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“This is some mess right here.”: Exploring interactions between Black sexual minority women and healthcare providers for breast cancer screening and care

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Abstract

PURPOSE—Few studies have explored how the intersection of race and sexual identity contribute to breast cancer disparities for Black sexual minority women (SMW). Issues within patient-provider relationships, including bias, contribute to health disparities for minority groups. We employed constructs from Self-Determination Theory (SDT) to explore the nature of healthcare provider interactions in breast cancer screening and care among Black SMW.

METHODS—Participants were sampled nationally through social media, targeted emails, and referrals. We conducted qualitative in-depth interviews with 15 Black cisgender SMW, ages 38–64, who had a breast cancer diagnosis or recent abnormal mammogram. Interviews were conducted face-to-face or online, audio-recorded, and transcribed verbatim. Two analysts coded the interviews. Codes were analyzed across interviews to identify themes salient to SDT.

RESULTS—Themes aligned with the SDT constructs of relatedness and autonomy. Some participants discussed feeling most understood by Black and/or female providers who shared at least one of their identities. Feeling understood through shared identity contributed to participants feeling seen and heard by their providers. Participants who discussed negative experiences with providers believed that the provider made negative assumptions about them based on their race and/or sexual orientation.

CONCLUSION—When interacting with healthcare providers for breast cancer screening and care, Black SMW face specific challenges related to their multiply marginalized social position. Reducing healthcare provider bias toward Black SMW may improve patients’ desires to continue

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in care. Providing equitable care while acknowledging and respecting women with multiply marginalized identities may improve the nature of these interactions.

Keywords

bisexual; breast cancer; lesbian; health-care provider interaction; Self-Determination Theory; sexual minority

Introduction

Breast cancer is the most frequently diagnosed cancer in women.¹ Disparities in breast cancer screening risk, and mortality have been found in studies of sexual minority women (SMW) and studies of Black cisgender women (i.e. women assigned female at birth).^{2–5} SMW have a higher prevalence of breast cancer risk factors than other women, including nulliparity, alcohol consumption, smoking, and obesity.⁶ Despite this higher risk, SMW have a lower lifetime prevalence of screening mammograms compared with heterosexual women,⁷ and less timely screening,^{7–11} due to negative beliefs about care, lower perceived severity, lack of health insurance, costs of care, and perceptions of heterosexism and homophobia among providers.^{8–11} We found no studies that examined if or how these barriers may affect follow-up after abnormal screening. Few racial/ethnic minority participants in prior studies limit the ability to assess whether barriers to screening and follow-up for sexual minorities apply across racial groups.⁴

Black women are diagnosed at later stages of breast cancer than White women due to lower frequency of mammograms, longer time between mammograms, and lack of timely follow-up after abnormal mammograms,^{12–15} even among the insured.¹⁶ The persistent racial disparity in follow-up after abnormal mammograms has contributed to disparities in breast cancer mortality between Black and White women.^{17,18} Previous studies suggest that Black women have 1.39-fold odds of a two-month delay in breast cancer diagnosis after abnormal mammogram and up to a 2.24-fold delay in diagnosis and treatment combined.¹³ Delays in diagnosis result in an increased risk of an advanced stage of breast cancer.¹⁴ In addition to race, barriers to timely follow-up after an abnormal mammogram include low-income, perceived discrimination, and lack of insurance,^{19,20} factors also common among SMW.^{8–11} However, there is a dearth of research on how having multiple marginalized identities (i.e., Black SMW) impacts breast cancer screening and follow-up.²¹

Black SMW who face intersecting issues of racism and homophobia may be less trusting of the healthcare system.²² This intersection creates a unique context for breast cancer screening and follow-up;²³ however, there are limited data to inform effective interventions for Black SMW.²¹ For example, when attempting to compare mammogram usage between Black and White SMW using 2015 National Health Interview Survey and Cancer Supplement data, the sample of racial and sexual minorities was too small for statistical comparison. The limitations of existing data highlight the need for a purposive sample of Black SMW.

