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"I Wasn't Presented With Options": Perspectives of Black Veterans Receiving Care for Uterine Fibroids in the Veterans Health Administration

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ABSTRACT

Introduction: Black women with uterine fibroids experience greater symptom severity and worse treatment outcomes compared with their White counterparts. Black veterans who use Veterans Health Administration (VA) health care experience similar disparities. This study investigated the experiences of Black veterans receiving care for uterine fibroids at VA.

Methods: We identified Black veterans aged 18 to 54 years with newly diagnosed symptomatic uterine fibroids between the fiscal years 2010 and 2012 using VA medical record data, and we recruited participants for interviews in 2021. We used purposive sampling by the last recorded fibroid treatment in the data (categorized as hysterectomy, other uterine-sparing treatments, and medication only/no treatment) to ensure diversity of treatment experiences. In-depth semi-structured interviews were conducted to gather rich narratives of veterans' uterine fibroid care experiences. Transcribed interviews were analyzed using content analysis.

Results: Twenty Black veterans completed interviews. Key themes that emerged included the amplified impact of severe fibroid symptoms in male-dominated military culture; the presence of multilevel barriers, from individual to health care system factors, that delayed access to high-quality treatment; insufficient treatments offered; experiences of interpersonal racism and provider bias; and the impact of fertility loss related to fibroids on mental health and intimate relationships. Veterans with positive experiences stressed the importance of finding a trustworthy provider and self-advocacy.

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Conclusions: System-level interventions, such as race-conscious and person-centered care training, are needed to improve care experiences and outcomes of Black veterans with fibroids.

Uterine fibroids, or noncancerous tumors of the uterus, can result in heavy menstrual bleeding, severe anemia, debilitating pain, and impaired fertility (Baird, Dunson, Hill, Cousins, & Schectman, 2003; Eltoukhi, Modi, Weston, Armstrong, & Stewart, 2014; Ghant, Sengoba, Vogelzang, Lawson, & Marsh, 2016). Treatment options for fibroids range from nonsurgical (e.g., hormonal medications and intrauterine devices) to surgical (e.g., myomectomy or hysterectomy) and vary in their impact on fertility, with only a limited set of choices (medical treatments and myomectomy) preserving the option for future fertility (Management of Symptomatic Uterine Leiomyomas: ACOG Practice Bulletin, Number 228, 2021). Black women have higher incidence rates of fibroids by age 50 compared with White, Latina, and Asian women (Baird et al., 2003; Stewart, Nicholson, Bradley, & Borah, 2013). Additionally, Black women are more likely to have an earlier onset of fibroids, greater size and growth rates, and more severe symptoms (Stewart et al., 2013). Beyond differences in onset and severity of fibroids, racial disparities exist in fibroid treatment and outcomes, with Black women more likely than White women to be treated with hysterectomy, despite data suggesting that many prefer to retain fertility and are more likely to experience surgical complications (Borah, Nicholson, Bradley, & Stewart, 2013; Eltoukhi et al., 2014; Ghant et al., 2015; Laughlin-Tommaso, Jacoby, & Myers, 2017; Marsh et al., 2013; Sengoba, Ghant, Okeigwe, Mendoza, & Marsh, 2017; Stewart et al., 2013; Templeman et al., 2009; VanNoy, Bowleg, Marfori, Moawad, & Zota, 2021; Wechter et al., 2011).

To date, most research on fibroid disparities has been quantitative. However, a few qualitative studies have explored the treatment experiences of Black women with fibroids (Sengoba et al., 2017; VanNoy et al., 2021). Findings from these studies point to life circumstances and provider interactions being influential to pathways to treatment and experiences among Black women (Ghant et al., 2015; 2016; Sengoba et al., 2017). In one study, Black women reported differential treatment in clinical visits due to race, including being offered only limited management options for fibroids (VanNoy et al., 2021).

