Transcript Details

This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/project-oncology/patient-first-smoking-cessation-lung-cancer-screening/39987/

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

A Patient-First Approach to Smoking Cessation and Lung Cancer Screening

Announcer:
This is *Project Oncology* on ReachMD. On this episode, Dr. Lisa Carter-Bawa will discuss strategies for reducing tobacco-related stigma and increasing lung cancer screening rates. In addition to being the Director of the Cancer Prevention Precision Control Institute at the Hackensack Meridian Health Center for Discovery & Innovation, she's also a Co-Leader of the Cancer Prevention and Control Program and the Deputy Associate Director of Community Outreach and Engagement for the Georgetown University Lombardi Comprehensive Cancer Center. Let's hear from Dr. Carter-Bawa now.

Dr. Carter-Bawa:
Most clinician-enacted stigma is not intentional. A clinician doesn't stand there and say, "I'm going to go in that room and stigmatize that patient." They don't do that. It's not malicious, but it is real, and it has measurable consequences.

It starts with language. The way we talk about tobacco use matters enormously. When a clinician refers to someone as a smoker, that collapses the person into the behavior. It becomes an identity label. Whereas saying a person who smokes, which is the person-first language standard that I and many of my colleagues advocate for, keeps the person at the center and the behavior as something they do, not who they are. And that distinction may seem subtle, but patients do feel it.

Beyond language, stigma shows up in tone and in framing. Asking, "Are you still smoking?" carries an implicit judgment. The word still signals disappointment. And compare that to asking, "Can we talk about where you are with your tobacco use right now?" which opens a conversation rather than closes one.

And then clinicians may also inadvertently communicate that cessation is a condition of care, that the screening is contingent on quitting, or that treatment is contingent on quitting smoking. And so when a patient perceives that kind of conditionality, they may shut down entirely and not come back. And here's the compounding effect: when the cessation conversation feels punitive, patients don't just disengage from cessation. They may also disengage from screening follow-up. So we lose them on two fronts. They don't get the cessation support that they need, or that they might have been open to, and they don't complete the screening process, which is the reason they were there in the first place.

I think the key principle here is that cessation should be offered as a resource, not imposed as a prerequisite. Meet people where they are; that's the foundation. I'm also a tobacco treatment specialist, and my patients would always be surprised when they would had their first consultation with me because they thought I was going to tell them to throw their pack of cigarettes out today. And that's not the approach that I ever took; I wanted them to decrease their smoking. So if they smoked 20 cigarettes a day, and they came back the next week and told me they smoked 17 a day, I was the biggest cheerleader for them, and they were so surprised, because nicotine is an addiction.

The first piece with clinicians, I think, is shared decision-making. The lung cancer screening conversation is already a moment where clinicians and patients are navigating complex information together. So cessation fits really naturally into that dialogue when it's framed as part of a comprehensive care plan rather than as a separate moral obligation. The clinician might say, "Screening is one way we're looking out for your health. Cessation support is another tool we can offer you if and when you're ready." That framing respects the autonomy of the patient. It keeps the patient in the driver's seat.

And the second piece, I think, is extending the conversation beyond the clinic. Not every meaningful health interaction has to happen in a clinical setting. Community health workers, lay health navigators, and peer-led support are all mechanisms for delivering cessation support in environments where people may feel less judged. And I think that community-grounded approach can reach people in ways

that a 15-minute clinical encounter simply can't.

And finally, the third piece, and this is really upstream, is training. We need to invest in training clinicians on stigma awareness, helping them recognize their own biases around tobacco use, giving them concrete language tools, building anti-stigma principles into screening program design from the start, and then not bolting them on after the fact. That's key. So when stigma reduction is baked into the structure of a program, every interaction that flows from that program is different.

Announcer:
That was Dr. Lisa Carter-Bawa explaining how we can reduce tobacco-related stigma and engage patients in lung cancer screening. To access this and other episodes in this series, visit *Project Oncology* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!