Only two peer-reviewed articles have specifically examined breast cancer screening and care in Black SMW.^{2,23} Matthews and colleagues found that breast cancer risk factors, including

obesity, physical inactivity, tobacco and alcohol use, were prevalent among Black SMW, yet perceptions of cancer risk were low.² This mismatch between risk factors and risk perception was associated with delays in care and low rates of prior screening mammograms.² Matthews et al. concede that their exploratory study was limited by recruiting participants from a single urban location and the lack of a comparator sample. Washington et al. describe an intervention designed to improve breast cancer screening among Black SMW but do not address engagement in care beyond screening nor provide data on the intervention's efficacy.²³ Both Matthews and Washington highlight the need for breast cancer care providers to be more sensitive to Black SMW; yet neither address specific barriers or facilitators to care-seeking after an abnormal screening. Importantly, neither study used qualitative methods to assess how to address barriers to follow-up care in ways that meet the expressed needs of Black SMW.

To address these gaps, we conducted a qualitative study assessing Black SMW's care experiences following an abnormal mammogram or breast cancer diagnosis. Our study was guided by Ryan and Deci's Self-Determination Theory (SDT), a theory of human motivation that has been applied to many domains, including health.^{24,25} SDT focuses on how social and cultural factors facilitate or undermine people's sense of volition and initiative. Social and structural conditions that support three basic human needs, i.e. autonomy, competence, and relatedness, are theorized to foster the highest forms of motivation and engagement in action (Figure 1).^{26,27} Autonomy is the feeling that one is in control of what happens to them.²⁵ Competence is one's belief that one can achieve a particular outcome.²⁵ Finally, relatedness is the sense of connection one feels with other people.²⁵ Support and subsequent satisfaction of these basic needs have been shown in other health studies to motivate the initiation and long-term maintenance of health behaviors.²⁸ We employed these SDT constructs to explore the types of healthcare interactions Black SMW have in breast cancer screening and follow-up care and to understand the barriers and facilitators women face in the healthcare system.

Methods

Sample

In partnership with ZAMI National Organization of Black Lesbians on Aging (NOBLA) – a non-profit organization serving Black SMW, we recruited a purposive sample of Black SMW via social media, grassroots organizations, Black churches, and referrals from participants. Participants had to meet the following inclusion criteria: 1) be 35 years of age or older, 2) assigned female at birth, 3) self-identify as a sexual minority (gay, lesbian, bisexual, or same-gender loving), 4) identify as Black or African American, and 5) have a history of breast cancer or an abnormal result on their most recent mammogram. Individuals were excluded if they were unable to provide consent in English.

Informed Consent

The study was approved by the Johns Hopkins University Institutional Review Board. Study staff provided either emailed or postal-mailed copies of the consent form to individuals who screened eligible and expressed interest in participating. The interviewer re-screened the

participant and conducted oral informed consent procedures prior to initiating data collection. No participant identifiers were requested or provided during data collection.

Data Collection

In consultation with the leadership of ZAMI NOBLA, study investigators developed the semi-structured interview guide (See Appendix). The interview guide focused on three major domains: intersecting identities, general health, and breast health. Participants were asked about facilitators and barriers to quality breast cancer screening, treatment, and follow-up care. In the domain of intersecting identities, participants were asked questions such as “What has been challenging about your identities? How do you manage the challenges?” In the domain of general health, participants were asked questions such as “How would you describe the availability and quality of services to meet your health needs?” In the domain of breast health, participants were asked questions such as “What, if anything, made it hard for you to get screening? What things made it easy?”

Author MAA interviewed 15 participants between September 2017 and July 2018 in person or virtually using Zoom, a HIPAA compliant video conferencing system. Interviews lasted 60-90 minutes, were audio recorded, and audio files were transcribed by a professional transcription service.

Data Analysis

Transcribed interviews were managed using the qualitative research software ATLAS.ti version 8 (Scientific Software Development GmbH). We developed a preliminary codebook using *a priori* codes that included topics from each domain in the interview guide as well as constructs from SDT (described above). JM coded the first seven interviews and NG coded the following eight interviews after reviewing JM’s coding scheme to ensure consistent application of codes. The two analysts discussed and resolved any differences in coding schemes throughout the coding process. Analysis included both vertical and horizontal comparisons (i.e. both within and across interviews) to identify recurrent and emergent themes with a focus on constructs of Self-Determination Theory.