In the Veterans Health Administration (VA), women veterans are the fastest-growing group of new VA users (Frayne et al., 2018), and they have unique health care needs related to a higher burden of medical and mental health comorbidities compared with their civilian counterparts (Haskell et al., 2010; Lehavot, Hoerster, Nelson, Jakupcak, & Simpson, 2012; Mattocks et al., 2010). Nearly one-third of women veterans using VA health care identify as Black or African American (Frayne et al., 2018). Previous quantitative research indicates that Black women veterans experience similar racial disparities in uterine fibroid outcomes as civilians, although these studies focused specifically on veterans undergoing hysterectomy for uterine fibroids (Callegari et al., 2019; Carey et al., 2022; Katon et al., 2017). More recently, we found that, compared with White veterans with fibroids, Black veterans with uterine fibroids were less likely to have any documented treatment, with one putative explanation being insufficient fertility-preserving options offered to Black versus White veterans (Katon et al., 2023). However, it is not possible to test this hypothesis through the use of administrative data alone and without exploration of the experiences of Black veterans in receiving care for fibroids.

This study aims to fill the gap in qualitative research among Black veterans and seeks to understand Black veterans' experiences of care for uterine fibroids from symptom onset through diagnosis and treatment, including the role of experiences of racism and bias. Given the large representation of Black women among veterans who rely on VA for care and evidence of poorer outcomes and disparities specific to Black women, research centering on their experiences and needs is critically needed to help VA to achieve its goal of ensuring equitable and high-quality care for all veterans (U.S. Department of Veterans Affairs, 2022).

Methods

To facilitate interrogation of the role of racism in fibroid experiences and outcomes, we applied the public health critical race praxis, a public health research methodology based upon the foundations of critical race theory, to the methodological framework and implementation of our study (Figure 1 and Appendix A) (Ford & Airhihenbuwa, 2010a,b).

Participants

Participants were sampled from a national retrospective cohort of veterans (aged 18–54) identified as part of a mixed-methods study investigating racial disparities in fibroid treatment pathways and outcomes among veterans using VA care. Veterans with newly diagnosed symptomatic uterine fibroids between fiscal years 2010 and 2012 who self-identified as Black or White race in VA Corporate Data Warehouse data were included and followed from the time of diagnosis through fiscal 2018 to capture the full trajectory of fibroid treatments (Katon et al., 2023). For the current analysis, we created a recruitment list of Black veterans in the cohort stratified by the last recorded fibroid treatment during the study period. We created three broad categories of treatments to ensure diversity in perspectives and experiences: 1) medication only or no treatment, 2) uterine-sparing surgical or procedural approaches, and 3) hysterectomy. We combined medication only with no treatment because medications to treat fibroids are often used for multiple purposes, including contraception, making it difficult to parse out separate groups with administrative data. Participants were mailed recruitment letters with an opt-out postcard; those who did not return the postcard were called and invited to participate in the study. The sample size was guided by the need to ensure balance across treatment groups and the principle of thematic saturation, or the point at which no new themes or findings are identified (Saunders et al., 2018); this occurred at 20 interviews. VA Puget Sound's Institutional Review Board approved all study activities. All participants in the study were mailed a $50 gift card.

Data Collection

The interview guide was designed to obtain data in specific domains based on Andersen's health care model and Diderichsen, Evans, and Whitehead's framework for understanding

