


## Breast Cancer: Meanings Attributed by Lesbian Women and Their Partners to Healthcare

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**Abstract:** In oncological services, questions on sexual orientation are not even addressed by professionals during appointments, which reinforces the invisibilization of lesbian women. This supports the assumption that all women assisted due to breast cancer have a hetero-oriented sexuality. This qualitative study aimed to analyze the meanings attributed by lesbian women with breast cancer and their partners to care practices and their health needs. Seven women participated, four of whom had been diagnosed with breast cancer and three were their intimate partners. Individual in-depth interviews were conducted, subjected to thematic analysis, interpreted from a gender perspective. Patients and partners reported receiving adequate care in health services and felt supported by professionals, but they also experienced episodes of disrespect and discrimination. The findings confirm the need to adopt inclusive health policies that are sensitive to the specificities of lesbian women.

**Keywords:** breast neoplasms, homosexuality, gender, health personnel attitudes, health services accessibility

### Câncer de Mama: Significados Atribuídos por Mulheres Lésbicas e suas Parceiras aos Cuidados em Saúde

**Resumo:** Nos serviços oncológicos, perguntas sobre orientação sexual sequer são incluídas durante as consultas, reforçando a invisibilização de mulheres lésbicas. Isso acaba sustentando o pressuposto de que todas as mulheres assistidas em decorrência do câncer de mama têm sexualidade hetero-orientada. Este estudo qualitativo teve como objetivo analisar os significados atribuídos por mulheres lésbicas com câncer de mama e suas parceiras às práticas de cuidado e às suas necessidades de saúde. Participaram sete mulheres, sendo que quatro haviam recebido diagnóstico de câncer de mama e três eram suas parceiras íntimas. Foram realizadas entrevistas individuais, em profundidade, submetidas à análise temática, interpretadas na perspectiva de gênero. Pacientes e parceiras relataram que receberam cuidados adequados nos serviços de saúde e se sentiram apoiadas pelos profissionais, mas também vivenciaram episódios nos quais se sentiram desrespeitadas e discriminadas. Os achados endossam a necessidade de adoção de políticas de saúde inclusivas, sensíveis às especificidades das mulheres lésbicas.

**Palavras-chave:** neoplasias mamárias, homossexualidade, gênero, atitude do pessoal de saúde, acesso aos serviços de saúde

### Cáncer de Mama: Significados Atribuidos por Mujeres Lesbianas y sus Parejas a la Atención de la Salud

**Resumen:** En los servicios oncológicos, ni siquiera se incluyen preguntas sobre la orientación sexual durante las consultas, lo que refuerza la invisibilización de las mujeres lesbianas. Esto acaba sosteniendo la idea de que todas las mujeres tratadas por cáncer de mama tienen una sexualidad heteroorientada. Este estudio cualitativo pretendió analizar los significados atribuidos por las mujeres lesbianas con cáncer de mama y sus parejas a las prácticas asistenciales y a sus necesidades sanitarias. Participaron siete mujeres; cuatro habían sido diagnosticadas con cáncer de mama y tres eran sus parejas íntimas. Se realizaron entrevistas individuales en profundidad, y los datos se sometieron a un análisis temático, interpretado desde una perspectiva de género. Las pacientes y sus parejas informaron que recibieron una atención adecuada en los servicios sanitarios y se sintieron apoyadas por los profesionales, pero también vivieron episodios en los que se sintieron ofendidas y discriminadas. Los resultados avalan la necesidad de adoptar políticas sanitarias inclusivas y sensibles a las especificidades de las mujeres lesbianas.

**Palabras clave:** neoplasmas de la mama, homosexualidad, género, actitudes del personal de salud, accesibilidad a los servicios de salud

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Diagnosis of breast cancer and surgery (mastectomy) potentially cause severe damage to body identity of women undergoing treatment. Total or partial removal of breast leaves many physical and emotional scars, which are at the same time embodied and intangible, affecting the subjective constitution of women. Fear of rejection and diffuse feelings of sadness and shame commonly follow experiences of critical life events, threatening the continuity of existence and leading to the estrangement of one's own body (Inocenti et al., 2016; Verenhitch et al., 2014).

