information about their disease and give patient the time to digest the news before initiating a smoking-related discussion.

Use of additional **supportive communication skills** was divided into seven subthemes. First, participants appreciated when the CCPs showed interest and asked open-ended questions about their overall physical and emotional well-being, including challenges faced while receiving oncologic treatment. Second, participants also commented favorably when their CCP gave them adequate time to ask questions. Third, participants noted that CCPs should provide a clear rationale for asking smoking-related questions, particularly when smoking history may have been previously assessed and documented. Fourth, participants value CCPs who gave them hope for the future. Fifth, participants expressed that CCPs should present their patients with tobacco cessation support and other quitting resources (not simply quitting advice). Some participants noted that hard-hitting, fear-arousing threats to quit smoking can come across as judgmental, demoralizing, leading to patient defensiveness and avoidance. CCPs should provide relevant information about the cancer-specific benefits of cessation and encourage use of cessation medications and behavioral support resources. Sixth, participants expressed relief when their CCP listened without judgment or pejorative comments about their past smoking behavior. Seventh, participants appreciated when CCPs tried to create a personal connection by using light, self-effacing humor, to establish rapport and ease the tension when discussing difficult subject matter.

The third theme for Dos described non-verbal communication behaviors that created a comfortable space for the CCP and patients to have a conversation about smoking (Study 1 only). Three non-verbal behaviors were described including maintaining good eye-contact

and sitting at eye-level with the patient, maintaining a body position that is oriented towards the patient, and maintaining consistent and caring tone.

The final theme for Dos centered around suggestions for **CCPs to receive additional training and education** to bolster CCP empathy and support (Study 2 only). This was further divided in two subthemes. Participants commented that CCPs should receive 1) empathic communication skills training and 2) additional training on nicotine addiction and strategies for engaging patients struggling with tobacco dependence.

Don'ts.—Overall, five themes emerged describing communication patterns to avoid when discussing smoking history. First, participants noted that CCPs should not make blaming statements about smoking and lung cancer diagnosis (e.g., "*She looked right at me and she said, 'Well, did you smoke? Is that why you had lung cancer*"). Second, some participants urged that CCPs should not doubt or second-guess patients who report never smoking or having quit smoking many years ago (e.g., "…*And he said to me, 'Well, you're still smoking, right? You're sneaking some cigarettes. You're having an occasional cigarette.' And I said, 'No, I'm not.'*"). This invalidating behavior creates an impression that the CCP does not trust the patient to accurately report their behavior. Third, some participants described that CCPs should not make fear-arousing threats that patient care will be negatively impacted by current smoking status (e.g., "…*he said, 'Yeah, no, I'm not going to operate on you because you have lung cancer because you smoked, and you're going to die within six months'*"). Fourth, CCPs should not be nihilistic and negate hope attributable to patients' smoking ("*the damage is done*"). Fifth, participants described that CCPs should not engage in avoidant behaviors towards patients such as avoiding eye contact, shrugging, eye-rolling or rushing out of the room (e.g., "…*but I've noticed that even healthcare professionals will, when they're talking to someone with breast cancer will move towards them. When they talk to someone with lung cancer, I've noticed they step back.*"). Some patients interpreted a CCP's brusque or dismissive demeanor as interpersonal discomfort or unspoken judgment about smoking history.

4. Discussion and conclusion

4.1. Discussion

Collectively, these qualitative findings provide a deeper understanding of lung cancer patients' perspectives on smoking-related discussions with their CCP. Consistent with prior research, the first theme derived from Study 1 was that smoking-related discussions were often cursory and lacked clinical explanation of the importance of assessing and treating tobacco use in the context of high-quality lung cancer care [11]. Considering that current best practices for cancer care delivery emphasize assessing current smoking status and advising all patients who currently smoke to quit, Theme 1 represents a modifiable error of omission easily remedied with professional education and training in brief tobacco assessment and treatment. Additional research is needed to understand the nature of CCP discomfort in addressing smoking, as well as knowledge deficits regarding the safety and effectiveness of tobacco treatment [11,15]. CCPs report inadequate training in tobacco use and dependence treatment [14,15] high-lighting the importance of increased education and

training for smoking cessation in cancer care [22]. The Theme 1 finding strikes a cautionary note for CCPs who may have good intention for avoiding a potentially up-setting discussion about smoking but may not fully appreciate the deleterious effects of giving short shrift to cessation counseling.

