2025, vol. 7, e4534
praxeologi.uib.no

PRAXEOLOGI
ET KRITISK REFLEKSIVT BLIKK PÅ SOSIALE PRAKTIKKER

The doxa of smoking and implications for lung cancer patients: from natural and glamorous to self-inflicted and impure

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Abstract

This paper explores the stigma associated with smoking and lung cancer patients by examining the doxical notions on which it rests and its implications for healthcare settings. Through the lens of Pierre Bourdieu's concept of doxa, we analyse how historical advertising and anti-smoking campaigns have reshaped the image of smoking – from glamorous to self-inflicted and filthy – reinforcing a 'stacked stigma' characterised by impurity, self-blame, and low prestige in the healthcare sector. Lung cancer patients do not align with the healthcare sector's ideal image of a patient who maintains a healthy body, leading to moral judgment and self-blame. This 'stacked stigma' also affects lung cancer patients by making them 'guilty by association', complicating their interactions with healthcare professionals.

Keywords: Doxa, lung cancer, stigma, smoking, medical prestige, Bourdieu

[1]The second author has previously been an editorial board member of the journal but has been excluded from all forms of editorial work related to this article.

Publisert: 30.06.2025

DOI: http://dx.doi.org/10.15845/praxeologi.v7.4534

Introduction

Lung cancer is the most frequently diagnosed cancer worldwide, with 2.5 million new cases each year, and it remains the leading cause of cancer-related deaths, resulting in 1.8 million deaths annually. In most countries, the five-year survival rate is below 20% (Bray et al., 2024), and the average age at diagnosis is 70. Approximately 80% of those diagnosed with lung cancer have a history of smoking (Cancer Registry of Norway, 2024). Lung cancer caused by smoking can be further described as evolving in slow motion, with a long interval between action (smoking) and consequence (cancer) (Lund & Vedøy, 2024, p. 5). Research also shows that smoking and lung cancer risk are associated with lower socioeconomic status (Pizzato et al., 2022).

The link between smoking and lung cancer also affects how those diagnosed are perceived. They are seen as individuals who, despite warnings and preventative efforts, have endangered themselves and others through their smoking habits (Auriol et al., 2023; Lobchuk et al., 2008), and as a significant economic burden on the healthcare sector (Apple et al., 2023; Yousefi et al., 2023). As symptoms develop gradually over time, lung cancer is both difficult to detect and challenging to treat, contributing to its relatively low prestige within the medical field (Album et al., 2017).

In this paper, we examine how lung cancer patients are generally perceived and the potential significance of how the healthcare sector relates to and approaches the patient group. We aim to provide a broad perspective on how cultural norms and social preconceptions have shaped the view of lung cancer patients.

The paper is an offshoot of a larger research project exploring hospital-to-home transitions for lung cancer patients in Norway from the perspective of healthcare professionals (Nilsen, Oksholm, et al., 2025; Nilsen, Samdal, et al., 2025). While conducting and analysing interviews, we were struck by how nurses and physicians described, categorised and approached lung cancer patients – as a particularly vulnerable group sharing predominantly negative characteristics, yet also as a group that struggles with being labelled. This apparent paradox – problematising generalisations and labels while simultaneously generalising and labelling – was not part of the project's original objectives, yet it left us both confounded and intrigued.

This led to a deeper interest in understanding how lung cancer patients are perceived, why they are perceived in certain ways, and the implications for patients and the healthcare system they navigate. Consequently, in this paper, we ask: What is the stigma associated with lung cancer patients? On which doxical notions does it rest? And what are its implications in healthcare settings? We first address these questions at a societal level, and then shift our focus to the healthcare sector, ultimately ending where our initial inquiry began. Before doing so, however, we take a step back to examine where lung cancer is perceived to originate in most cases: tobacco smoking and its associated perceptions.

Theoretical framework

Our analyses are grounded in Bourdieu's theories and approaches, particularly the notion of doxa, which refers to the dominant agreement within a given social field. According to Bourdieu, each field develops uncontested doxical beliefs about the 'right' way to perceive, think, and behave (Bourdieu & Wacquant, 1992). These beliefs remain largely obscured, that is, both invisible and unquestionably

accepted. Doxa is, in this sense, the mechanism through which a social order 'tends to produce (to very different degrees and with very different means) the naturalization of its own arbitrariness' (Bourdieu, 1977, p. 164).