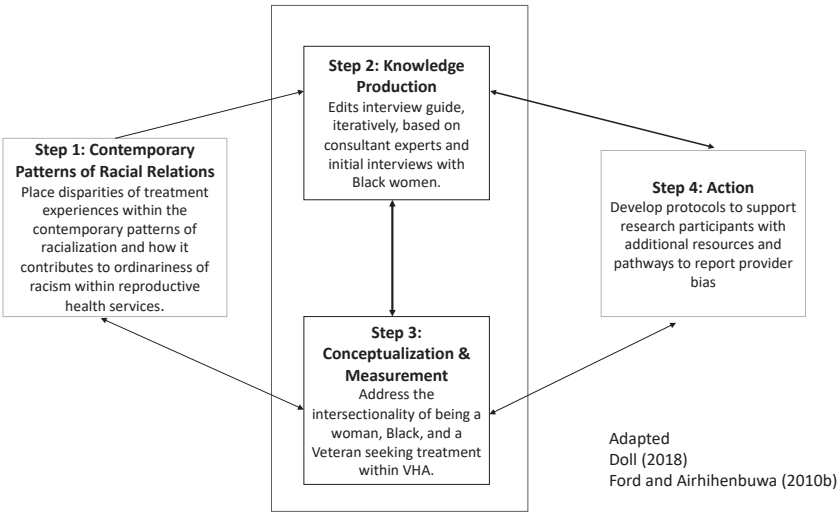

Figure 1. Research process using four steps of public health critical race praxis.

the social basis of health disparities (Andersen, 1995; Diderichsen, Evans, & Whitehead, 2001). Domains included experiences of symptoms, seeking care, receiving a diagnosis, treatment decision-making, and post-treatment reflections (Appendix B). Construction of the interview guide was an iterative process with input from health disparities and qualitative researchers, as well as Black individuals who had received fibroid treatment but were not participants in the study. Two trained study staff (both Black women and one with a history of fibroid treatment) conducted interviews by telephone. Study staff conducted interviews between May and November 2021. Veterans provided verbal informed consent before being interviewed. On average, calls lasted 31 minutes. We transcribed interview recordings verbatim before analysis. A brief survey at the end of each interview collected key demographic characteristics.

Analysis

The analytic team used deductive and inductive content analysis to analyze interview transcripts (Bernard, Wutich, & Ryan, 2017; Bradley, Curry, & Devers, 2007; Elo & Kyngäs, 2008). An initial codebook was developed deductively based on the domains described elsewhere in this article. Three team members reviewed five transcripts and identified additional codes to add to the original codebook, using inductive coding to reflect participants' perspectives and data observations (Bernard et al., 2017; Bradley et al., 2007; Elo & Kyngäs, 2008). Next, two analytic team members each coded all transcripts using the final codebook. Following coding all transcripts, the analysis team identified key themes and subthemes. The team met regularly to discuss any discrepancies in coding and to come to a consensus on codes, themes, and subthemes (Elo & Kyngäs, 2008; Stemler, 2004). Analysis and data collection continued until thematic saturation was reached, with no new concepts emerging from the data. Atlas.ti (Version 9) was used for coding and data management.

Results

Table 1 presents sample characteristics. Age at the time of diagnosis ranged from 26 to 50 years old, with a mean of 40.0 ± 7.8 years. More than one-half of the participants (60%) completed at least a college degree, and 25% had an annual household income of more than $80,000. More than one-half (55%) reported a hysterectomy as their final treatment. Five key themes regarding participants' experiences of fibroids and fibroid treatment are described.

Theme 1: The Impact of Severe Fibroid Symptoms in Male-dominated Military Culture and Beyond

Many veterans described experiencing severe fibroid symptoms (i.e., heavy bleeding, blood clots, pain, cramping, and weakness) during and after their military careers, which had far-reaching impacts on their well-being across their professional and personal lives. When veterans experienced fibroid symptoms during active duty service, they described a tension between wanting to seek help for symptoms and fearing being perceived as failing to meet their obligations as soldiers or shirking their duties:

Table 1
Sample Demographics ($n = 20$)

Characteristics	Total *N* (%)
Education	
High school/GED	3 (15)
Some college	5 (25)
College degree	4 (20)
Master's degree or higher	8 (40)
Income	
$20–40k	6 (30)
$40–60k	4 (20)
$60–80k	4 (20)
≥$80K	5 (25)
Sexual orientation	
Lesbian/bisexual	3 (15)
Straight	17 (85)
Last treatment (self-report)	
Hysterectomy	11 (55)
Uterine-sparing surgery/procedure	7 (35)
Medication only or no treatment	2 (10)

Note: No participants identified as Hispanic or Latina; one declined to share income information.