Reflexivity

The authors are a diverse group of Black cisgender women, three of whom identify as sexual minorities (i.e., queer, lesbian, bisexual) and two who identify as heterosexual. Four authors are academics, with one being an academic and a clinician. One author is a social worker and community organizer.

Findings

Participant Characteristics

Patient characteristics are outlined in Table 1.

Themes

Each construct from Self-Determination Theory was salient across the interviews: autonomy, competence, and relatedness (Tables 2–4). The theme of alienation also arose for

participants who described environments that failed to support autonomy, competence, and relatedness – usually environments in which they were not treated fairly.

Autonomy: Participants described positive interactions with healthcare providers as times when providers listened to and respected her choices regarding breast cancer treatment and care. Positive interactions with providers were described dyadic conversations between the participant and the healthcare provider. Participants who had positive interactions with providers may have had better outcomes. For example, one participant described medication adherence despite not liking the medication because she feels like she is in control of her treatment (Table 2, Quote 6).

Participants described negative interactions as times when providers failed to listen to or respect her views regarding treatment and care. In some cases, providers failed to explain treatment options or other information to the participant. Many participants believed that their race, gender, or sexuality played a significant role in providers not respecting their choices surrounding treatment and care. Some participants were able to exercise agency to get the care they needed though doing so required additional effort.

This is my third bout with breast cancer, and the first and second time, it [chemotherapy] did not give me a good chance. I was like [to the doctor] ‘I was really sick. I almost died. Here I sit before you a third time. So this time, I’m going to choose for myself. I will do radiation, but I will not do chemotherapy.’ { ... } I think that healthcare providers should accept whatever treatment option you choose and I think they think that Black women, especially Black women, because they think we’re dumb already, you know, that we don’t know. And so if you go in there like you do know, they don’t have any choice but to respect it.

A supportive environment for autonomy was often described by participants who were able to have open conversations with their healthcare providers about screening, treatment, and care.

Competence: Participants who described more positive experiences with healthcare providers not only were able to exercise autonomy, but also had the self-efficacy to ask for and find the type of care that fit their needs (Table 3, Quote 1).

By contrast, some participants described feeling lost and unable to find the necessary information they needed within the healthcare system and providers who failed to help them. In recalling her initial screening, one participant described:

So I’m just laying there and I’m really scared and so he [the doctor] gives me an order to go see another doctor. I don’t have another doctor so he’s like ‘Just call this doctor for follow-up’ and I’m like ‘I don’t know where this doctor is. I don’t know where I’m going.

Again, many participants believed that their race, gender, and sexuality may have played a role when healthcare providers or administrative staff were unhelpful in connecting them to the services and care they needed (Table 3, Quotes 4; Table 4, Quotes 8-9).

Relatedness: Participants described positive interactions with healthcare providers who shared at least one characteristic (e.g., race, gender, sexuality) with the provider. While some participants sought healthcare providers that were Black women, many participants choose providers based on recommendations or who were in their network. It seemed rare for participants to have providers who identified as sexual minorities. When some congruence existed between the participant and her provider, participants more often described providers as treating them like human beings, understanding and being aware of their needs, and being accepting of all the participant's intersectional identities (Table 4, Quote 2).

Generally, feelings of relatedness appeared to facilitate an environment in which participants could ask for what they needed and felt that they were in control of their experience.

However, there were exceptions. One participant described a scenario with a Black female primary care physician who made erroneous assumptions about her religious beliefs on the basis of her race which the participant did not appreciate (Table 4, Quote 3).