Further, in this article, we lean on Erving Goffman's description of stigma. According to Goffman (2009), by emphasizing particular characteristics of others, social agents transform first impressions into normative expectations of what to expect. Often such (assumed) characteristics and the expectations that follow from them, are concerned with incongruities (from the norm or the majority), creating an expression of stigma. Stigma is, as we interpret Goffman, a form of non-spoken label pointing to a flaw or something unwanted (Goffman, 2009).

Using doxa as an analytical lens to examine the stigma associated with smoking – and, by extension, lung cancer – allows for an exploration of the assumptions and presuppositions held by those who interact with lung cancer patients, such as healthcare professionals. In other words, we seek to illuminate the doxa of smoking and lung cancer. While our primary focus is on the Norwegian context, this is mainly for illustrative purposes, as we believe our core arguments have broader relevance.

Cigarette smoking and its perceptions: A brief overview

For much of the 20th century, cigarette smoking was considered glamorous and associated with wealth and success. It was portrayed as a symbol of modernity, freedom, and advancement (Skretting et al., 2016) and even promoted as a natural product that could improve health (Lund & Vedøy, 2024). A typical cigarette advertisement from the 1920s, for instance, featured glamorous and attractive models or celebrities smoking, highlighting the social benefits of the habit. Later, iconic advertising introduced figures such as 'the Marlboro man', a symbol of masculinity and independence (White et al., 2013). Other campaigns targeted women – who had previously smoked less than men – by emphasising independence, liberty and sexuality (Lund, 2002), while others associated smoking with the outdoors and family life (Lund & Vedøy, 2024).

Tobacco companies also marketed cigarettes directly to physicians, as seen in RJ Reynolds' campaign slogan, 'More doctors smoke Camels than any other cigarette' (Gardner & Brandt, 2006, p. 222). Through such targeted advertising, smoking was promoted as glamorous and beneficial across various aspects of life. Different cigarette brands were tailored to specific population segments, shaping societal perceptions of smoking both in general and within particular groups. This contributed to a doxa of smoking as natural in a dual sense: as both normal behaviour and as a natural/earthly product. Additionally, these advertisements reinforced social classifications based on cigarette brands, linking smoking to social identity formation. For example, in 1960, the American gospel group Deep River Boys, composed of African American men, was hired to create a cinema commercial for the South State cigarette brand, specifically targeting African American consumers (Lund & Vedøy, 2024, p. 34).

Anti-smoking information campaigns, in stark contrast, can be traced back to 1964, when the first report on the association between smoking and lung cancer, chronic bronchitis and the potential risk of coronary heart disease was published by the U.S. Surgeon General (Hall, 2022). The report received significant attention internationally, including in Norway (Skretting et al., 2016). This

marked the beginning of a slow societal shift in how smoking was perceived and how those suffering its adverse consequences were regarded.

In Norway, the report led to both immediate and gradual changes in how smoking was addressed and framed through public policies. It contributed to the passage of the Tobacco Control Act in 1973, which came into effect in 1975 (Tobakksskadeloven, 1975). The Act prohibited tobacco advertising, mandated health warnings on tobacco products, and established an age limit for purchasing tobacco. Subsequently, public health campaigns were launched to actively inform the public about the dangers of smoking. Taxes on tobacco were increased, justified on health policy grounds, and awareness of the harms of passive smoking grew. This led to the introduction of legislation in 1988 to protect the public from exposure to second-hand smoke in shared spaces and public transportation.

Further measures followed. In 2004, warning labels were introduced as a means to evoke fear and encourage smoking cessation (Larsen et al., 2006). Regulations protecting against passive smoking were continuously expanded, and in 2004, they were extended to cover all public places, including workplaces (Lund & Lund, 2018). The implementation of tobacco laws, intended to protect both workers and visitors to various venues, effectively required smokers to leave these premises to smoke, often in designated areas, putting them on display and creating a 'pillory' experience (Pettersen, 2015, p. 59). These and other measures have also been implemented to protect children, who are seen as particularly vulnerable, from the dangers of second-hand smoke (U.S. Department of Health and Human Services, 2006).[1]