Women with breast cancer face deep transformations, largely resulting from the impact of diagnosis and the adverse effects of treatment. Numerous barriers and challenges experienced throughout treatment require significant adaptations on their way of thinking and acting. Such changes resonate physically and emotionally, affecting personal and social life (Bervian & Girardon-Perlini, 2006). Affected women experience psychosocial transition, which involves personal readaptation and reorganization of social roles, also impacting family and other social network's members. Thus, along with breast loss comes the loss of femininity and of sense of identity (França et al., 2021; Inocenti et al., 2016).

Considering the magnitude of changes and their consequences in women's lives, cancer treatment involves a long journey into the unknown, triggering numerous fears and increasing uncertainties about the future. Therefore, these affected women tend to develop a relationship of dependence and trust to the oncologists and to the healthcare teams. A strong bond makes them feel safe and confident toward medical authority, and it often leads them to accept, for example, the professional's indication of a breast reconstruction (Inocenti et al., 2016).

The breast is often subjectivized as an erogenous organ invested with esteem and affection in the process of constituting female identity. It is important to construct women's self-esteem, as it helps them to develop their sense of identity as a sexed and gendered person. Thus, it is understandable that removing such a fundamental part of subjective and relational life leads women to the idea of having become "incomplete" after cancer, further reinforcing concerns about being close to the end of their existence, undesirableness, and physically unattractiveness (Silva et al., 2018). Faced with the possibility of experiencing successive losses, family and affective relationships tend to acquire prominence and become object of reflection, changed while resuming routine after treatment. Those women who can rely on a quality marital relationship can help women to perceive and signify their condition beyond pain and suffering (Bervian & Girardon-Perlini, 2006; França et al., 2021).

Rich (2019), pioneer in studies on lesbianities, formulated the concept of compulsory heterosexuality, defined as a system of domination based on the binary division of genders and the heterosexual matrix, reproducing perverse oppression spaces and mechanisms. Notably, lesbian women accumulate a compound discrimination: against their gender and against their (homo)sexuality, invisibilizing aspects of their sexual orientation and gender identity. One manifestation of the prevailing misogyny in society is the enormous disdain for female sexuality, often transformed into violence when women contest the social status attributed to their gender (Borrillo, 2010).

Healthcare services do not address the topic of sexuality in context of breast cancer (Verenhitach et al., 2014) and women's sexual orientation is openly neglected and ignored by professionals during consultations, which reinforces the invisibility of women with dissident sexual-affective orientation (C. Souza et al., 2021). Thus, in health practices,

professionals, without being fully aware of this erasure process, end up sustaining the assumption that all women assisted due to breast cancer have a hetero-oriented sexuality (Dullius et al., 2019; C. Souza et al., 2021).

Because of omission and erasure of the heterosexual matrix that structures social relationships (Rich, 2019), health professionals tend to neglect relational and sexual-affective aspects, naturalizing that women with breast cancer necessarily have a male partner. They ignore the possibility of the patient being affectively and sexually attracted to another woman and having a female intimate partner, who also needs attention, guidance and healthcare during cancer treatment. Therefore, it must be acknowledged risks of reproducing failures in care, which can weaken the bond with fundamental social support actors (C. Souza et al., 2021; Wandrey et al., 2016).

According to gender studies (Cabral et al., 2019; Xavier et al. 2010), it is assumed that health professional's representations of sexuality potentially affect the communication with patients. These findings have practical implications, because they can help to improve the qualification offered to nurses and other health professionals (Palma & Orcasita, 2018).

For professional help to be effective, comprehensive understanding of sexuality(ies) as well as the deleterious effects of gender- and sexual-orientation-based discrimination is necessary. When such understanding is absent or neglected in health services, the diverse range of homosexual and bisexual women in need of help is ignored. In addition, considering that receiving social support is important to meet mental health needs, to provide sensitive care to the LGBTQIAPN+ population becomes a critical need in the current health agenda (Liu & Yeo, 2021; McNair & Bush, 2016).