A potential reason why the theme of cursory tobacco use assessment emerged in Study 1 but not in Study 2 is that participants in Study 1 were all asked about whether they had a discussion with their CCP about smoking during *the specific clinical encounter* that preceded the interview, whereas participants in Study 2 were asked to reflect on *all of their prior stigmatizing interactions* with CCPs. Some participants in both the studies expressed frustration about the frequency or time CCPs spent revisiting their smoking history without a clear rationale for repeated assessment. Participants from Study 1 seemed relieved when smoking-related discussions were brief, suggesting that patients might have been anxious about or anticipating stigma from smoking-related discussions with their CCP. It is essential for CCPs to share the clinical importance of assessing and treating tobacco dependence in the context of cancer care [23]. These findings underscore the need for adoption of de-stigmatizing communication strategies that CCPs can use to engage patients with lung and likely other cancers in sensitive discussions about the risks of persistent smoking and the benefits of cessation.

Consistent with prior qualitative research [1,12,13], the second theme revealed that routine assessment of smoking can prompt experiences of lung cancer stigma. That said, similar to prior work, there was considerable variability in the extent to which participants in Study 1 reported experiencing stigma during clinical consultation with CCPs [24]. Across both studies, participants expressed feelings of internalized stigma (e.g., guilt), perceived stigma, and enacted stigma (e.g., unfair or harsh treatment) supporting the conceptualization of lung cancer stigma as multifaceted [6,9]. Research is needed to better understand the impact of lung cancer stigma on patient-clinician communication and engagement outcomes. Empathic communication skills training may be beneficial for reducing stigma within the clinical encounter and may have downstream effects on strengthening the patient-clinician relationship and enhancing patient engagement and satisfaction with their cancer care.

Our third finding summarizes patient preferences and practical suggestions for how CCPs can communicate more effectively with lung cancer patients to mitigate stigma and increase patient comfort when discussing tobacco use. Specifically, our findings suggest that empathic, supportive, and non-judgmental communication skills may improve patient-clinician communication about smoking and could reduce stigma in the context of lung cancer care. Many of the communication skills identified are consistent with broad communication preferences expressed by cancer patients in other clinical contexts [25–27] such as allowing time to ask questions and demonstrating supportive non-verbal communication. However, several identified communication strategies are more specific to the clinical context of taking a routine smoking history in the context of cancer care, such as acknowledging the challenges of quitting, avoiding judgment/nihilism and blame, providing a cancer-specific rationale for cessation and repeated questioning about smoking, and offering cessation support and resources for tobacco cessation beyond quitting advice. Participants recommended that CCPs clearly recognize nicotine addiction and acknowledge

longstanding struggles with tobacco dependence. Several participants recommended that CCPs acknowledge marked generational changes in the societal norms about smoking. CCPs who treat patients with lung cancer are encouraged to adopt these recommendations. We also acknowledge that many of these suggestions are likely beneficial for broadly enhancing patient-clinician communication, particularly in the broader context of assessing and treating tobacco use among all patients diagnosed with cancer.

Patients expressed clear preferences for CCPS to refrain from using judgmental labels when assessing smoking history, including a preference for questions such as "*have you smoked cigarettes in the past 30 days*" rather than "*are you a smoker?*". This perspective is consistent with the broader clinical efforts and dissemination of resources to reduce illness-related stigma through the increased use of person-first language and other bias-free language in clinical care and research [28–31].

Regarding study limitations, participants in Study 1 were patients treated at a single institution with a strong emphasis on provider-patient communication whereas participants in Study 2 were patient volunteers recruited from the Go_2 Foundation for Lung Cancer. This difference was reflected in the findings, particularly regarding Study 2 patient experiences with stigma specifically triggered by discussions about smoking with CCPs. The experiences elicited from these two studies provides useful perspectives for raising clinician awareness and reducing stigma in smoking discussions. Second, all participants reported a prior history of cigarette smoking, so we did not capture the perspectives of patients with no smoking history. Third, we only focused on experiences of smoking-related stigma but did not probe about other sources of stigma (e.g., stigma due to race, ethnicity, smoking status). Future research in this area would benefit from inclusion of more diverse patient samples and to examine how intersectional stigma (i.e., stigma co-occurring from multiple marginalized identity sources such as race, ethnicity, smoking status, and lung cancer diagnosis) influences patients' communication preferences and perceptions of the patient-clinician relationship. Fourth, the participants in Study 2 self-identified as having prior stigmatizing interactions with their CCPs. This was important for the study to ensure that we captured perspectives of stigmatizing interactions; however, it is important to acknowledge that these patients likely experienced high levels of lung cancer stigma. Fifth, detailed demographic, smoking, disease and treatment characteristics were not collected. Finally, as we did not elicit perspectives of CCPs, future research is needed to ascertain the acceptability of these patient recommendations to CCPs treating patients with lung cancer.