Since the early 2000s, the glamorous posters promoting the benefits of smoking have been replaced by warning campaigns highlighting its health hazards, alongside various other preventive measures. This shift reflects the extensive efforts of governing authorities worldwide to inform society about the dangers of smoking, which aligns with the World Health Organization Framework Convention on Tobacco Control (WHO FCTC) and its MPOWER package, introduced in 2007 (World Health Organization, 2023b). Alongside this increased awareness of smoking hazards, there has also been a shift in both the prevalence and demographic profile of smokers. In Norway, for instance, throughout the 1960s, a majority of the population smoked cigarettes regularly (Lund et al., 2009). In the first half of the 20th century, smokers were typically young and affluent, whereas today, smoking is more prevalent among older adults with low socioeconomic status (Garrett et al., 2019). In other words, the profile of smokers and how they are perceived have changed dramatically in recent decades.

The stigma of lung cancer patients

The doxa of smoking has shifted fundamentally throughout the 20th century. A distinct break in the doxa of smoking can, in other words, be identified as beginning around the mid-1960s. According to Bourdieu, a break implies a comprehensive shift in everyday perceptions and people's taken-for-granted assumptions about the social world, caused by governing forces providing new knowledge that challenges previously acknowledged truths, or doxa. In other words, a break signifies a shift in the fundamental beliefs and values taken for granted in society (Bourdieu et al., 1991), resulting in the establishment of a new doxa. In our context, this break marked a shift in how smoking was

[1] For example, exposure to second-hand smoke is linked to a substantially increased risk of sudden infant death syndrome (SIDS) and childhood diseases such as respiratory infections, weakened lung function, ear infections and asthma.

viewed – from glamorous to despicable, from associated with health to associated with illness – instigated by the established link between smoking and lung cancer.

This doxical break has also affected lung cancer patients, who are now often seen as 'guilty by association'. Lung cancer patients are perceived, rightfully or wrongly, as current or previous smokers and are therefore caught in the same doxical space as smoking. Accompanying this shift in doxa, a stigma (Goffman, 2009) has gradually and profoundly developed towards those who – despite warnings – continue to smoke (Auriol et al., 2023; Stuber et al., 2008; Williamson et al., 2020); those who no longer fit the dominant doxical notion. Especially in recent decades, everyday smokers have experienced a 'fall from grace' in public perceptions, a shift rarely seen for other patient groups or broader segments of society (Lund & Vedøy, 2024). Smokers have moved from being seen as ordinary to anomalous, from associated with youth and prosperity to linked with old age and poverty, all within a relatively short time span.

To some extent, negative perceptions of smokers have a generational element. Many of those diagnosed with lung cancer are older and began smoking at a time when the health hazards were less well-known, while younger generations have been far less exposed to smoking. Patients with lung cancer may possibly experience an additional dimension of stigma due to the dual label of being smokers and having a medical diagnosis. Meanwhile, patients diagnosed with lung cancer who have never smoked report feeling similarly stigmatised (Bédard et al., 2022; Criswell et al., 2016; Dao et al., 2020).

So far, we have described general perceptions of smoking and lung cancer patients and have preliminarily concluded – unsurprisingly – that both are associated with negative attributes. There is a stigma associated with smokers and, by extension, with lung cancer patients. This stigma, we argue, consists of two primary elements.

Lung cancer as self-inflicted

Lung cancer patients often experience being treated as stereotypes or as members of an outgroup, both in encounters with the healthcare system and in broader society (Criswell et al., 2016). An essential aspect of this, we argue, is that the illness is perceived as self-inflicted. Lung cancer is commonly linked to a history of smoking – past or present – thereby associating the disease with characteristics such as unhealthy lifestyle choices and poor personal character. As a result, lung cancer is often seen as the consequence of individual vices, overindulgence, and a lack of self-control. Smoking, in particular, is considered a habit that can be controlled. One can choose to quit; it is, in this view, simply a matter of willpower.

The significance of self-infliction may be further reinforced by the perception that both smokers (Garrett et al., 2019; Hiscock et al., 2012) and people diagnosed with lung cancer (Redondo-Sánchez et al., 2022) tend to have low socioeconomic status. In a healthcare context, continued smoking may be framed as an indication of low health literacy (National Institutes of Health, 2023), reflecting both the smoker's (low) level of knowledge and (lacking) ability to use available information to make appropriate health-related decisions.