Alienation: Participants described feelings of alienation when health care providers failed to create environments that supported autonomy, competence, and relatedness. Feelings of alienation led some to not seek care with a provider again as one participant describes below:

I went to see a reconstruction doctor, and the way that he talked to me was the main decision that I decided that I wasn't going to have reconstruction. I don't even think he spent 10 or 15 minutes talking to me about it. He just vaguely described what happened and all of this stuff and then looked at my breast and then said something to the effect "That was my decision," or whatever. I felt like it was just him getting his money. It wasn't any real concern of his. So I didn't feel comfortable at all. I remember that day when I walked out that I was like "This is some mess right here. I'm not even comfortable with this."

In some cases, participants described healthcare environments that did not provide them the same access to supportive services as other patients and their families. One participant described issues she faced trying to access a partner support group for her partner (Table 4, Quote 11)

Conclusions

These findings suggest that Black SMW face challenges in the healthcare system for breast cancer screening and follow-up care because healthcare environments and healthcare providers may be less likely to support them. Some participants described positive interactions with providers who listened to and respected their choices regarding treatment and care, recognized and attended to their specific needs, and empathized and cared for them. In these interactions, autonomy, competence, and relatedness were supported. By contrast, other participants who described negative experiences recalled providers making assumptions about them, neglecting to listen to their concerns, and failing to create supportive and welcoming environments. In these circumstances, autonomy, competence, and relatedness were not supported and participants described feelings of alienation. The refusal to relate to Black sexual minority female patients further alienated those who may

already have a difficult time navigating the healthcare system. Mistrust of healthcare providers already keeps many SMW from obtaining breast cancer screening.¹¹ Our findings confirm that these issues are compounded for Black SMW across the breast cancer care continuum from initial screening through treatment and survivorship. Thus, breast cancer care should be offered in the context of a trusting healthcare environment and relationship, which maximizes Black SMW's autonomy, competence, and relatedness.

Several recommendations follow from these data (Table 5). Black SMW in this study felt they received better care from healthcare providers with whom they shared one or more identities. They were more likely to trust healthcare advice and engaged in recommended care when there was racial or gender congruence with healthcare providers. Therefore, diversifying the healthcare workforce across the breast cancer care continuum can increase opportunities for relatedness and improve healthcare interactions for Black SMW. However, even in contexts when providers were not identifying as either Black or sexual minority, providers who were open about their identities facilitated relatedness.

All healthcare providers, regardless of race, gender, or sexuality, need more training in providing culturally humble and empathetic care to diverse patients. While several participants expressed agency in being able to respond to discrimination, this is an added burden to their access to care, and thus providers should address implicit biases when delivering care to Black SMW. Our findings suggest that dyadic conversations that used a shared clinical decision-making approach, that gave patients the opportunity to share their preferences and experiences, boosted feelings of autonomy and made patients more comfortable. Previous quantitative studies have shown that racial and ethnic minority cancer survivors lack access to physicians who understand their unique cultural backgrounds.²⁹ Respecting patient's autonomy, seeking to relate across differences to find common ground, and providing space for patients to exercise competence are core skills that those who work in the healthcare profession should cultivate. Training in shared decision-making should be provided and modeled for all healthcare providers across the breast cancer care continuum. Finally, providing support to help patients navigate an overwhelming healthcare system could support competence and autonomy.

Providing culturally inclusive healthcare environments and care can increase autonomy, competence, and relatedness, while reducing alienation, and increase the likelihood of Black SMW being retained in breast cancer care. While our analysis is focused on providers, we acknowledge that institutions, including administrative staff, can also better embrace the needs of Black SMW. This might include having structures and resources in place that directly speak to their needs and the needs of their caregivers or same-sex partners (e.g., support groups for same-sex partners). This could also include trainings for multiple members of the oncology care team on how to best meet the needs of Black SMW. Our research illuminates the needs of Black SMW, who have received little attention in the area of breast cancer care. However, because we used a small, purposive sample, results may not be applicable to all Black SMW or other groups. Many women in our sample were college educated, and some had the ability to do their own research and choose their own doctors. The limited range of socioeconomic statuses across participants prevented us from being able to identify any potential differences in experiences by socioeconomic position. Despite

having the means to eventually find the care they needed, many women in the sample had negative experiences that they attributed to their race and/or sexuality.