> The field that I was in was a male-dominated field, it's not like I could stop and say, 'hey, I have a heavy period.' It was quite depressing…Yeah, trying to keep up. And I mentioned the male dominated field because you don't want to be seen as someone that can't pull their own weight, you know? What we used to say is everybody needs to carry their own water. And so, I mean it was not like you wanted to be seen like you're having a female issue, because those are actually seen as things to try to get people out of doing work. And that was never me.

In addition, those who experienced symptoms while serving in the military reported feelings of embarrassment and isolation related to having to manage their symptoms in the field and being unable to share their experiences or concerns with others:

> And, you know, there was one incident, I was in the reserves…and we had an exercise where we'd be outside all day long. And I tried to get out of that because I had to be at a restroom like every hour changing my, it was during the time of my period, and it was really embarrassing. I didn't know how to tell anyone that, I can't do it because I have a really heavy period.

After separation from the military, participants also described major disruptions to work and relationships due to severe symptoms. Veterans described acute stress related to managing fibroid symptoms at work: "When I got to my office, I had difficulty walking, I tried just about everything to get the pain to go away. I curled up, balled up on my desk, under my desk, in my chair, just trying to do anything to get it to go away." Another participant explained that her symptoms "ended up progressing to heavy bleeding where I would have to call out from work, because trying to get out of bed, I would ruin my sheets, my mattress, my clothes." Many participants also described embarrassment and shame related to heavy bleeding that they experienced with intimate partners, even in well-established, long-term relationships. One participant described, "you're laying next to your spouse at night, not necessarily engaging in sexual activity, but you're just lying there, and you wake up, and your sheets are full of blood. And he's looking at you, although you might have been married numerous years, it's still rather embarrassing."

Theme 2: Multilevel Barriers to Receiving Timely, High-quality Care for Fibroids

Although participants' experiences along the pathway from symptom recognition and diagnosis to treatment varied widely, several key subthemes emerged: limited knowledge and education about fibroids among veterans, relationships with VA providers and VA provider behaviors, and health care system factors.

Limited knowledge and education about fibroids

Many veterans reported limited awareness of fibroids and fibroid symptoms and assumed that prolonged, heavy periods or severe pelvic pain were part of a normal menstrual cycle. One participant explained that she "didn't think it was extremely unusual to bleed so long for a period of time." This lack of awareness served as a barrier to care seeking, with participants experiencing fibroid symptoms for extended periods of time without realizing something was wrong.

> Like I said, I didn't know what they were. I didn't know what the feeling was supposed to be, until after I got older and that's when they told me that I had fibroids. And I was like, oh that's what that pain was?… Because I'd always be wondering, is this my period? Damn, I already had my period. I just didn't know what it was?

Veterans emphasized the importance of receiving education about fibroids as a facilitator of earlier diagnosis and intervention. One participant recommended that VA provide this education to women veterans "just so that we're aware of it prior to finding ourselves in a situation."

Veterans also emphasized the importance of having friends or family members who had experienced fibroids in increasing their knowledge or comfort in seeking care: "[My mother] just informed me of her having lots of bleeding, having some of the symptoms that I was having also. So, it inspired me to want to talk to my doctor even more about it, because of the history in my family."