Furthermore, smokers' self-indulgence is also a considerable societal burden,[2] entailing substantial healthcare expenses for treating tobacco-related diseases as well as 'the loss of human capital due to tobacco-attributable morbidity and mortality' (World Health Organization, 2023a, Overview section, para. 4). Meanwhile, Norway and the other Nordic welfare states remain firmly committed to ensuring equitable healthcare for all citizens through publicly funded services (Hansen & Dahl, 2023), while also facing increasing financial strain in healthcare, linked to demographic changes and the rising costs of advanced medical treatments. In essence, healthcare expenditure is increasingly debated, weighed against potential benefits, and redistributed in what is effectively a zero-sum game. While ethical debates about healthcare prioritisation are not the core focus of this paper, it is relevant that lung cancer patients may be perceived – both by others and themselves – as an economic burden, potentially adding to feelings of shame and stigma (Tran et al., 2015).

The notion of self-infliction and blame can, we believe, be reinforced by the internalisation of these characteristics. Patients with lung cancer, especially those who are current smokers or have a history of smoking, report experiencing self-blame, regret, shame, guilt, and a sense of personal responsibility for developing the disease (Bédard et al., 2022; Chambers et al., 2015; Hamann et al., 2014). Likewise, those who struggle to quit may perceive themselves as failure in the eyes of others (Criswell et al., 2016; Hamann et al., 2014), and, ultimately, as a burden.

Lung cancer as filthy

Self-infliction appears to be only a partial explanation for the stigma of lung cancer patients. Smoking is linked to more than 45 different disease states, approximately 20 of which can be fatal (U.S. Department of Health and Human Services, 2014). Cardiovascular diseases, such as myocardial infarction, for example, have a solid correlation with smoking, with a two to three times higher risk compared to non-smokers (Teo et al., 2006). Still, these diagnoses do not breed the same degree of shame as lung cancer. As we will return to later, they are considered a more prestigious area of medical expertise. Furthermore, other diseases, such as type 2 diabetes, liver diseases, skin cancer and dental problems, can all be considered self-inflicted due to lifestyle choices or behaviours, but do not carry the same stigma. Various traumas, such as car accidents, sports injuries, or accidents after extreme sports like paragliding, can also be seen as self-inflicted and can place a significant financial burden on the healthcare system. However, 'self-infliction' in these instances, takes a different meaning to that of lung cancer.

In contrast to these and similar afflictions and diseases, lung cancer is perceived as stemming not only from bad choices, but also from choices that are somehow morally problematic. This difference can perhaps be explained with the assistance of Mary Douglas' (1997) concept of 'matter out of place'. As Douglas (1997) writes, the revolutionary discoveries made in the 18th century – that dirt could contain bacteria – radically changed the history of medicine and, at the same time, highlighted the link between dirt and infections or diseases. Furthermore, Douglas (1997, pp. 50-51) argues that dirt is relative. A pair of shoes is not dirty in and of itself; however, placing them on the kitchen table is considered dirty. Impurity occurs, in short, through the condemnation of an object or idea that might confuse or disrupt our indoctrinated classifications: a matter has a certain place to which it belongs and can lose value or even be considered dangerous when placed differently. The introduction of a smoke-free regime at all hospital venues in Norway illustrates how smoking was considered a 'matter out of place' in venues of healing. To simplify, before the change in the law,

[2] The global economic cost of smoking is estimated to be around $1.85 trillion, or approximately 1.8% of the global gross domestic product.

smoking indoors was familiar and natural, while the introduction of the smoking ban reclassified indoor smoking as unclean and foreign. The smell of smoke indoors is now largely considered unnatural and impure, as something belonging to another sphere altogether, especially in healthcare settings.

