

Stigma, Bias & Equity Draft Guidelines

Patients & Families

- If you currently or have previously smoked, it is important to ask your doctor about your eligibility for lung cancer screening. Screening may be able to detect lung cancer early, when it is more likely to be curable.
 - Take a 2 minute quiz to see if you're eligible for lung cancer screening: [Saved by the Scan](#)
- Smoking is a risk factor for lung cancer, **but people that have never used tobacco can also develop lung cancer**. Other risk factors include exposure to radon gas, secondhand smoke, asbestos, air pollution, and family history.
- **Do not assign blame.**
- Resources
 - Lung Cancer Screening
 - [About The New Low-Dose CT Lung Cancer Screening Test | American Lung Association](#)
 - Tobacco Cessation
 - [Washington State Quitline](#)
 - Calling 1-800-QUIT-NOW (1-800-784-8669);
 - Visiting quitline.com; or
 - Texting READY to 200-400.
 - [Tobacco Cessation Treatment: What Is Covered? | American Lung Association](#)

Clinicians

- **Practice empathic, non-stigmatizing, person-first language** found in [IASLC language guide](#) (e.g., “person who smokes” instead of “smoker) with all patients
 - Communicate with empathy, not blame. Do not imply a person’s choices led to their condition.
 - Normalize tobacco use as a common challenge
- Screen all patients for **health-related social needs**

- Refer to support staff (e.g., social worker, care coordinator, etc.) and lung cancer screening navigator as available for support
- **Do not delay or withhold diagnostic tests or treatments** due to smoking status
- **Refer patients and family to peer support** for those with tobacco use and/or lung cancer
- **Resources to support tobacco cessation** during the clinical visit: [Tobacco Use and Dependence Treatment | Washington State Department of Health](#)

Healthcare Delivery Systems

- **Prioritize stigma reduction organization-wide.** integrate training to identify and address stigma and bias, including against those who smoke, into onboarding and annual competencies
- **Make tobacco cessation programs highly visible** and easy to access as part of routine care
- **Dedicate quality improvement resources to addressing disparities in screening and access to guideline-driven follow-up,** based on race and ethnicity at a minimum.
- In value-based contracting arrangements, **prioritize equitable lung cancer screening,** based on race and ethnicity.

Health Plans

- **Prioritize stigma reduction organization-wide.** Integrate training to identify and address stigma and bias, including against those who smoke, into onboarding and annual competencies
- **Provide access to robust tobacco cessation** as a standard benefit, defined as:
 - Sessions of individual, group, and phone counseling
 - 90 days of all FDA-approved smoking cessation medications
 - 2 quit attempts per year
 - No prior authorization
- **Minimize, and if possible eliminate, out of pocket cost** for tobacco cessation benefits
- **Avoid punitive premiums/surcharges** for people who smoke.
 - If surcharges are in place, they should be waived if the member participates in tobacco cessation program or fulfill a reasonable alternative standard during benefit coverage period.

- **Track lung cancer screening rates** for eligible individuals according to national guidelines (e.g., [USPSTF](#))
- **Identify disparities in screening and mortality due to lung cancer**, including at a minimum:
 - Screening
 - Screening outcomes
 - Demographic factors such as race, ethnicity, language, sexual orientation and gender identity

Employers

- Implement smoke-free environment policies, using empathic, non-stigmatizing language (e.g., [IASLC language guide](#))
- Ensure tobacco cessation interventions are offered at minimal to no out of pocket cost to employees; If possible, offer on-site tobacco cessation support.
- **Consider utilizing positive incentives** for those who currently smoke to engage in cessation resources; move away from punitive premiums/surcharges.
- **Foster peer support** for employees who are patients or caregivers for those currently smoking and/or diagnosed with lung cancer.