The experiences of Black SMW during breast cancer screening and follow-up care captured in this study speak to a larger need to address individual and structural-level biases that hinder quality care for Black SMW. Better collection of sexual orientation and racial identity data in electronic medical records and other databases is essential for building the evidence base to understand disparities for those at the intersection of marginalized racial and sexual identities. Integration of antiracism and anti-homophobia training into professional training programs for healthcare providers and continuing education for practicing providers should be implemented. Pipeline programs to ensure diversity within the healthcare workforce can ensure that all those in care have access to providers who relate to their cultural needs. These broad structural changes may not only improve healthcare for Black SMW, but for all patients.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Figure 1: Self-Determination Theory

Adapted from Center for Community Health & Prevention, University of Rochester Medical Center

Table 1:

Characteristics of Black Sexual Minority Interviewees (N=15)

	Mean	Range
Age (years)	50.2	38 – 64
	N	%
Sexual Identity		
Lesbian	12	80
Gay	2	13.3
Bisexual	1	6.7
Education		
High School	3	20.0
Some College	4	26.7
College Graduate/Advanced Degree	8	53.3
Employment		
Employed	13	86.7
Unemployed/Retired	2	13.3
Relationship Status		
Single	8	53.3
Married or Partnered	7	46.7
Breast Cancer Diagnosis		
Yes	13	86.7
No (abnormal mammogram only)	2	13.3

Table 2:**Representative Quotes Demonstrating the Autonomy Construct**

1	With almost any doctor, you're going to come in and you're going to be patient number 12345. They are challenged with seeing fifty of you every day. {...} I just accept the fact that I've got to be my own advocate. I've got to do my own research and I've got to have a network or resources to be able to ask other people questions. (Participant 1, age 53 y lesbian, employed, college graduate, partnered)
2	Interviewer: Do you think education or class or anything had to do with how you were perceived and how they [healthcare providers] engaged with you? Participant: That's a good question, because I think people do. People who are in authority, especially doctors who sometimes think they're god, I think they do adjust, and for lack of a better term, fall back when they realize like, okay, this person has a brain. (Participant 3, age 53 y, lesbian, employed, college graduate, single)
3	Yeah, I go to the doctor more now but I trust my instincts in me and my body and then I listen to the doctor also. But I hate say, doctors don't really know or feel what's going on in you. {...} When I was going through chemo, they gave me...steroids. I took the pill like they told me to. I couldn't sleep. I couldn't eat. I was pissed. I was mad. I told that doctor, 'Don't you ever give me that pill again and if you do, I'm not going to take it.' {...} I never did and she gave me some other one. (Participant 5, age 64 y, gay, employed, some college, single)
4	This is my third bout with breast cancer, and the first and second time, it [chemotherapy] did not give me a good chance. I was like [to the doctor] 'I was really sick. I almost died. Here I sit before you a third time. So this time, I'm going to choose for myself. I will do radiation, but I will not do chemotherapy.' {...} I think that healthcare providers should accept whatever treatment option you choose and I think they think that Black women, especially Black women, because they think we're dumb already, you know, that we don't know. And so if you go in there like you do know, they don't have any choice but to respect it. (Participant 6, age 39 y, lesbian, employed, college graduate, married)
5	I'm glad I advocated for myself. I'm glad that I had the ability that I can tell my doctors "No, I'm not doing that," that we can have conversations, that I have good relationships with my doctor. I'm glad that I did the research to see what type of cancer that I have. So I didn't allow them to just say "Oh, well we're going to give you chemo whether you like it or not." (Participant 11, age 56 y, lesbian, employed, some college, single)
6	I did what the doctors, for the most part, wanted in terms of the surgery, doing the tamoxifen and all of that. I knew that it was ultimately my decision, but I went with their recommendation. The tamoxifen, like this 10-year thing, I'm not crazy about it. I'm doing it because it's recommended. I know I could stop if I wanted to just because it's my choice, but I still feel like it's primarily my decision to keep taking this, even though I'm not crazy about it. Yeah, I think overall it's my decision. (Participant 12, age 41 y, lesbian, employed, college graduate, single)