Importance of trusting provider relationships and information sharing

Indifference or dismissal, combined with inadequate provision of information and education, led many participants to feel that VA providers did not take their fibroid symptoms seriously, which resulted in delays to care and eroded trust. One veteran described being dismissed by a provider when disclosing her symptoms: "I didn't talk to anybody else because they just acted like they thought it was just my period too. Because they never did any other kind of tests and stuff." Another veteran highlighted poor communication and inadequate information sharing on the part of providers as impeding trust and engagement in care:

> Once he gave me the paper, from the nurse, it actually didn't even come from him, it came from his nurse. It's like, okay, you were diagnosed with fibroids… So he leaves the building, and you're left there to deal with the nurse, she's not really saying anything, she just prints out whatever she knows or whatever you can get off of Google about fibroids, and she hands it to me and, you're done.

Conversely, veterans with positive experiences emphasized how their providers fostered trust by thoroughly explaining fibroids and their impact on health and well-being. As one veteran explained:

> I felt comfortable with her. She talked to me about fibroids, she had the model sitting on the desk… she pulled up pictures online and showed me specifically what we were talking about. So she did her best to make me comfortable and to show me what we were talking about.

Another veteran emphasized the continuity of care and collaborative communication as key facilitators for accessing care and treatment, "I mean, I felt trust with them…felt like what they were telling me were valid things that they thought maybe was wrong at the time, and problem solving together…Walking through a process together, especially being with [a provider] I trusted and had known for a while, it was much easier." Seeking a provider who could be trusted was seen as an important facilitator of receiving desired care: "I would encourage someone to get their checkups and try to build a relationship with their provider. And if they feel that they're not respecting them, to try and get a new provider. Because that really, I felt really terrible, how they were treating me, honestly."

Health care system factors

Barriers related to the health care system, such as the inability to schedule timely appointments, inadequate follow-up from care teams, and lack of responsiveness to patient complaints, were described as important determinants of receiving timely and high-quality care. Time delays to being able to schedule appointments emerged as a common concern:

> I think they could get us in a little sooner… I feel like they should have more doctors to be able to see… There's a whole lot of women going to [the] VA…And I just feel like they don't have enough doctors…But if I have a problem between that 6 months, I still have to wait until the next appointment, because all of the appointments are booked up.

Furthermore, veterans identified a lack of consistent follow-up from care teams as a factor that created barriers to diagnosis and treatment: "They could've followed up when they said they were going to. They could've rescheduled that appointment for the ultrasound when they said they would have, or at least reached back out to see, hey, did you have this ultrasound…it's practically no follow-up care at all."

These barriers were compounded by frustration with lack of accountability for mistreatment and limited options for race- and gender-concordant providers:

> When I reported it to the Patient Advocate, they could have, you know, did something. Or at least responded back to me. Or at least act like they cared. The doctor, gynecologist, after I came back a day or two after the procedure she did, bleeding like crazy. They did nothing, she still worked there…They didn't even offer to get me another ObGyn. And then it took forever to get me a Black female. They kept saying they don't have any, they don't have any Black female doctors. I mean, [the] VA doesn't have Black female doctors… So they gave me a woman of color. But it's still not a Black woman. Because, it's a difference."

Theme 3: Insufficient Treatment Options and Need for Self-advocacy to Obtain Desired Treatments

Veterans' satisfaction with their treatment experiences heavily depended on how providers discussed treatment with them and whether they were given multiple options, including ones aligned with their fertility goals. Veterans also described the importance of self-advocacy in obtaining a second opinion when providers fail to offer sufficient options.

Veterans frequently reported frustration with being given only one option for treatment versus a range of alternatives. "I really feel like, if they would've given me options, I would've been okay. Just give me options. Don't just tell me, this is it, this is what you have to do. Take the time and look up to see, and let's try this." Inadequate discussion of options that preserve fertility was experienced as particularly harmful, causing patients not to feel seen or heard. "I knew that my main concern was whether or not I would still be able to have kids when I reached 40… But it was more or less me talking to them about my concerns, and my concerns not being addressed."

For the minority of participants who were given a full range of options by providers, this positively impacted their experiences and satisfaction with care:

> They discussed with me … that these are the options when you have fibroids. And the options we talked about were, I know surgery, shrinking them and seeing if they would just dissolve, that was I think the first thing. And the surgery was either a myomectomy or a hysterectomy. We talked about if I still wanted to have children. We talked about all of those things together.

