A Systemic Account of Medical Gaslighting and its Moral Implications

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Certification of Approval

I certify that I have read A Systemic Account of Medical Gaslighting and its Moral Implications by Genesis Maria Sorrick, and that in my opinion this work meets the criteria for approving a thesis submitted in partial fulfillment of the requirement for the degree Master of Arts in Philosophy at San Francisco State University.

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Abstract

From a philosophical standpoint, it is unclear precisely what medical gaslighting is, how it presents, its conditions for success, and how it is differentiated from the more popular interpersonal interpretation of gaslighting. My project aims to remedy this lacuna by developing an account of medical gaslighting as distinguished from that in strictly interpersonal relationships. My approach consists of first exploring the importance of developing a philosophical account of medical gaslighting and providing five criteria that a sufficient account must meet. I then analyze and appraise two accounts of ordinary gaslighting by Kate Abramson and Carla Bagnoli and argue that neither account accurately explains the features and characteristics of medical gaslighting. Further, I describe the key characteristics and identifiable features that make up my account of medical gaslighting. I also address the moral implications of medical gaslighting and argue that it involves two distinct moral harms: the primary moral harm undermines a patient's agency, and the secondary moral harm causes moral injury to doctors. Finally, I call for institutional reform by discussing the policy implications resulting from developing an accounting of medical gaslighting. By developing and identifying the specific nature of medical gaslighting, we will be better equipped to understand patients' experiences and aim toward better quality care.
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I. Introduction

In institutionalized medical\textsuperscript{1} care, attention to a pervasive phenomenon, "medical gaslighting," has been increasing due to its profound impact on patients' lives and experiences. A simple Google search on medical gaslighting pulls up the popularly used medical website, WebMD, which defines medical gaslighting as "Having one's symptoms dismissed by a healthcare professional" (Yasgur, 3). Another Google search of medical gaslighting pulls up a New York Times article stating, "Gaslighting is real; it happens all the time. Patients — especially women — need to be aware of it" (Caron, 1). Discussions of medical gaslighting are also prominent on social media. For instance, one can find thousands of TikTok videos with the hashtag \textup{#MedicalGaslighting}, in which thousands of women share their experiences with what they claim to be medical gaslighting, from having their symptoms repeatedly dismissed to being silenced, mistreated, manipulated, interrupted, or misdiagnosed, often to the detriment of their mental, emotional, and physical health. One such viral video shows a young woman crying with relief after waking from a surgery during which doctors, finally, after years of dismissal, found the source of her abdominal pain. Her tears are palpable through the screen, and thousands (over 23k) of comments chant, "This is what it looks like to be medically gaslit for years!"

The term "medical gaslighting" stems from the more commonly understood version of gaslighting as an interpersonal phenomenon where one is manipulated or coerced in an intimate

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\textsuperscript{1} In this paper, I use “Medical Care” and “Healthcare” interchangeably. While a broader understanding of healthcare may include fitness instructors or alternative medicine professionals, this paper focuses on the medical professionals (doctors, nurses, physicians, gynecologists) that also provide preventative healthcare, rather than the broader notion of healthcare professionals that work outside of the medical industry.
relationship (Ruiz, 3). However, cases of so-called medical gaslighting differ from “ordinary”
gaslighting in essential respects. Some firsthand stories even seem to involve the blasé misuse of
the term for comedic purposes, e.g., “I’m gaslighting myself into believing I’m not that allergic
to peanuts so I can enjoy this organic peanut butter cup!” Whereas ordinary gaslighting involves
emotional manipulation, blame, or coercion, some people experience medical gaslighting as a
one-time or ongoing event involving being dismissed by their doctor. Alternatively, some
experience medical gaslighting as simple miscommunication or even systematic frustrations with
the medical system, such as hours-long emergency room wait times, whereas others describe
being treated as if they do not know their own bodies. Nevertheless, there is no doubt that the
notion of medical gaslighting is gaining traction and popularity in the media. Academic scholars
have started to address the phenomenon, as well. For example, in “Long covid and medical
gaslighting: Dismissal, delayed diagnosis, and deferred treatment,” Larry Au provides research
that shows how “long Covid patients mobilize the language of ‘gaslighting’ to understand their
own experience and to frame their interactions with medical professionals” (Au, 3). Overall,
evidence suggests that a real-world phenomenon resembling gaslighting is ever present in
medical care and can aptly be described as “medical gaslighting.” From a philosophical
standpoint, however, it is unclear precisely what medical gaslighting is, how it presents, its
conditions for success, and how it is differentiated from the more popular interpersonal
interpretation of gaslighting. As it stands, there is no sufficient philosophical theory of
medicalized gaslighting.2