Local Health Jurisdictions/Public Health Departments

- **Prioritize stigma reduction organization-wide**
 - Set an example with inclusive public messaging, utilizing empathic, non-stigmatizing language (e.g., [IASLC Language Guide](#)) such as using “people who smoke,” instead of “smokers.”
 - Design tobacco prevention campaigns that educate without shaming. Judgmental language can imply that lung cancer is a self-inflicted disease.
- **Partner with community-based organizations, tribes, community leaders, and others** to amplify stigma-reducing narratives.

Department of Health

- **Encourage local and regional public health organizations to reduce stigma** by utilizing empathic, non-stigmatizing language found (e.g., IASLC Language Guide) in all smoking prevention and cessation materials
- **Integrate education about benefits of lung cancer screening in health promotion for tobacco prevention and cessation.**

- Develop and/or use healthcare professional-focused concise material communicating eligibility, benefits and risks to screening, and resources available to support screening.

Literature

Citation	Abstract	Findings
<p>Hamann HA, Ver Hoeve ES, Carter-Harris L, Studts JL, Ostroff JS. Multilevel Opportunities to Address Lung Cancer Stigma across the Cancer Control Continuum. J Thorac Oncol. 2018 Aug;13(8):1062-1075. doi: 10.1016/j.jtho.2018.05.014. Epub 2018 May 23. PMID: 29800746; PMCID: PMC6417494.</p>	<p>Introduction: The public health imperative to reduce the burden of lung cancer has seen unprecedented progress in recent years. Realizing fully the advances in lung cancer treatment and control requires attention to potential barriers in their momentum and implementation. In this analysis, we present and evaluate the argument that stigma is a highly significant barrier to fulfilling the clinical promise of advanced care and reduced lung cancer burden.</p> <p>Methods: This evaluation of lung cancer stigma is based on a multilevel perspective that incorporates the individual, persons in their immediate environment, the healthcare system, and the larger societal structure which shapes perceptions and decisions. We also consider current interventions and interventional needs within and across aspects of the lung cancer continuum, including prevention, screening, diagnosis, treatment, and survivorship.</p> <p>Results: Current evidence suggests that stigma detrimentally impacts psychosocial, communication, and behavioral outcomes over the entire lung cancer control continuum and across multiple levels. Interventional efforts to alleviate stigma in the context of lung cancer show promise, yet more work is needed to evaluate their impact.</p> <p>Conclusions: Understanding and addressing the multi-level role of stigma is a crucial area for future study in order to realize the full benefits offered by lung</p>	<ul style="list-style-type: none"> • Intrapersonal: internalized stigma – barrier to LDCT; question whether they “deserve” treatment • Interpersonal: biases of HCPs prevent empathetic smoking cessation advice and support; direct education and support can show value to primary care – Kentucky LEADS Collaborative • Societal: harsh judgment of those smoking in public messaging -> stigma for those who smoke, screen for lung cancer, and are diagnosed with lung cancer • Focus on stigma in other domains (e.g., HIV/AIDS) can be useful to reflect

	<p>cancer prevention, control, and treatment. Coordinated, interdisciplinary, and well-conceptualized efforts have the potential to reduce the barrier of stigma in the context of lung cancer and facilitate demonstrable improvements in clinical care and quality of life</p>	
<p>Miriyala S, Nguyen KV, Park A, Hwang T, Aldrich MC, Richmond J. Racism, discrimination, medical mistrust, stigma, and lung cancer screening: a scoping review. Ethn Health. 2025 Apr;30(3):372-397. doi: 10.1080/13557858.2025.2458303. Epub 2025 Feb 3. PMID: 39901346; PMCID: PMC11961322.</p>	<p>Objective Lung cancer screening can reduce lung cancer-specific mortality, but it is widely underutilized, especially among minoritized populations that bear a disproportionate burden of lung cancer, such as Black Americans. Racism, discrimination, medical mistrust, and stigma contribute to lower uptake of preventive screenings in general, but the role these factors play in lung cancer screening is unclear. We therefore conducted a scoping review to synthesize the literature regarding how racism, discrimination, medical mistrust, and stigma relate to lung cancer screening.</p> <p>Design Informed by PRISMA-ScR guidelines, we searched five databases for relevant literature, and two trained researchers independently reviewed articles for relevance. We conducted a narrative, descriptive analysis of included articles.</p> <p>Results A total of 45 studies met our inclusion criteria. Most articles reported on medical mistrust or one of its cognates (e.g. trust and distrust, n = 37) and/or stigma</p>	<ul style="list-style-type: none"> • Racism, discrimination, medical mistrust, and lung cancer–related stigma are deeply interconnected and consistently associated with lower awareness, acceptability, and uptake of lung cancer screening—particularly among Black and other historically marginalized populations. • Experiences of interpersonal and structural racism, longstanding medical mistrust rooted in historical and ongoing injustices, and stigma tied to smoking and lung cancer blame jointly shape risk perceptions, reduce trust in clinicians and health systems, and