Participants also reflected on the importance of self-advocacy if presented with few or no alternatives by providers, explicitly asking providers questions and advocating for additional medical opinions or seeking a second opinion:

> So, I feel like I should've gotten a second opinion. I feel like the military, [the] VA, could've taken this more serious, since it's so big. More women, because I was dealing with my doctor, but he was a guy… I think I wanted a second or third opinion to see if I could've avoided [being] cut.

Theme 4: Interpersonal Racism and Provider Bias

Many participants described how they felt their care for fibroids was affected by interpersonal racism and bias in interactions with providers within VA. As one veteran explained:

> I guess I feel that with me being an African American woman, that issues like this, when it comes to health, are not as important as other races. I feel that, probably if I was Caucasian that there would've been more of an effort to give me options… And I have friends that are Caucasian. I had one friend that also had fibroids…but she had some type of embolism for uterine fibroids. And she still has a period, you know. Probably won't have to worry about going into menopause early. It's not just something that affected me back then, I mean it's something that stays with you.

Participants also described that having a hysterectomy presented as the main or only treatment option was particularly harmful given the history of forced sterilization of Black women in the United States: "I never went back, because, I mean, why would you want to be under somebody's care like that, that all he wants to do is take your womb? And I know historically for Black women, people have tried to sterilize us, whenever we go in for treatment." Discussing treatment experiences with other veterans of color served to surface persistent patterns of provider discrimination: "It's only because I've run into other women that have seen him, and we've all recounted the same type of experience, where hysterectomies were being pushed on all of us." Participants also highlighted harm from racial stereotyping of Black women with fibroids by providers: "Just because of the percentage of African American women that have fibroids, don't treat us all the same. It might be a high percentage of us, but that doesn't mean that we're all coming with the same symptoms. Just look at us, don't group us together. Individualize us as we come in and treat us that way." Participants further reflected on how their intersecting racial and gender identities resulted in compounded trauma from receiving biased or discriminatory care or being pressured to have a hysterectomy.

> With me being still in my late 20s and early 30s, it was a little bit hurtful for a doctor to come at me like that. …And here I am, I'm Black, I'm single, and he was a White male in his late 40s, early 50s, and for him to come at me like that. Because I'm pretty sure other races, White races, they don't come at them like that. But for me being in that position, it was like wow. Like just tell the Black lady who still has a possibility to get married and have kids, to just take her uterus out.

Collectively, these experiences led to feelings of betrayal by the VA health care system and society more broadly: "As a veteran, I felt betrayed. Because, you know, I almost put my life on the line for you. I felt betrayed because I felt like they could've treated me better than that." One strategy for combatting these experiences of discrimination was to insist on seeing a race- and gender-concordant provider: "And at this time I demanded a Black female doctor, because the original doctor was a White female. And I said, no, I refuse to be seen by a White female doctor because of the way I was treated."

Theme 5: Impact of Fertility Loss Owing to Fibroids on Mental Health and Relationships With Partners

Participants whose fibroids or treatment for fibroids affected their fertility described significant adverse impacts on their mental health and intimate relationships. For those who had a hysterectomy, experiencing surgical removal of the uterus marked a sensitive, emotional topic to discuss.

Impact on mental health

Loss of fertility owing to fibroids impacted emotional well-being, frequently leading to depression. As one veteran described, "By the time I got to the point where I went to a fertility doctor, and you know, that's something I could have addressed or did if I would've been treated accordingly in the very beginning. So, my life is, I don't have a child. And it really did put me into severe depression." Furthermore, loss of fertility generated significant anxiety related to dating and relationship building: "I kind of got depressed that [pregnancy] would never happen to me, I got anxiety issues, because I was like, whenever I'm dating, do I bring this up? Does somebody want to deal with that? Because I may have to do IVF, I may have to have a surrogate."