2 At the time of writing this paper. While there are philosophical theories of gaslighting, none define medical
gaslighting as distinct from gaslighting.
This paper attempts to remedy this lacuna by developing a philosophical account of medical gaslighting. To be successful, a theory of medical gaslighting must account for the many characteristic features across various cases that claim to be medical gaslighting (even though these features may differ in important ways, as I have mentioned). First, medical gaslighting, as currently understood, happens often. While it is a challenge to determine its exact frequency, the reports that do surface suggest that medical gaslighting is a regular occurrence. Second, the experience of medical gaslighting seems to be predictable. Reports of medical gaslighting consistently describe doctors as rushing their patients, interrupting their patients, dismissing their concerns, blaming symptoms on anxiety or stress, and, importantly, that gender and racial biases play a part in how providers treat their patients (Laderer, 2). Many studies suggest that women and women of color are more susceptible to medical gaslighting and are often misdiagnosed or even wholly ignored until their symptoms develop into severe and long-lasting conditions, such as chronic pain, cancer, or autoimmune diseases. A 2014 study by the National Pain Institute found that 90% of women felt that the healthcare system had discriminated against them, and 84% felt that they were treated differently by doctors strictly because they were women. For example, on average, it can take a woman of color up to six years to be correctly diagnosed with Lupus, even if they had many of the classic and telling symptoms (Millard, 2022). Third, the frequency and predictability at which many reports of medical gaslighting surface suggest that medical gaslighting is not the product of a few "bad doctors" but rather a problem structurally

embedded in the medical field. Lastly, a significant characteristic of reported medical gaslighting purports that those affected suffer detrimental psychological, physical, and emotional damage.

My project aims to develop an account of medical gaslighting, which distinguishes medical gaslighting from the gaslighting that occurs in strictly interpersonal relationships, i.e., romantic. An adequate account of medical gaslighting must identify the essential features of medical gaslighting. These include its aim, nature, conditions for success, psychological effects, and the distinctive moral harms it involves. For example, to accurately explain the phenomenon of medical gaslighting, understanding it as a *systemic* and widespread issue in healthcare is crucial. Also, while the wrongs of medical gaslighting should be apparent after defining its essential characteristics, I nonetheless argue that it is morally wrong and has long-lasting moral implications for those affected, patients and doctors alike.

My arguments will proceed as follows. First, in section II, I will explore the importance of developing a philosophical account of medical gaslighting. To do this, I provide five criteria that a sufficient account of medical gaslighting must meet. These five criteria will serve as a “North Star” for my project, guiding and ensuring that my account meets these criteria to successfully explain an account of medical gaslighting. In section III, I analyze and appraise two accounts of ordinary gaslighting that aid in developing my account of medical gaslighting. I argue that neither account of general gaslighting accurately explains the features and characteristics of medical gaslighting. Then, in section IV, I describe the key characteristics and identifiable features that make up my account of medical gaslighting. I also address the moral implications of medical gaslighting and argue that it involves two distinct moral harms: the primary moral harm undermines a patient's agency, and the secondary moral harm causes moral injury to doctors. In
section V, I discuss the potential policy implications that would result from developing an account of medical gaslighting, which aims at preventing medical gaslighting from occurring. I conclude by theorizing toward a brighter and more inclusive medical system free from medical gaslighting.

II Goals for Developing an Account of Medical Gaslighting

To begin, one might ask two questions. What is the overall purpose of developing an account of medical gaslighting distinct from more general accounts of gaslighting? What should a philosophical theory of medical gaslighting do? In a general sense, the purpose of developing a philosophical theory of medical gaslighting is to provide a comprehensive framework for understanding, evaluating, and addressing this common yet damaging issue in healthcare. Developing such a theory can contribute to ethical and practical advancements in the field, ultimately improving the quality of care and patient outcomes. Given these aims, a successful philosophical account of medical gaslighting must meet five distinct criteria: (1) to gain conceptual clarity about the phenomenon, (2) to identify its root causes, (3) to explain the phenomenon from the perspective of its victims, (4) describe the moral ramifications of medical gaslighting, and (5) make preliminary policy recommendations designed to reduce its prevalence. I will elaborate on each criterion and its significance below.

Criteria 1 - Conceptual Clarity

First, to gain conceptual clarity about medical gaslighting is to achieve a clear and well-defined understanding of the phenomenon. This includes identifying its characteristics, features, and boundaries and eliminating ambiguities by showing how medical gaslighting is a distinct
occurrence. Also, to provide conceptual clarity about medical gaslighting, a theoretical account should define "medical gaslighting" as a distinct phenomenon separate from the more popularized understanding of gaslighting in personal and domestic relationships. Conceptual clarity answers questions such as "What qualifies cases as medical gaslighting?" "What sort of conditions constitute the perpetuation of such an ongoing phenomenon in medical care?" The advantages of defining medical gaslighting's characteristics enable patients, doctors, scholars, and policymakers to understand the phenomenon better as it presents in medical care, allowing for the proper recognition of medical gaslighting. By gaining conceptual clarity, philosophers also secure the theoretical tools needed to better filter out cases of reported medical gaslighting that are not necessarily medical gaslighting but are cases of malpractice, racial bias, or a clear case of a "bad" doctor. Cases of "bad" doctors are trickier to identify because, while the doctor-patient relationship is essential for manifesting medical gaslighting, medical gaslighting goes much deeper than the doctor-patient relationship. That is, doctors are restrained by medical protocols, regulations, and rules and have to adhere to a specific set of directives that generally override any personal preferences for enacting patient care.