Although sexuality is increasingly recognized as a constitutive part of human experience, it is rarely incorporated as an inseparable dimension of care (Cabral et al., 2019; Jahn et al., 2019), denying women the right to choose and decide. Moreover, oncology studies were not designed to consider patients' and their partners' perceptions of the physician-patient relationship (C. Souza & Santos, 2021; C. Souza et al., 2021). Most research was conducted in specific populations of developed countries, mainly the United States, and their results may not be fully applicable in other contexts and cultures (C. Souza & Santos, 2021). Based on this perspective, this qualitative study aimed to analyze the meanings attributed by lesbian women with breast cancer and their partners to care practices and their health needs, exploring whether, in their perceptions, professionals are sensitive to their demands.

## Method

This is a qualitative, descriptive-exploratory and cross-sectional study. The perspective of qualitative research was chosen because it seeks to support the

understanding of meanings, senses, experiences, beliefs, and representations, valuing different perspectives of the participants and considering their biopsychosocial aspects (Flick, 1998/2009). The Consolidated Criteria for Reporting Qualitative Research (COREQ) guide was used to report the essential elements that should make up a qualitative research (V. R. Souza et al., 2021).

## Participants

Seven women who self-identified as cisgender and lesbian participated in the study, four of whom had been diagnosed with breast cancer and three were their intimate partners, regardless of how long they had been together. Participants were located through social networks, healthcare services, and third-party referrals. The researcher contacted LGBTQIAPN+ collectives, support groups for people with cancer, and hospitals, both in-person and through social media and email. Nine women were identified, but two of them declined the invitation, one being the wife of one of the participants (Nina), and another woman who initially expressed interest in participating, but stopped responding to the researcher's messages. Nina's wife declined the invitation after the participant had already been interviewed.

Participants were selected based on the following inclusion criteria: self-declared lesbian; aged 18 years or older; diagnosed with breast cancer (in the case of patients) or being their affective partner; stable clinical condition. The exclusion criterion was: women who had significant understanding and communicating difficulties.

The number of participants was determined by the concept of "information power" proposed by Malterud et al. (2016). "Information power" indicates that the more information the convenience sample holds, which is relevant to the study, the smaller the number of participants needed. The size of a sample with sufficient information power depends on: (a) study objective, (b) sample specificity, (c) level of theoretical foundation of the study, (d) quality of the dialogue obtained in the interview, (e) analysis strategy used (Malterud et al., 2016).

## Instruments

*Sociodemographic data form*: form with necessary information for characterization of sociodemographic and clinical data.

*Brazilian Economic Classification Criteria – Brazilian Criteria (CCEB)*: standardized instrument that characterizes participants by their social status (Associação Brasileira de Empresas de Pesquisa [ABEP], 2016).

*Semi-Structured Interview Script*: to build the *corpus*, episodic narrative interviews were conducted, which, according to Flick (1998/2009), focus on exploring participants' reports about facts, episodes, and events that are relevant to the understanding of the studied phenomenon. The interview script was developed according to a review of

scientific articles on the subject (C. Souza & Santos, 2021) and with the experience of the research group.

## Procedure

**Data collection.** The researcher had access to the participants and their partners from contacts obtained via interpersonal indications and the first participants' relationship network, by snowball sampling. The researcher preliminarily contacted the eligible women, explaining the research objectives and requesting their collaboration. In case of consent, the researcher scheduled a meeting according to the participant's availability. On this occasion, permission was requested to contact participants' partners. If the partner was willing to collaborate, her interview was scheduled. From November 2017 to May 2018, interviews were scheduled at the participants' household or other places of preference.

Separate interviews were conducted, except for one couple, Débora and Helena, who attended both interviews together. Despite that, it had been previously agreed that the researcher would talk to Débora first. The participants were not asked to attend the interviews alone (or accompanied). In order to respect the wishes of Débora and Helena, who organized themselves to be present on the scheduled days and times, the researcher chose to conduct the interviews in the presence of the partner. The decision considered that the focus of the investigation is not on the couple's relationship, but on each spouse's perceptions of breast cancer and healthcare services. Therefore, it was not considered an obstacle to interview couples who attended together or separately, neither patients whose partners did not agree to participate in the research.

All interviews were conducted face-to-face and lasted from 77 minutes to 331 minutes. The interviews were audio-recorded on a digital recorder, with the interviewees' consent. The conversation was held in a private environment, safeguarding participants' comfort and privacy.