Intimate relationships

Participants also described how their fibroid treatments, particularly hysterectomy, impacted intimate relationships and their partner's perception of their womanhood. As one participant explained, "He felt like by having a hysterectomy, that made me less of a woman. But I'm still a woman, I just don't have that part." Being unable to reproduce or having trouble conceiving after fibroid treatment led to conflict with partners and marital difficulties: "[My husband] wasn't happy about the hysterectomy because he wants more kids… And I feel like I'm empty now because I can't make him happy, you know? I can't. We argue all of the time and I know that's a part of it." In some cases, infertility due to fibroid treatment was a catalyst for divorce.

> I had the hysterectomy because there were no other options. That ended in us divorcing. I know that a kid probably wouldn't have kept us together, but we had, I guess, plans, and because there were no other options and that being the last resort.

Discussion

In this qualitative investigation of Black veterans who sought treatment at VA for fibroids, we identify multiple factors that influenced their care experiences. Furthermore, our study reveals that participants' experiences of interpersonal racism and provider bias in VA health care system profoundly affected their quality of care and led to a sense of institutional betrayal. Black veterans with fibroids have unique experiences compounded by the dynamics of holding multiple identities and collective experiences that influence care and treatment experiences within the VA health care system. Therefore, an intersectional lens is necessary to illuminate how these identities individually and collectively influence care pathways for Black veterans with fibroids (Combahee River Collective, 1983; Crenshaw, 1991; Owens, 2017).

Similar to studies among non-veterans, we found that a lack of knowledge regarding fibroids and normalization of abnormal and disruptive menstrual symptoms contributed to significant delays in receiving care and experiences of isolation (Bossick, Sangha, Olden, Alexander, & Wegienka, 2018; Ekpo et al., 2014; Marsh, Brocks, Ghant, Recht, & Simon, 2014; Riggan, Stewart, Balls-Berry, Venable, & Allyse, 2021; Yu, Janga, McAlister, Jeffe, & Sonn, 2021). A unique aspect of women veterans' experience, specifically for those who developed fibroid symptoms during military service, was reluctance to request accommodations in a male-dominated military environment. This reticence, which was related to their professionalism and desire to "pull their own weight," may have contributed to significant delays in care-seeking owing to not understanding abnormal periods and continual worsening of fibroid symptoms, further heightening participants' feelings of isolation.

A key determinant of veterans' decision-making and treatment experiences was the quality of patient-provider interactions. An important driver of the quality of these interactions was the providers' ability or willingness to establish trust between themselves and veterans by providing comprehensive information and listening to veterans' priorities and primary concerns about their desired treatment. Black veterans who described positive experiences emphasized that their providers elicited their preferences and involved them in decision-making, which empowered Black veterans to feel autonomy over their bodies. These findings align with studies in the civilian population (Eltoukhi et al., 2014; VanNoy et al., 2021) and are consistent with work by Solberg et al. (2009), highlighting how patient preferences for treatment are paramount in discussions of fibroids and quality of life. Participants also emphasized the need for providers to see and hear them as individuals rather than a monolith of Black women with fibroids, consistent with other studies that show eliminating stereotyping of people of color can address disparities in health care services (Balsa & McGuire, 2003; Cooper et al., 2003; Hagiwara, Slatcher, Eggly, & Penner, 2017; Johnson, Roter, Powe, & Cooper, 2004; Penner et al., 2010).