4.2. Innovation

These findings add to the accumulating body of multi-level research that aims to reduce lung cancer stigma. A recent review cited the multiple untapped opportunities and the dearth of anti-stigma interventions in this area [9]. In particular, there is growing consensus of the need for greater awareness of the importance of using destigmatizing language among health care providers [29]. The International Association for the Study of Lung Cancer (IASLC) has recently published a Language Guide [30], for promoting best practices for destigmatizing language. The findings reported in this study play an essential role in guiding the development of an empathic communication skills intervention

for CCPs treating patients with lung cancer. Preliminary results have demonstrated the feasibility an acceptability of this empathic communication skills training module among CCPs who work with lung cancer patients [17,32]. These findings build upon our prior work demonstrating the strong association between perceived stigma and the quality of provider-patient communication [7]. Lastly, these findings have contributed to the success of a tobacco treatment training workshop targeting CCPs and found that CCPs report increased post-training self-efficacy when discussing smoking with their patients. [22] The patient perspectives reported in this paper greatly advance the field by providing specific communication recommendations that CCPs can adopt to mitigate stigma and enhance lung cancer patients' comfort, particularly when taking a routine smoking history.

Ultimately, the clinical goal is to integrate best practices for the empathic assessment and treatment of tobacco dependence as standard of high-quality cancer care. Consistently providing a clear and compelling rationale for smoking assessment and cessation advice coupled with adherence to a clinical guidelines whereby all cancer patients who report current smoking are referred for specialized and empathic tobacco cessation support is most likely to achieve the complementary goals of mitigating lung cancer stigma and promoting tobacco cessation in cancer care [33,34]. While the importance of advising cessation in the context of cancer care is well-established, this is the first paper to the best of our knowledge that provides patient-centered recommendations for how CCPs should communicate about smoking with their patients.

4.3. Conclusion

Lung cancer patient perspectives highlight how CCPs' routine assessment of smoking history can trigger feelings of stigma. These patient perspectives yield specific communication recommendations that CCPs can adopt to mitigate stigma and enhance patients' comfort. By following these patient-centered recommendations, taking a smoking history need not be a painful medical procedure.

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Table 1

Lung cancer patient recommendations about do's and don'ts that CCPs treating lung cancer ppPatients should use to improve communication and create de-stigmatizing interactions around smoking.