**Data analysis.** The interviews were transcribed and analyzed from a thematic-reflective perspective (Braun & Clarke, 2019). Exhaustive readings of the transcribed material were carried out, to identify units of meaning and thematic axes, which subsidized the final outcome. After the *corpus* analysis, the results were systematized into themes and interpreted according to the adopted theoretical framework, unveiling the meanings attributed to the experience of breast cancer and oncological treatment from the perspective of the affected women and their intimate partner. Gender and sexuality analysis was used as theoretical perspective (Rich, 2019; Scott, 1986), applied to health and cancer (Xavier et al., 2010).

## Ethical Considerations

The project was approved by the Research Ethics Committee of the institution to which the researchers are linked, CAAE 65391517.4.0000.5407, following Resolution No. 466/12. Proper names have been replaced by fictitious names.

## Results and Discussion

The results will be presented and discussed in two stages. Firstly, the interviews of the following women diagnosed with breast cancer will be analyzed: Débora, Nina, Yele,

and Frida. Afterwards, the interviews of their affective partners will be analyzed: Helena, Marília, and Fernanda. Table 1 presents the sociodemographic data of participants.

Table 2 presents some clinical data of the participants, related to their personal trajectory with breast cancer.

**Table 1**

*Sociodemographic characteristics of participants (n = 7)*

Ref.	Name (fictitious)	Age (years)	Relationship time	Occupational situation	Education	Household income	CCEB
1	Débora	37	1 year	Production Operator and <i>Bartender</i>	Complete higher education	R\$ 3,000	B2
	Helena	22		Law Student	Incomplete higher education (attending)		
2	Nina	53	30 years	Occupational therapist	Complete higher education	Not informed	Not informed
3	Yele	38	6 months	Barber	Complete higher education	R\$2,000 to R\$3,000	B1
	Fernanda	43		Chemist	Complete higher education	R\$ 10,000	A
4	Frida	51	13 years	Administrative Officer	Complete high school	R\$3,000 to R\$3,500	B1
	Marília	59		University professor	Complete higher education	R\$ 13,000	A

Note. CCEB: Brazilian Economic Classification Criteria.

**Table 2**

*Clinical characteristics of participants affected by breast cancer*

Name (fictitious)	Age at diagnosis (years)	Surgery time (years)	Type of surgery	Complementary treatments to surgery	Breast reconstruction
Débora	33	4	Modified radical mastectomy	Chemotherapy and radiotherapy	Yes
Nina	51	2	Modified radical mastectomy	Chemotherapy and hormone therapy	No
Yele	33	5	Modified radical mastectomy	Chemotherapy, radiotherapy and hormone therapy	Yes
Frida	48	3	Quadrantectomy	Chemotherapy, radiotherapy and hormone therapy	No

### Analysis of the interviews with women who experienced breast cancer

Thematic analysis allowed the construction of the following thematic axes: (1) welcoming; (2) lack of care; (3) female physicians' empathy; (4) discrimination. Débora, Nina, Yele, and Frida reported that, during their therapeutic treatment, they met professionals who made them feel welcomed and comfortable (Theme 1), both regarding the environment and the professional's approach.

This theme can be exemplified by the following statements: "[...] In all my situations, she [gynecologist] would ask, 'So, how did you get through, how did you

get through a certain situation?', so, by that, she tried to understand the situation before saying anything" (Débora, 37 years old). "I mean, the atmosphere is different, you know? Then, there are a lot of pictures of her [gynecologist] with a dog [laughter], placed in her office, where she welcomes you [...]" (Nina, 53). "I had the opportunity to be treated by the head of the hospital [...]. He welcomed me in an incredible, incredible way, I was very good" (Yele, 38). "[...] In chemo, the girls are just amazing, wow, lovely, all of them, you know? Even in welcoming you, you know? [...]" (Frida, 51).

Physicians who provide support and a safe environment for lesbian and bisexual women can help them

develop adaptive and healthy coping skills. Furthermore, more efficient and affable communication practices contribute to a better relationship between physician and patient (Andrade et al., 2021; Inocenti et al., 2016; Whitehead et al., 2016). All participants reported having encountered healthcare professionals who supported and comforted them at different periods of the treatment and with whom they maintained a good relationship, which highlights the importance of humanized care for all service users, including lesbian women.