Table 3:**Representative Quotes Demonstrating the Competence Construct**

1	I was sort of looking for what are the best facilities for treating cancer... and what I found was that the best facility that was fairly close. And I really liked my experience there. (Participant 12, age 41 y, lesbian, employed, college graduate, single)
2	I think that I got the best available doctors because I was able to go out and do my own research. A lot of women don't do it. They just take what they're given... I ask a lot of questions, and then the majority of the time they [doctors] say "Well you ask a lot of question [s]." Yes, because I'm very concerned and I want to know what this means and I want to know what that means and I want to know what's the timeline for this or are you just telling me stuff to be telling me or is this really going to happen or how is this going to turn out for me and how is this going to make me feel and what is that going to do for me? (Participant 14, age 59 y, lesbian, some college, retired, single)
3	My mom had to take her chemo treatments in the hospital and doctors would come in and they had great bedside manner, but they don't want to tell you anything. With my mom we didn't have options. We took what they gave us. I think that prepared me for when I did have to fight that on my own journey. I built my team of my cancer doctors. I vetted people and I knew if I didn't like someone or one of my doctors recommended someone and I didn't find good reviews on them or I didn't feel comfortable with them, then I turned them down. (Participant 1, age 53 y lesbian, employed, college graduate, partnered)
4	The doctor-- white doctor he's just checking and feeling and he's saying, 'Oh, you're kind of young. I'm sure it's not a malignant lump.' I had no idea what he was talking about so I'm just listening and he's talking over me to the nurse like I'm not even there. So I'm just laying there and I'm really scared and so he gives me an order to go see another doctor. I don't have another doctor so he's like 'Just call this doctor for follow-up' and I'm like 'I don't know where this doctor is. I don't know where I'm going.' (Participant 6, age 39 y, lesbian, employed, college graduate, married)