Themes/Sub-Themes	Description	Illustrative Example(s)
DO'S: Communication-Related Skills that CCPs Should Use with Patients		
1. **Responding in an empathic manner: Patients described empathic statements/responses that they had experienced or wished the CCPs had used in communication with them**.		
1a. Do **normalize** taking smoking history.	CCPs should provide clinical rationale and normalize the taking of a smoking history as a routine part of high quality cancer care.	- "The first oncologist that I saw at the small community hospital, the staff was very good with me. Everyone asked the question, 'Do you smoke?' and it kind of upset me for a while, and then the oncologist said, 'We ask everyone that question no matter what you have. It's just part of the standard of care and part of the stock questions that we ask. ' That made me feel a little bit better." [Study 2] - "Saying, 'This is a list of things we go over with all patients so that we can develop a treatment plan that meets your needs'" [Study 2]
1b. Do **acknowledge** the causal relationship between smoking and lung cancer, as well as other known and unknown risk factors for lung cancer.	CCPs should acknowledge that smoking is a likely contributor to lung cancer but that unfortunately people who never smoked and those who quit smoking years ago can get lung cancer.	- "The smoke... it [the cancer] is definitely from smoking. But [he said it] not in a judgmental way. He was very factual, and he was very kind about it. I was upset, but I felt relieved that he explained it to me, and that he was hopeful." [Study 1] - "I guess it depends upon the way in which it's approached. My oncologist once said to me, maybe I was feeling guilty, I don't know, but she once said to me, 'If you smoked when you were 26 years old and then quit when you were 27, your chances of getting lung cancer are just like everybody else.' And that made me feel better. I don't know if it was true or not, but it made me feel better." [Study 2] - "That [smoking history] wasn't even in the conversation [about symptoms, cancer]. But I would like to have some discussion about giving me a better understanding about how, even though you smoke, how it may have impact. Even if you stop for like 33 years, or 33 years ago, how it still could have some impact in terms of the disease. That conversation never really came up. [Study 1]
1c. Do **acknowledge** nicotine addiction and quitting challenges (for patients who smoke).	CCPs should acknowledge the addictive nature of smoking and challenges in quitting, as well as a shift in social norms/attitudes around smoking.	- "I mean I think he may recognize that some of us older people when we started, it was known that it was bad, but in those days, people smoked in the movies. They smoked on airplanes. They smoked in bars. It was a different world from what it is today." [Study 1] - "Back in the day when I was coming up, like [my doctor] and I talked about how she went to the store and was able to purchase cigarettes for her parents [asachild]. [...] Imean everybody Iknew smoked. " [Study 1] - ".and I was at the doctor's office with her, and her pulmonologist, I think he handled it very well. He said I'm looking at your records, and I see that you are a current smoker, and she said, 'Yes,' and he said, 'Well, I realize that it's very difficult if you've been smoking—especially if you've been smoking for, you know, several years, it's very difficult to quit, and would you be interested if I could help you to quit?' And my mother said, 'Well yeah, I would be interested.' And then he told her about different medications that would help her overcome her nicotine addiction, and I think he handled it very well." [Study 2] - "So saying, you know, 'Patient, we're here to help you. If you make a decision, if you have a concern that smoking is compromising your health, we're here to help you address that by all the different things that can be done to address nicotine addiction.'" [Study 2]
1d. Do **respond empathically** to patients receiving distressing information.	CCPs should respond in an empathic manner when patients receive serious news regarding their diagnosis.	- "I felt my oncologic nurse was a little abrupt. Wasn't very sympathetic...Just the way she talked to me. And answered my questions. With no warmth in her voice." [Study 2] - "I think they should just be warm. And empathic. And I think that it helps if an oncologist sits beside the patient rather than behind the desk. And if he touches the patient. I think that really is very meaningful." [Study 2] - "Acknowledging vulnerability, acknowledging that there are questions and will be questions and taking time to stop and actually listen to the responses and then take cues from there to see if you as a practitioner need to either clarify, amplify, or ask additional leading questions." [Study 2]
2. **Use of supportive communication skills: Patients described other communication skills that can be used by CCPs to help create a comfortable environment for the patients to communicate openly with their providers**.		