However, the four participants also reported situations in which they did not receive adequate care (Theme 2) in healthcare services. Frida mentioned delay in care and non-compliance with the order of arrival at the service: “[...] I think it’s disrespectful. You know? Because I think they could [...] respect the order [...] of arrival, I saw people who arrived long, long after me, being called first”; Débora pointed out the delay in her exams results; Yele said she did not receive hormone therapy medication for three months, for it was in short supply in the public healthcare system; and Nina commented that the hospital surgeon did not want to perform a bilateral mastectomy, even though the surgery was indicated for her.

[...] The exam had been finished since 11:30 p.m., and it was 2 a.m. when she [health professional] went to check it [...]. So, I was sleeping on the chair [...] in a hospital waiting room [...] (Débora, 37).

[...] They suspected the cancer had spread to the pelvis and... I was desperate. When they [nurses] entered the [consultation] room [...] I said: “If I get cancer again, you are all fucked up.” I was three months without medication [hormone therapy] (Yele, 38).

In a specific forum for lesbian women with breast cancer, patients reported being mistreated due to lesbophobia, heterosexual bias, as well as expressing feelings of exclusion in the main breast cancer support services, which indicates that the available services may not be adequately meeting these women’s needs (Wandrey et al., 2016). Although the participants did not explicitly reported suffering from lesbophobia and heterosexual bias in health services, Débora, Nina, Yele, and Frida found some professionals who were not able to provide adequate care to their needs. In the participants’ perception, those professionals were unable to put themselves in the difficult situation they were experiencing as patients.

Nina and Débora reported that they felt a lot of understanding and empathy from the female physicians (Theme 3): “And I had also already decided I wanted another female [oncologist]. [...] Because it’s different. I mean like, they understand what we are feeling [...]” (Nina, 53). “[...] I felt very comfortable with her [gynecologist]. Maybe because I am a woman and maybe

because she is so understanding and always talked to me [...]” (Débora, 37).

A study showed that female physicians are more empathetic and are able to establish communication that addresses a broader life context and the real conditions of patients, which promotes more positive physician-patient interactions, and results in greater comfort during consultations (Andrade et al., 2021). The reports of Nina and Débora corroborate the findings reported in the two mentioned studies.

Furthermore, Nina, Débora and their respective physicians can be considered part of the lesbian *continuum* (Rich, 2019), as these female professionals, regardless of their sexual orientation, were able to identify with their female patients, and vice versa, providing support to Nina and Débora at the time.

On the counterpart, Débora also reported having suffered discrimination (Theme 4) from physicians she encountered in her long treatment journey. The feeling of helplessness and lack of protection experienced by Débora in one of these situations was so traumatic she found herself invaded by a terrifying panic because of the prejudice.

For example, a professional who, instead of saying: “Look, Débora, you have pneumonia, I’m going to prescribe you an antibiotic,” he kept saying: “Look, but you are such a beautiful woman” [...]. Even though my wife was by my side! [...] It was horrible. [...] It totally scared me because he wanted to hospitalize me. And I said: “What is this doctor capable of doing while I am hospitalized?” [...] (Débora, 37).

The representations about gender and sexual orientation internalized by professionals affect the organization and routine of healthcare services. Professionals who disrespect the existence of orientations other than heterosexuality invisibilize non-heteronormative patients and are seen by patients as a potential barrier to access to healthcare services (Lisy et al., 2018; C. Souza et al., 2021). Notably, the physician’s abusive posture, mentioned by Débora, frightened her to the point of compromising the treatment continuity by threatening the necessary trust basis of a physician-patient relationship.

It can be observed how the distribution of power is different between men and women, since social relations are marked by male domination as a legacy of patriarchy (Scott, 1986). The white and male physician, placed in a power position within social hierarchy directed an offensive speech at his female patient, without considering the potential catastrophic effect of his sexist comment (which happened). Thus, heterosexuality can be analyzed as a form of oppression, as the patient felt intimidated and was afraid to follow the treatment prescribed by the professional (Rich, 2019; Scott, 1986).

Nina, Yele and Frida, on the other hand, claimed they had not suffered any type of discrimination in healthcare



services because of their sexual orientation: “[...] So there has not, never had... a difference in treatment [by health professionals]. And I do not feel like they should have asked me anything about it [sexual orientation] to make a difference, right?” (Nina, 53). “[...] As for sexuality, I have never undergone such experience [prejudice]. I am openly lesbian. [...] I have never had any problems” (Yele, 38). “No one asked [about sexual orientation], she [Marília] also did not go in with me [to health services] holding my hand. She was just a friend. That is how she behaved, got it?” (Frida, 51).