	<p>(n = 25), with several articles focusing on multiple constructs. Few articles reported on racism (n = 3), and n = 1 article reported on discrimination. Results from empirical studies suggest that medical mistrust, distrust, and stigma may be barriers to lung cancer screening, whereas trust in health care providers may facilitate screening. The articles reporting on racism were commentaries calling attention to the impact of racism on lung cancer screening in Black populations.</p> <p>Conclusions Overall, novel interventions are needed to promote trust and reduce mistrust, distrust, and stigma in lung cancer screening initiatives. Dedicated efforts are especially needed to understand and address the roles that racism and discrimination may play in lung cancer screening.</p>	<p>discourage engagement in shared decision making and screening.</p> <ul style="list-style-type: none"> • Effective strategies must incorporate culturally responsive, community engaged approaches, explicitly address racism and mistrust, and redesign screening programs to be more equitable and trustworthy in order to meaningfully reduce lung cancer screening disparities.
<p>Ostroff JS, Banerjee SC, Lynch K, Shen MJ, Williamson TJ, Haque N, Riley K, Hamann HA, Rigney M, Park B. Reducing stigma triggered by assessing smoking status among patients diagnosed with lung cancer: De-stigmatizing do and don't lessons learned from qualitative interviews. PEC Innov. 2022 Dec;1:100025. doi: 10.1016/j.pecinn.2022.100025. Epub 2022 Mar 4. PMID: 36865902; PMCID: PMC9977138.</p>	<p>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.</p> <p>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.</p> <p>Results Three broad themes were identified: cursory questions about smoking history and current</p>	<p>Do's and don'ts of communication related to tobacco use and lung cancer screening</p> <p>Four themes:</p> <ul style="list-style-type: none"> • Responding in an empathic manner • Use of supportive communication skills • Non-verbal communication skills