Themes/Sub-Themes	Description	Illustrative Example(s)
2a. Do ask more **open-ended questions** about patient experiences. [study 2 only]	CCPs should show interest in patients and ask them more questions about their treatment and other experiences.	- "I would expect they'd ask me more details, like 'What was your treatment?' or 'What did you go through?' and you know, 'How are you now?', 'Are you still receiving treat—' you know, that they would ask me some medical questions, but they never did. They never did." [Study 2] - "And I think another way to frame that is, you know, 'What are your challenges right now? Is there anything that you find challenging, you know, things that you want to talk about?'" [Study 2]
2b. Do allow patients time to **ask questions**. [study 1 only]	Most participants commented favorably on the fact that they did not feel "rushed" during the appointment and felt that their CCP took their concerns about smoking seriously.	- "[My doctors is] very caring, and makes me feel very special. I feel like I'm his only patient... and he gets specific with me and not generalized questions, answers about my smoking." [Study 1] - "He wasn't impatient as all. He didn't cut off my questions. No sense of being rushed, and that was important to me." [Study 1]
2c. Do **provide a rationale** for asking smoking-related questions.	CCPs should provide a reason/rationale for asking smoking-related questions, despite the fact that this information may be documented in medical records.	- "So instead of 'Were you a smoker, yes or no?' it's 'Do you have a history of smoking and can you tell me, you know, tell me if anyone in your family did?' And listening, explain that, you know, I like someone else's suggestion, I forget who it was, but 'Here's a list of questions that we ask all of our patients.'" [Study 2] - "...That is more helpful and it sounded also like that the—having the questions asked with an explanation or just a qualifier, like you know, 'I need to, you know, just complete this things' is helpful?" [Study 2]
2d. Do **offer hope**.	CCPs should provide hope to the patients, for their treatment and future.	- "The thing that I like, I told him how many years I had smoked [and] he said 'well, that's in the past.' You know, 'let's take it from now.'" [Study 1] - "My oncologist was wonderful. He said, 'I'm very hopeful for five-year survival,' and because he gave me hope, my hope blossomed." [Study 2] - "My oncologist said to my husband and I the first time I met with her and we had gotten the pathology back, she held one of our hands each, and she said, 'We're going to do beautiful things together,' and we have. That was three and a half years ago." [Study 2]
2e. Do **offer tobacco cessation and other resources (like support groups)**.	CCPs should offer tobacco cessation and other resources to patients, because the lack of support sends a negative message to patients about their care.	- "[He] never, never puts me down for smoking or drinking. We just discuss it, and he gives me again options and why I shouldn't smoke or why shouldn't drink or whatever it may be." [Study 1] - "I think, generally speaking, they give out the information that gives us facts. And then the next thing they should say is 'if you decide you want to stop, I'm here to help you.' And not just say that as a general term but list the things that [help]." [Study 1]
2f. Do **avoid judgment-laden questions. [Study 1 only]**	Patients expressed relief when their CCP listened to their smoking history without judging their behavior	- "He wasn't acting, using words that were judgmental [like] 'why did you start smoking? How come you smoked so long?" [Study 1] - "He didn't say, you know, 'why in the world did you do it?' or 'I'm fed up with treating these people who mistreated their bodies.' He didn't do any of that. He seemed to recognize that there are many good people who smoked, which is true." [Study 1]
2g. Do **create a "personal connection"** with the patient. **[Study 1 only]**	Patients appreciated how some CCPs mentioned mutual acquaintances or used light, self-effacing humor to establish rapport and ease the tension when discussing difficult subject matters.	- "I have been able to say to him exactly what's on my mind [...] even to the point of being able to interject a little humor." [Study 1] - "He mentioned people we knew in common. He didn't have to do that. And I thought he was attentive to me and not distracted and gave sufficient time, the amount of time that the situation warranted." [Study 1]
3. **Non-verbal communication skills: Patients described non-verbal communication skills that create a supportive environment for the CCP and patient to have a conversation [Study 1 only]**		
3a. Do **maintain eye contact** and sit at eye-level with the patient.	Patients felt that eye contact with their CCP made a significant impact on equalizing the power imbalance during the appointment and put patients at ease. Some patients also noted that eye contact was an indicator that the CCP was not embarrassed by the patient's past smoking history.	- "He was sitting there and had good eye contact; not embarrassed for asking me, not embarrassed with my answers." [Study 1] - "I noticed that he had eye contact with me constantly, and he had a calming effect on me." [Study 1] "He's generally sitting, so that we are meeting at eye-level, which is very important to me." [Study 1]