Again, we can return to advertising campaigns (or rather, anti-smoking campaigns) to further illustrate the symbolic repertoire that has followed or instigated, depending on one's interpretation, this change. The many anti-smoking campaigns emerging around the millennium were explicitly designed to provoke disgust and fear, portraying smoking as something filthy. The first anti-smoking campaign of this kind emerged in Australia in 1997 under the name 'Every cigarette is doing you damage' (Bayly et al., 2022). Several countries adopted this campaign, including Norway, where the slogan 'Every single cigarette is harming you' was used. The campaign was promoted through radio advertisements, newspapers, magazines, cinema advertisements and five different television advertisements. The graphics and messages in the television advertisements were so intense that, out of concern for children, it was decided not to air them until after 9 p.m. Three out of five video advertisements contained images showing damage to the lungs. One video showed the process of lung tissue becoming increasingly brownish and grey after inhaling cigarette smoke, before the lungs ended in a state of decay. The second showed how a tumour began to grow after inhaling cigarette smoke, and the third showed a dissected lung with a decilitre of tar poured over it, while a voiceover stated: 'that is as much tar as you would inhale if you smoked a 20-pack every day for a year' (Larsen et al., 2006, pp. 12-14). These campaigns helped shape society's perception of smoking by drawing on emotions of fear and disgust, thus also contributing to an added dimension in the doxa of lung cancer. The impurity of smoking became not only implied and metaphoric but also explicit.

The dissonance between the act of smoking and health is intensified by how the body is viewed in modern Western society. The body is increasingly revered and seen as a vessel that should be nourished, shaped and maintained. Larsen (2021) argues that the body has become a substitute for religious worship, through acts of physical exercise and the maintenance of good health. The body, consequently, should not be spoiled or soiled. In the context of smoking, the body is seen as clean in its natural state but becomes polluted through smoking. In the logic of the body as clean and sacred, smoking, as an activity that pollutes and debates the body will get status akin to a vice. As a vice, smoking not only besmirches the body; it does so because of the smoker's moral flaws. Moreover, this vice can also affect others through second-hand smoking, which adds to the degree of impurity. Conceptually, this is especially the case when children are involved. Children are pure and vulnerable, to be protected at all costs, and thereby in many ways represent the very opposite of the act (and habit) of smoking. Linking smoking to something that could harm children thus adds a new level to the stigma of smoking.

As we see them, these rules and campaigns are not necessarily a simple cause explaining how lung cancer came to be viewed as impure and 'matter out of place', but perhaps also a result of it. We argue that advertisements have played a significant role in shaping societal views on smoking while at the same time reflecting them. Advertisements contribute to reinforcing a specific perception of smoking and, by extension, of lung cancer patients. The impurity and danger associated with smoking, we further argue, make the stigma directed at smokers and lung cancer patients particularly effective, potent, and thus different from that of other patient groups.

So what? The doxa of lung cancer patients and the healthcare sector

So far, we have discussed the doxa of smoking and argued that self-infliction and impurity/danger are central components in the stigmatisation of lung cancer patients. We believe this has implications for how lung cancer is perceived within the broader medical field, and in everyday interaction between patients and healthcare agents.

According to Album and Westin (2007), three different prestige criteria influence how healthcare professionals rate diseases. First is the disease characteristics, where high prestige is given to acute and lethal diseases with clear diagnostic signs, especially those affecting the brain or heart. Second is the treatment type, where diseases treated with active, high-risk, and high-technology methods that lead to quick and effective recovery are highly prestigious. Third is the patient profile, where diseases affecting young patients who accept the physician's diagnosis and whose treatment avoids disfigurement or heavy burdens are awarded high prestige. Considering these criteria, lung cancer appears as a disease low in the medical pecking order. But does this translate to how lung cancer patients are met and treated in healthcare system?

Studies show varying experiences among patients with lung cancer regarding their interaction with healthcare system. Some studies report that patients experience stigma from healthcare professionals, although less compared to what they experience from society at large (Bédard et al., 2022; Criswell et al., 2016). Other studies indicate that patients experience significant stigma from healthcare professionals, primarily due to an assumed smoking history (Hamann et al., 2014). This negative perception can be intensified by the connection to low socioeconomic status (Hovanec et al., 2018; Sofianidi et al., 2024), such as having low-paying, hazardous jobs (Sofianidi et al., 2024). Similar associations have been observed in Norway, where individuals with a college or university education are reported to have a significantly lower risk of developing lung cancer compared to those whose highest level of education is primary school (Larsen et al., 2020).