Studies show that healthcare services are still unable to include and satisfactorily meet the demands of non-heteronormative women, even though health discourses and policies ensure the right of all women to respectful and adequate care (Lisy et al., 2018; Wandrey et al., 2016). In contrast to this negative expectation, Nina, Yele, and Frida reported not perceiving any kind of discrimination for being lesbians or any disparities during treatment. On the other hand, the lack of talk about dissident sexual orientations between professionals and patients as well as the partners’ constraint to public displays of affection reinforce compulsory heterosexuality, as it invisibilizes lesbian existence (Rich, 2019).

### Analysis of the interviews with affective partners

Thematic analysis allowed for the construction of the following thematic axes: (1) helplessness; (2) discrimination; and (3) welcoming. In their interviews, Helena and Marília shared the feeling of helplessness (Theme 1) they experienced when attending healthcare services as companions of their affective partners. Helena reported a lack of attention from Débora’s mastologist, who botched her wife’s breast prosthesis implantation. Marília was uncomfortable with her girlfriend going through several different physicians throughout treatment.

We are being very poorly supported by physicians, for example, her [Débora’s] mastologist. He messed up something on her breasts and the breast implant is flipped. [...] It has an air ball that can [...] be ruptured at any moment and [...] he said disdainfully: “[...] You’ll need to change this prosthesis within a year at the latest, but it’s normal” (Helena, 22 years old).

One thing that I find challenging in the hospitality [of the hospital] is the fact that each appointment is conducted by a different resident. For me, this is very difficult in cancer treatment [...]. I think that, for these pathologies, it is very important to have a permanent physician [...] (Marília, 59).

Professionals’ rotation, which characterizes services in teaching hospitals, highlights the importance of maintaining the bond in healthcare to reassure patients

and their partners. It allows them to keep contact, clarify doubts and request new recommendations (Duman & Yildirim, 2022; C. Souza et al., 2021). Being a chronic and progressive disease, breast cancer requires professionals to follow patients longitudinally. When they are assisted by a trusted professional, they feel supported and motivated to follow the recommended therapeutic plan (Duman & Yildirim, 2022; Inocenti et al., 2016).

Marília felt that Frida was not being supported by the physicians with whom she was consulting due to professional’s rotation and Helena stated that Débora’s surgeon made a medical error, leaving the patient helpless by not taking responsibility for his mistake. However, unlike the literature indicates (Lisy et al., 2018; Palma & Orcasita, 2018; C. Souza et al., 2021), the two companions did not associate negative episodes with prejudice.

On the other hand, Helena felt that she and Débora were not treated as a couple during medical appointments, which constitutes discrimination (Theme 2) based on sexual orientation.

It’s like we were not a couple [during consultations]. [...] She [the physician] barely greets me when I walk into the room. She speaks only to Débora, addresses only her. If I say something, she looks [...] and turns to Débora, as if they were alone there (Helena, 22).

Due to gender socialization, female sexuality is denied, repressed, and feared, as well as the right to one’s own body. The persistence of patriarchal-inherited representations invisibilizes lesbianity (Cano, 2019; Rich, 2019; Scott, 1986). To authentically consider lesbian women, health professionals need to step out of their comfort zone and abdicate their privileges. Physicians must have the courage to listen to a lesbian/bisexual patient as this is a significant process; they must also bear the understanding that difficulties will always exist, because there are questions that remain unanswered or that are not easy to understand (Cano, 2019). In Helena’s report, we perceive that the professional does not authentically listen to her and denies that the two women in front of her form a couple, manifesting their sexuality, which reinforces assumptions of compulsory heterosexuality (Rich, 2019) in healthcare.

On the contrary, Marília and Fernanda reported never suffering discrimination from healthcare professionals when they were treated with their partners: “I would go into the room [during Frida’s appointments], talk, and so on. [...] Whether they [healthcare professionals] understood that we were a couple... they never asked [...]. But it never happened ... I have never been mistreated [...]” (Marília, 59). “I didn’t [feel discriminated], on the contrary, on the contrary, when we went to the emergency care unit [...] Yele knew everyone [...]. We were treated just like everyone else, within the routine. [...] It was OK [...]” (Fernanda, 43).