	<p>behavior; stigma triggered by assessment of smoking behavior; and recommended dos 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.</p> <p>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.</p> <p>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.</p>	<ul style="list-style-type: none"> • Training suggestions to bolster empathic communication <p>DO</p> <ol style="list-style-type: none"> 1. Do normalize taking smoking history 2. Do acknowledge the causal relationship between smoking and lung cancer, as well as other known and unknown risk factors for lung cancer 3. Do acknowledge nicotine addiction and quitting challenges for patients who smoke 4. Do respond empathically to patients receiving distressing information 5. Do ask more open-ended questions about patient experiences 6. Do allow patients time to ask questions 7. Do provide a rationale for asking smoke-related questions 8. Do offer hope 9. Do offer tobacco cessation and other
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		<p>resources (support groups)</p> <ol style="list-style-type: none">10. Do avoid judgment laden questions11. Do create personal connection with the patient12. Do maintain eye contact and sit at eye level13. Do maintain body position oriented towards the patient14. Do maintain consistent tone throughout conversation15. Do get more communication training16. Do get educated about smoking status and lung cancer <p>DON'T</p> <ol style="list-style-type: none">1. Don't blame2. Don't presume3. Don't make threats about sub-optimal care delivery for patients who smoke4. Don't be nihilistic and offer poor prognosis5. Don't avoid the patient
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<p>Richmond J, Fernandez JR, Bonnet K, et al. Patient Lung Cancer Screening Decisions and Environmental and Psychosocial Factors. JAMA Netw Open. 2024;7(5):e2412880. doi:10.1001/jamanetworkopen.2024.12880</p>	<p>Importance Screening for lung cancer using low-dose computed tomography is associated with reduced lung cancer-specific mortality, but uptake is low in the US; understanding how patients make decisions to engage with lung cancer screening is critical for increasing uptake. Prior research has focused on individual-level psychosocial factors, but environmental factors (eg, historical contexts that include experiencing racism) and modifying factors—those that can be changed to make it easier or harder to undergo screening—also likely affect screening decisions.</p> <p>Objective To investigate environmental, psychosocial, and modifying factors influencing lung cancer screening decision-making and develop a conceptual framework depicting relationships between these factors.</p> <p>Design, Setting, and Participants This multimethod qualitative study was conducted from December 2021 to June 2022 using virtual semi-structured interviews and 4 focus groups (3-4 participants per group). All participants met US Preventive Services Task Force eligibility criteria for lung cancer screening (ie, age 50-80 years, at least a 20 pack-year smoking history, and either currently smoke or quit within the past 15 years). Screening-eligible US participants were recruited using an online panel.</p>	<ul style="list-style-type: none"> • Historical and present-day racism is a critical factor contributing to mistrust of HCPs and avoidance of cancer screening. • HCPs can reduce this through empathic and transparent communication • HCPs should know how to share what to expect financially for patients with different kinds of insurance • Quality and occurrence of SDM for lung cancer varies across different locations
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	<p>Main Outcomes and Measures Key factors influencing screening decisions (eg, knowledge, beliefs, barriers, and facilitators) were the main outcome. A theory-informed, iterative inductive-deductive approach was applied to analyze data and develop a conceptual framework summarizing results.</p> <p>Results Among 34 total participants (interviews, 20 [59%]; focus groups, 14 [41%]), mean (SD) age was 59.1 (4.8) years and 20 (59%) identified as female. Half had a household income below \$20 000 (17 [50%]). Participants emphasized historical and present-day racism as critical factors contributing to mistrust of health care practitioners and avoidance of medical procedures like screening. Participants reported that other factors, such as public transportation availability, also influenced decisions. Additionally, participants described psychosocial processes involved in decisions, such as perceived screening benefits, lung cancer risk appraisal, and fear of a cancer diagnosis or harmful encounters with practitioners. In addition, participants identified modifying factors (eg, insurance coverage) that could make receiving screening easier or harder.</p> <p>Conclusions and Relevance In this qualitative study of patient lung cancer screening decisions, environmental, psychosocial, and modifying factors influenced screening decisions. The findings suggest that systems-level interventions, such as those that help practitioners understand and discuss patients'</p>	
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	<p>prior negative health care experiences, are needed to promote effective screening decision-making.</p>	
<p>U.S. Department of Health and Human Services. (2024). Eliminating tobacco-related disease and death: Addressing disparities: A report of the Surgeon General. U.S. Department of Health and Human Services. https://escholarship.org/uc/item/2s92w7jm</p>	<ul style="list-style-type: none"> • Despite strong progress in reducing tobacco use at the population level, disparities in use persist by race and ethnicity, level of income, level of education, sexual orientation, gender identity, type of occupation, geography, and behavioral health status. Exposure to secondhand tobacco smoke remains disproportionately higher among Black people than among people in other racial and ethnic groups, youth than among adults, and people from lower socioeconomic backgrounds than among those from higher socioeconomic backgrounds. Tobacco-related health disparities are a social injustice, in addition to an economic and health burden. Addressing disparities requires reflection on the complex history of the commercialization of tobacco and both past and present-day experiences of racism, discrimination, and targeted marketing by the tobacco industry. • Social, structural, and commercial determinants of health—such as persistent poverty and inequitable economic and social conditions—lead to inequitable opportunities for living a life free from tobacco-related death and disease. Racism, discrimination, and targeted marketing by the tobacco industry; geographic disparities in evidence-based policy protections; preemptive laws that 	<ul style="list-style-type: none"> • Tobacco related disease disproportionately affects populations facing structural inequities – prioritize equity focus in LCS programs • Structural and commercial determinants of health drive disparities – integrate structural supports (e.g., transport, navigation, scheduling flexibility) • Stigma and blame undermine engagement with prevention and care – use non-stigmatizing, person-centered messaging emphasizing early detection, survivability and respect instead of risk-based or blame-oriented narratives • Access barriers persist even when preventive services are covered –