In sum, both in terms of their disease and their personal characteristics, lung cancer patients do not seem to fit the image of an ideal patient. The discrepancy between what medical logic wants and what is actually encountered in lung cancer patients is also linked to the growing societal emphasis on maintaining a healthy body, as discussed earlier. A healthy body is pursued through exercise, a balanced diet and wholesome lifestyle choices, which also provide advantages when interacting with the healthcare system. We believe this is related to the disciplinary role of the state in Nordic countries, which is particularly prominent in the medical field. Broadly speaking, healthcare systems increasingly provide guidelines on how the population should behave in health-related matters. These include dietary advice, physical activity recommendations, and warnings against harmful substances like tobacco and alcohol, and the guidelines are communicated through official webpages, reports, social media, advertisements, and other information campaigns. The state also plays a significant role in public debates. While individuals are free to choose whether they follow these guidelines, compliance is expected and, in some cases, rewarded in healthcare interactions. A lack of investment in the body, for instance, can be seen as non-compliance and can result in resistance and even exclusion (Larsen, 2021). Moral judgment and blame for individual inadequacies may thus be a consequence of not following guidelines on health-related matters.

Failing to meet the image of an ideal patient becomes a moral issue, placing the responsibility for one's health (or lack thereof) squarely on the individual: patients are held accountable for building and maintaining their healthy bodies and are blamed when they fail to do so. (Larsen, 2021). This

dynamic can be seen as an execution of symbolic power, described as: ' the violence which is exercised upon a social agent with his or her complicity' (Bourdieu & Wacquant, 1992, p. 167), where social systems are reproduced and, most importantly, appear as a natural order. Healthcare professionals, drawing on their relative legitimacy based on their position in the medical field, function as caretakers or transmitters of this symbolic violence. An important note is that symbolic violence is imposed not to disempower but can be based on good intentions by governing bodies (Askheim, 2012, p. 97), such as encouraging people to quit smoking and improve their health. This disciplinary role is, we argue, especially evident with lung cancer patients. A study by Auriol et al. (2023), for instance, on how healthcare professionals approach lung cancer patients, finds that healthcare professionals struggle to accept when patients continue to smoke after a diagnosis, failing to adapt to the ideal, even in dire circumstances. Lung cancer patients are seen not only as morally responsible for their condition but also as poorly suited to meet the expectations placed upon them. This blame often leads to self-blame, resulting in both smokers and non-smokers feeling discomfort when sharing their lung cancer diagnosis with others (Williamson et al. (2020), further complicating healthcare interactions. Additionally, nurses and physicians working in pulmonary units, as reported by Nilsen, Oksholm, et al. (2025), expressed that lung cancer patients rarely assert their formal rights to treatment and support, often due to feelings of guilt and shame. In these settings, patients are seen as a group that is grateful for any assistance and hesitant to demand anything. In summary, lung cancer patients fail to align with the 'ideal patient', both in the view of the healthcare sector and in their own view, rendering both smoking as an activity and the smokers themselves as 'matter out of place'.

The stigma surrounding lung cancer is multidimensional, consisting of various elements that reinforce one another. This is referred to as 'stacked stigma', which encompasses the interactive and cumulative effects of self-blame related to a smoking history, poor prognosis, limited resources, inadequate support services, and insufficient research funding (Conlon et al., 2010). In this article, we contribute to understanding the concept of 'stacking' in the case of lung cancer by arguing that the disease, and thereby the patient, is also perceived as impure and associated with low prestige within the medical field.

Concluding considerations

Lung cancer has long been associated with poor outcomes, often seen as a death sentence due to late diagnosis, with palliative therapy as the only option. Historically, lung cancer has received significantly less research funding compared to other types of cancer in Norway (Nilsen, 2017). However, the situation is improving. Advances in preventive screening, targeted therapies, and better follow-up care enable more patients to live longer (Bray et al., 2024). In Norway, the five-year survival rate for lung cancer has doubled over the past 20 years, and the number of people living with a lung cancer diagnosis has tripled (Cancer Registry of Norway, 2024). Additionally, there is an increasing focus on screening high-risk individuals, such as smokers and previous smokers, to detect the disease earlier (Bray et al., 2024).

The treatment available for lung cancer is now more active and high-risk, and utilises more advanced technologies, which can lead to quicker and more effective recoveries. This shift may challenge the doxa of the lung cancer patient, at least from a medical perspective. According to Album and Westin (2007) prestige criteria, this change in treatment could alter how lung cancer is perceived and treated in healthcare settings. Therefore, further exploration of how the medical field understands

and approaches lung cancer today and in the future would be valuable. While we believe that the doxa of the lung cancer patient remains strong and continues to impact how the diagnosis is valued in healthcare settings – and how patients are perceived and treated – change might be on the horizon.

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