Within health services, there are still large gaps and negligence in treatment offered to non-heteronormative

people (Cabral et al., 2019; Jahn et al., 2019). Lesbophobia is a device for producing and regulating heterocentric femininities. Equity should be seen as a guiding principle of health practices and services, to meet the specific needs—not only of lesbian women, but of the entire LGBTQIAPN+ population — and for the fulfillment of social justice, prioritizing those who need it most and seeking to reduce inequities (Lisy et al., 2018; Palma & Orcasita, 2018).

Based on Fernanda's report, it can be inferred that she did not perceive negligence when she accompanied Yele in healthcare and, in fact, she characterized the treatment received as egalitarian. Marília also did not perceive any form of discrimination against her when she accompanied Frida to consultations. However, it must be mentioned that when professionals do not address the topic of sexual orientation, they may lead to inequity in treatment by disregarding sexuality as an important dimension of patients' quality of life.

Marília also commented on welcoming (Theme 3) in healthcare services and mentioned the benefits of Frida being treated by a fixed multidisciplinary team, including a psychologist: “[...] She [Frida] has a stronger bond [with a fixed team]. And the psychologist was also [...] a person with whom she created a very strong bond, of support, of security [...]”.

Prepared and sensitive healthcare services to the specificities of the LGBTQIAPN+ population are important, as well as being respectful of sexual orientation and gender identity differences (McNair & Bush, 2016). Culturally appropriate care for sexual minority patients includes avoiding heterosexual assumptions, using inclusive language, and bringing partners closer to healthcare procedures (Lisy et al., 2018). Marília reported satisfactory experiences in healthcare services when accompanying Frida during treatment, with sensitive and appropriate care as recommended by the studies (Andrade et al., 2021; Liu & Yeo, 2021; Whitehead et al., 2016).

This study analyzed the meanings attributed by the participants to healthcare practices according to their needs, exploring whether professionals are especially sensitive to the peculiarities of their dual condition: women and lesbians. Participants of this research reported experiencing different feelings regarding healthcare service, regardless of being diagnosed with breast cancer or the partner being diagnosed.

Generally, the women described receiving adequate care in the health services they attended to and they felt supported by the professionals. Despite this, the participants also reported episodes in which they felt disrespected, either because they were denied treatment, by fatigue in waiting for treatment and test results, or even being discriminated by physicians because of their sexual orientation.

Manifestations of prejudice and acts of discrimination were directed at both patient and her partner and were inflicted by both male and female health professionals. Although all participants in the study reported episodes of inadequate care in hospitals, only Débora and Helena attributed it to

their sexual orientation. All the participants, even those who experienced some type of discrimination, also highlighted that they had contact with supportive professionals, emphasizing the female physicians' role in treatment.

This study has some limitations. The sample was restricted to the area with the country's highest socioeconomic development and almost all participants were from economic classes A or B, therefore, it did not include lesbian women who would not have access to medical care due to economic difficulties. In addition, the research did not extend to other significant people in the couples' social network, including health professionals, which disregard analyzing how social support can function as a mitigating factor for eventual negative impacts triggered by health services.

It is expected that this study outcomes may reinforce health as a public service and reaffirm the need for policies implemented by the State to be truly inclusive of the specificities of lesbian women. Especially, the recommendations of the National Policy on Comprehensive Health of Lesbians, Gays, Bisexuals and Transsexuals need to be incorporated to private care and the Brazilian Unified Health System (SUS), integrated with policies for women's health and for breast cancer prevention and treatment.

This urgency lines up with the women's and female collective's demand of recognized and guaranteed rights, to ensure the legitimacy of their singularities in health services. Universalization depends on respect for multiple identity configurations in healthcare. To unveil the compulsory character of heterosexuality in health allows us to reflect on how gender relations act on lesbian bodies and lives.

By comprehending the experiences of lesbian patients and their affective partners during cancer treatment, health professionals can account aspects of gender/sexuality not only regarding possible influences on the habits and behaviors of this minority group, but also regarding healthcare guidelines and prescriptions.

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