Themes/Sub-Themes	Description	Illustrative Example(s)
3b. Do **maintain a body position** that is oriented towards the patient.	By facing the patient, rather than a medical chart, participants felt that their responses were heard and taken seriously.	- "When she sat, her upper body actually moved towards me, which is a good inclination that she was focused on me [...] It made me feel like I was important." [Study 1] - "He faced me and looked me in the face. I like that." [Study 1] - "I found him to be very connected to me as a patient. It wasn't like he came in and was reading the chart [...] he actually knew in advance when he walked in that room what my status was." [Study 1]
3c. Do **maintain consistent tone throughout the consultation**.	When CCPs asked smoking history questions in the same tone they used during the rest of the appointment, patients did not feel stigmatized.	- "He didn't dwell on it [tobacco use], he didn't make a big deal about it, nor did he dismiss it. I mean it's a fact [...] I didn't feel there was any moral judgment made." [Study 1]
4. **Additional training and education: Patients made suggestions for other trainings and education that CCPs could get in order to make them more empathic and supportive of their patient [Study 2 only]**		
4a. Do get more **communication training**.	CCPs should get additional training in communication with patients.	- "And the medical professionals that are coming in contact with patients need to be educated about what it means to a patient that has lung cancer to be confronted with that, whether they were a smoker, whether they weren't a smoker, if they're currently a smoker, if they're a former smoker, they need education." [Study 2] - "I think a lot of the stigma is due to a lack of education or a lack of maybe attention on what is, you know, really going on." [Study 2] - "But it is the entire community of healthcare professionals that we may meet as we move not only for treatment for lung cancer but for other health challenges we may have in our life, and all of those folks need to be educated that an 'it's your fault' attitude is not appropriate for folks who have lung cancer." [Study 2]
4b. Do get **educated about smoking status and lung cancer**.	CCPs should receive more education on engaging patients struggling with tobacco dependence and appreciating nicotine addiction (i.e., most lung cancer patients are former, not current) smokers.	- "No, just that I think everyone needs to be better educated that, you know, most smokers, most people that get lung cancer are former smokers." [Study 2]
DON'T'S: Communication-Related Skills that CCPs Should Avoid Using with Patients		
1. Don't **blame**.	CCPs should not ask blaming questions or make blaming statements.	- "I mean, they were saying like everybody else, like the doctors were saying, that I really should stop smoking, you know? That's a nasty habit [....] but I think to myself, I say, I try." [Study 1] - "They were telling me, you know, 'you've got to be crazy that you're continuing to smoke!' and stuff like that. You don't get [through] to me that way." [Study 1] - "And I said, 'No, I had lung cancer.' They said, 'Did you smoke?' And I said, 'I did smoke.' And they said, 'Well then, what did you expect?' And they all reacted the same way. It was always the same, that same conversation." [Study 2] - "She looked right at me and she said, 'Well, did you smoke? Is that why you had lung cancer?'" [Study 2] - ".and you know, she stood there and talked with us for a few minutes, and then all of a sudden it was just, 'Well, you wouldn't get lung cancer if you didn't smoke. People who have lung cancer did it to themselves.'" [Study 2] - "And they even had the same physical response where they would shrug their shoulders, turn their hands palms up, and they didn't even need to say 'Well, what did you expect?'" [Study 2]
2. Don't **presume. [Study 2 only]**	CCPs should not form presumptions about the patient or assume the patient has smoked/is smoking.	- "And at one of the follow-up appointments with him, I had a cold, I had a fever and a cold, and I was coughing, and he said to me—and this is a footnote here, I had given up smoking. I had quit smoking nine and a half years before diagnosis. And he said to me, 'Well, you're still smoking, right? You're sneaking some cigarettes. You're having an occasional cigarette.' And I said, 'No, I'm not.' And - - truthfully I wasn't. And he said, 'Oh, come on.' And I said, 'No, I'm not. I haven't had a cigarette in over ten years.' And he said, 'Oh, come on, you can tell me. I know you're smoking,' and I don't even have a smoker's cough or anything. And I said, 'No, I don't.' And he insisted. He said, 'Once in a while you have a cigarette, don't you?' And I said, 'No, I don't.' And my husband was with me. And he said, 'Doctor, she doesn't,' and he dropped it." [Study 2]
3. Don't make threats about **sub-optimal care** delivery for	CCPs should not indicate that patients' care will suffer or be less than top quality due to patients' smoking status.	- "Seriously, he barely looked at me, and said, 'Yeah, no, I'm not going to operate on you because you have lung cancer because you smoked, and you're going to die within six months' - - and my husband, I told my husband I was going to

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Themes/Sub-Themes	Description	Illustrative Example(s)
patients who smoke. **[Study 2 only]**		pass out, and I just looked at him and went, ‘What?’ And my - - said, ‘No, that’s—no, what, what?’ You know, just like we could not believe that somebody would be so blunt. [Study 2]
4. Don’t be **nihilistic** and offer poor prognosis.	CCPs should not negate patients’ hope, because of their smoking status.	- “So I said, ‘Well, what should I do?’ He said, ‘I don’t know. Go home, get your affairs in order and get ready to die.’ He said, ‘You know, maybe you should think about not smoking anymore.’ He said, ‘Not that it’ll do you any good anyway, but whatever.’ [Study 2] - “Well, my pulmonary knows of me and says, ‘you’re going to die.’ [...] I think I like [my current doctor’s] approach better. It was more comfort in the way he would make me try to give up smoking.” (Study 1)
5. Don’t **avoid** the patient.	CCPs should not engage in avoidant behaviors (avoiding eye contact, shrugging, rushing out of the room, etc.).	- “When I asked questions, he was like trying to rush me out [...] with this kind of disease, you can’t make a person feel like a statistic.” [Study 1]