Table 4:**Representative Quotes Demonstrating the Relatedness Construct**

1	My nurse, my infusion nurse, was amazing. She wasn't LGBT, but she was very supportive of S [participant's partner] and when S wasn't there, she's, like, 'Where's S? I need S here,' and 'You're not doing what I'm telling you to do. I'm going to tell S.' <laughs> 'Don't let me call S.' <laughs>... It means the world. You know, because I can only imagine going through this and then, you know, having to hide who you are at the same time. I couldn't do it. (Participant 1, age 53 y, lesbian, employed, college graduate, partnered)
2	It just so happens that the majority of my doctors are minority women. My radiologist, my breast specialist, my oncologist, my primary are... all women, and they're all minorities. They treated me fairly. They asked about my partner... I mean, it [sexual orientation] was just like that was just another piece of information about me that they knew. It didn't make a difference one way or the other. (Participant 2, age 49 y, lesbian, high school, employed, partnered)
3	I had a doctor one time... She was a primary care physician... a black female, and this had nothing to do with sexuality, but who prayed with me. I was a little thrown, because I got a church for that. I didn't come here for that. I'm not sure how I felt about it. But I know I didn't appreciate it. I was experiencing some anxiety, and she went on to tell me, "Oh, we don't--" you know, we, as in black people, "We don't need this [therapy], because we believe in God and we pray," (Participant 3, age 53 y, lesbian, employed, college graduate, single)
4	Very good relationship because I did tell him I was gay, and he was a drag queen, so, he was like 'I got you girl.' That's what he said, you know, 'You're my girl.' He'd say, 'You know you're my girl.' (Participant 8, age 48 y, lesbian, high school, employed, single)
5	Initially I was sort of, like, hesitant about having the male doctor as my radiation guy... Because. I'm a big old dyke at that point. I'm like, I don't want a dude in my stuff... But, you know, I said finally, you know, they say he's good. ... [He] was a black Caribbean man. Even though he wasn't a woman, I felt comfortable with him... I'm not sure I would have felt as comfortable if it had been a white guy. (Participant 10, age 41, bisexual, college graduate, self-employed, partnered)
6	I think my race and gender played a role in why I chose the surgical team and facility that I chose. If I'm going to have to have surgery, I want it to be with people who are accustomed to dealing with black patients -- because I feel like that will hopefully make it less likely that their stereotypes and biases will color the health care encounters... that I have with them. (Participant 12, age 41 y, lesbian, college graduate, employed, single)
7	If [the healthcare providers] present to me that they are concerned and care about the type of care that you get I'm open to whatever color because I've had some wonderful experiences with white doctors and Indian doctors... (Participant 14, age 59 y, lesbian, some college, retired, single)
8	The day of the mammogram, I met with a woman-- oh my gosh, she was so nice. She was a Black woman, and she was a patient financial representative... She was amazing, and she actually went above and beyond her job. And she was almost like a mother figure, in that she was like, "You've got to get this taken care of." You know, she hugged me, and she said, "You got this. She was just talking to me, you know, like a person. I'd never seen a patient advocate... that treated me like a person... The first time was a white woman, and she was very condescending. "So you don't have it? Do you have a second insurance?" I felt embarrassed. (Participant 15, age 38 y, lesbian, some college, employed, partnered)
9	None of the healthcare providers, aside from my primary, when I do force her to do so, sit down and talk to me in layman terms, where I can understand. I suppose they talk over me because I'm a Black woman walking in there. After you get the ultrasound, they take you in a room and they talk to you. And he was like, "I see this in a lot of Black women," you know? "A lot of Black women don't come here and access care." And how dare you? I'm not talking about Black women. I'm talking about me. I'm walking in, -- talk to me like I'm an individual, having this experience. I understand that your experience, as a healthcare provider and a white man as a healthcare provider, who is older, understand that your experience is that Black women don't come in here and get care until it's too late. I don't want to hear that. Already, I feel like I don't have a team around me. (Participant 15, age 38 y, lesbian, some college, employed, partnered)
10	I remember seeing this doctor once that was just not a nice guy. I got his name from an LGBT organization and he was supposedly an ally, but he just had a horrible bedside manner, he was very rough, didn't talk to me and tell me what was about to happen. I remember leaving his office that day feeling violated. So I never went back, but I just found another doctor because it was still important (Participant 1, age 53 y, lesbian, college graduate, employed, partnered)
11	I used to ask T to go with me, so I'm sure they knew I was a lesbian. I even asked for a support group for T. "We don't have that. We have support group for husbands." But she's not a husband. "We don't have that." (Participant 6, age 39 y, lesbian, college graduate, employed, partnered)
12	I went to see a reconstruction doctor, and then when I went to see him his attitude and the way that he talked to me was the main decision that I decided that I wasn't going to have reconstruction, {...} I don't even think he spent 10 or 15 minutes talking to me about it. {...} I felt like it was just him getting his money. It wasn't any real concern of his. So I didn't feel comfortable at all. (Participant 14, age 59 y, lesbian, some college, retired, single)
13	When we got there-- I didn't know what to expect. We were told just to go to the breast cancer center. There were a lot of women in there, and they just packed them in there.... We were all cattle, sitting in that one little room, waiting to be called, you know? I think that as soon as a woman comes in there, I think that there should be some kind of conversation about what to expect... the result of what happens here could be like something life-changing for us. I think having someone there with you that has gone through this very same thing, that might volunteer to sit with you and not talk, or talk, hold your hand, or help you put this robe on, or, you know, be there with you from start to finish-- I had to muster up all of my courage to even go to this appointment. I almost-- I rescheduled it twice. And I can imagine some people not even rescheduling, just saying, "F it, I'm not going to go," because they're scared, you know? (Participant 15, age 38 y, lesbian, some college, employed, partnered)

Table 5:

Recommendations to improve breast cancer screening and follow-up care among Black sexual minority women

Recommendation 1	Diversify the healthcare workforce across the breast cancer care continuum including healthcare providers and administrative staff to increase opportunities for relatedness for patients.
Recommendation 2	Provide training in and model shared decision-making for all healthcare providers across the breast cancer care continuum to increase autonomy among patients.
Recommendation 3	Redesign healthcare environments and resources to be inclusive of patients from all backgrounds including support groups.