	<p>thwart communities from protecting their residents' health and safety; and financial and other structural barriers to accessing cessation treatments also drive tobacco-related health disparities.</p> <ul style="list-style-type: none">• The tobacco industry has designed, engineered, and marketed menthol cigarettes and other tobacco products that deliver multisensory flavor experiences which increase the likelihood of tobacco initiation, addiction, and sustained use. Policies that restrict the availability of menthol cigarettes can reduce smoking initiation and prevalence among adolescents, young adults, Black people, and other population groups that have disproportionately higher use of menthol cigarettes.• For decades, the tobacco industry has targeted its products and marketing to specific groups, including through concentrated marketing in neighborhoods with greater percentages of Black people, Hispanic people, and residents with lower incomes. Tobacco companies employ multiple tactics to undermine tobacco prevention and control efforts and enhance their corporate image.• Cigarette smoking remains a major cause of death and disease—including cancer, cardiovascular disease, and chronic obstructive pulmonary disease— among all racial and ethnic groups. More than 490,000	<p>screening programs should include active coordination rather than assuming coverage will translate to uptake</p> <ul style="list-style-type: none">• Community-engaged and culturally responsive strategies are essential – LCS should co-design outreach and education with CBOs, tribal health, culturally specific providers to align with broader tobacco cessation and screening initiatives
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	<p>deaths attributable to cigarette smoking and exposure to secondhand tobacco smoke are estimated to occur in the United States each year— about one in five of all deaths in the United States. This includes more than 473,000 deaths attributable to cigarette smoking and more than 19,000 deaths attributable to exposure to secondhand tobacco smoke.</p> <ul style="list-style-type: none">• Each year, more than 50,000 Black adults, 15,000 Hispanic adults, and 400,000 White adults are estimated to die from causes attributable to cigarette smoking. Despite large absolute differences in the numbers of smoking-attributable deaths by race and ethnicity, smoking account for a similar proportion of deaths among non-Hispanic Black (18%) and non-Hispanic White (20%) people and for approximately 10% of deaths among Hispanic people.• Data from surveillance and intervention research are limited for many groups known to be at high risk for tobacco use, exposure to secondhand tobacco smoke, and targeted marketing by the tobacco industry. While protecting recent gains in measurement, further efforts are warranted to assess structural and social determinants of health across the lifespan, disaggregate data, oversample disparate populations, and increase understanding of the impact of	
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	<p>interventions on tobacco-related health disparities.</p> <ul style="list-style-type: none">• Endgame efforts to eliminate tobacco-related disease, disability, and death should create opportunities and conditions for all people to live healthy lives that are free from commercial tobacco. Interventions designed to reduce the use of tobacco products and the influences of the tobacco industry on society should accompany efforts to remove the underlying social, structural, commercial, and political drivers of health inequities.• In addition to social and structural interventions, a comprehensive and multilevel effort toward health equity must include a combination of complementary approaches to reduce the affordability, accessibility, appeal, and addictiveness of tobacco products; eliminate exposure to secondhand tobacco smoke; conduct high-impact media campaigns; and promote barrier-free access to cessation support with broad reach to disparate populations. Strategies should be implemented equitably and with fidelity in all jurisdictions	
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