Consistent with a large body of non-VA research, our findings also demonstrated the harmful impacts of racial bias on provider–patient communication and relationships (Cooper et al., 2003; Hagiwara et al., 2017; Penner et al., 2016). Veterans in our study shared how their experiences of racial bias, combined with the history of structural and interpersonal racism in medicine and particularly in gynecology, underscored the critical importance of being seen and heard as an individual and being able to trust their providers. This experience was particularly salient when veterans were not offered multiple treatment options or when they felt pressured to undergo a hysterectomy, regardless of their fertility goals. Veterans also described how provider bias resulted in the dismissal of pain symptoms related to fibroids, leading to delayed treatment. Our findings were consistent with the known impacts of medical racism, including providers often failing to see Black women as whole beings deserving of compassion (Davis, 2019), leading to unrealistic

perceptions of pain tolerance and obstructing effective pain treatment for Black patients (Burgess et al., 2014; Trawalter & Hoffman, 2015).

Finally, our findings demonstrate the powerful impact that fibroid symptoms and fibroid treatments have on mental health, well-being, and intimate relationships (Bossick et al., 2018; Ghant et al., 2015; Henry, Ekeroma, & Filoche, 2020; Nicholls, Glover, & Pistrang, 2004). Black veterans expressed various forms of psychological distress during their care and treatment journey for fibroids. The impact of fibroids and fibroid treatment on relationships with partners was the cause of significant anguish and was detrimental to how participants viewed their womanhood. The vulnerable and emotional experiences of Black veterans who received a hysterectomy, particularly among those who still wanted to have children, demonstrated how the loss of the uterus and fertility could lead to psychological distress. Multiple studies document a significantly higher prevalence of depression, post-traumatic stress disorder, and suicide in veterans compared with the civilian population, underscoring the critical need to attend to the mental health impacts of fibroids and loss of fertility among Black women veterans (Haskell et al., 2010; Lehavot et al., 2012; Mattocks et al., 2010).

Several limitations of our study deserve mention. Conducting research with patients within VA health care system limits the generalizability of our research findings to other health care systems, although our results largely align with those of other research conducted within civilian populations (Myles, 2013; Porter, 2020; Riggan et al., 2021; VanNoy et al., 2021). Additionally, in some cases, participants received care and treatment for their fibroids several years before the interview, potentially introducing recall bias. However, the time between the treatment received and the participant interview might have allowed veterans to reflect upon their treatment and care experiences more deeply. Finally, this qualitative work only focused on the patient perspective and did not include the providers' perspectives (Gray et al., 2020).

Implications for Policy and/or Practice

Our findings have multiple policy and practice implications for the care and treatment of uterine fibroids within the VA health care system. First, our findings demonstrate a need to increase knowledge about fibroid symptoms among patients and primary care providers to improve early detection and diagnosis of fibroids, as accessing VA gynecology care typically requires a referral from primary care. Second, our work underscores the importance of training VA gynecology providers in race-conscious, patient-centered communication and shared decision-making to ensure veterans are given information about their options that centers their values, preferences, and needs. Finally, our findings indicate that better integration of supportive services to address the emotional and mental health of veterans suffering from fibroids before and after treatment is needed.

As the largest unified health care system in the United States, the VA has a unique opportunity to lead nationally in promoting equity in reproductive health services, particularly for the treatment of fibroids. Our data highlight several concrete steps that VA can take to improve equity in fibroid care, in addition to those mentioned above. These include increasing the number of Black gynecologists providing care in VA women's health clinics throughout the nation, creating opportunities for veterans with fibroids to share their stories and insights about their fibroid journeys, leveraging successful examples of veteran peer-support communities such as the Women Veterans Network (2021), and ensuring accountability for poor care experiences that veterans share with patient advocates about VA reproductive health services. Taking actionable steps toward advancing health equity within VA women's health services will be essential to improving the reproductive care experiences and health outcomes of Black veterans with fibroids.

Conclusions

Our research provides insights into the lived experiences of Black veterans with fibroids and highlights the need for culturally appropriate, race-conscious care and shared decision making when treating Black and other minoritized veterans with gynecologic conditions. These findings can inform efforts to improve experiences with reproductive health services for all veterans who rely on VA for their care.

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Supplementary Data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.whi.2023.07.006.

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