Current reviews have illustrated that research since 1970 has produced little progress toward the elimination of racial and ethnic disparities in cancer health outcomes (Aziz, 2007; Kagawa-Singer, Valdez Dadia, Yu, & Surbone, 2010). Complex social-ecologic mechanisms contribute to racial and ethnic cancer disparities, including sociodemographic and healthcare system characteristics, tumor biology, and cancer screening behaviors. However, studies have consistently demonstrated that racial and ethnic differences in cancer morbidity and mortality outcomes exist independently of those social, biologic, and clinical variables, suggesting that processes related to poorly understood cultural factors may be involved (Morris, Rhoads, Stain, & Birkmeyer, 2010; Virnig, Baxter, Haberman, Feldman, & Bradley, 2009). In a comprehensive review of cancer disparities research, Kagawa-Singer et al. (2010) stated, “The path of cancer care we have been traveling requires that we rechart our course, for we know what is wrong, but we are unclear why” (p. 35).

Attention has been increasingly focused on the exploration of institutional and interpersonal discrimination in healthcare delivery, with both overt and subtle forms of discrimination contributing to racial and ethnic health disparities (Smedley, Stith, & Nelson, 2003; van Ryn & Fu, 2003). Substantial evidence shows that perceived discrimination is associated with a broad range of poor mental and physical health outcomes in the general population (Facione & Facione, 2007; Williams & Mohammed, 2009). Although researchers are beginning to consider how perceived discrimination may contribute to cancer-related disparities, most studies in this area have focused on the effects of discrimination on cancer screening behaviors, with few examining perceptions of healthcare discrimination in the cancer treatment context (Campesino, 2009; Howard, Balneaves, & Botorff, 2007; Mandelblatt et al., 2003).