Further, as it stands, the only way to identify medical gaslighting is to attribute key characteristics of the more generally understood interpersonal style of gaslighting to cases of medical gaslighting, including the feature that gaslighting is emotionally manipulative and coercive. However, this is not the case in medical gaslighting. As I mentioned in the introduction, there are hundreds of reported cases of medical gaslighting daily. Many reports accurately represent medical gaslighting, while others may lie outside the scope of what qualifies as medical gaslighting. Achieving conceptual clarity about medical gaslighting and how it
manifests will significantly help reduce any inconsistencies, confusion about what qualifies as medical gaslighting, or unlikely explanations. Defining the key characteristics and understanding its features will enable informed decision-making in medical care, not only for patients who fall victim to medical gaslighting but also for doctors who will be able to recognize better how they contribute.

Criteria 2 – Identify Root Causes

Second, an adequate account of medical gaslighting must identify some of the phenomenon's root causes. Identifying root causes explains why it continues to be prevalent in healthcare today, aids in developing solutions, and procuring preventative measures. For example, the only method we have currently for addressing medical gaslighting is to teach patients how to "advocate for themselves" and speak up to their "manipulative doctors." For instance, an article by CNBC suggests that patients can avoid becoming victims of medical gaslighting by "bringing another person to the appointment with you if allowed. This will give you an extra ear and emotional support…Someone who knows you well can help validate and reiterate your concerns if they are being dismissed" (Onque, 4). However, articles and suggestions such as this place a significant responsibility onto the patient to avoid medical gaslighting for themselves. Placing the responsibility onto patients reflects the traditional notion of gaslighting, which suggests that medical gaslighting results from a few "bad" doctors who tend to gaslight or manipulate their patients for their satisfaction. Identifying root causes, then, allows us to understand better why doctors medically treat their patients as they do, shifting the perspective that places much of the gaslighting blame onto doctors and instead looks to improve the medical system in which doctors are bound.
Thirdly, to understand medical gaslighting from the perspective of its victims is to explore the circumstances of medical gaslighting as they are experienced by victims rather than focus on the psychology of doctors who gaslight. It is currently challenging to analyze cases of medical gaslighting because, as I mentioned, doctors are easily blamed and seen as psychological manipulators harming patients. However, to accurately understand the pervasiveness of medical gaslighting, we must reorient our understanding of the phenomenon from the perspective of its victims. Kate Manne's ameliorative project of misogyny helps us understand why this perspective is imperative.

In her book *Down Girl*, Manne ameliorates the term misogyny from its more general understanding of being described as the hatred of women. Manne criticizes and rejects the original understanding of misogyny, defined as the hatred of women. An essential aspect of Manne's definition of misogyny is that it is not reliant on psychological factors but is instead upheld by social norms. Manne develops her definition of misogyny from what "women face in navigating the social world" rather than from the psychological perspective of why men instill hostility towards women (Manne, 59). Because many "misogynists" can deploy misogynistic tactics and claim to love women, identifying misogynists is almost impossible in the ordinary understanding of misogyny. For example, picture a man (usually, but not exclusively) who reveals deeply misogynistic behavior towards women, such as sexually abusing or physically harming them. Yet, this man also has a grandmother he cares for and sisters he loves deeply. In this case, the man cannot be considered a misogynist if he does not deeply hate women. Instead, reasons for his "misogynistic" behavior can be incorrectly attributed to his psychological
motivations or mental state – such as his need for approval, jealousy issues, or even traumatic childhood. However, the psychological explanation creates an epistemological barrier – a person's psychology is so nuanced, complex, and often abstruse that we can never know for sure if a person is a misogynist or merely a person suffering from psychological issues or mental trauma. Nonetheless, the experience of misogynistic behavior from a woman's perspective is incredibly damaging and warrants a deeper understanding of misogyny. So, for Manne, the psychology of a misogynist is unimportant, as it leaves room to discount women's experiences and places the blame on psychological factors (Manne, 61). Psychological factors ignore the vastness and nuance of societal roles and the ways they are forcefully perpetuated under not only a patriarchal society but one that is ravaged by other "intersecting systems of disadvantage," such as racism, classism, xenophobia, transphobia, homophobia, and more (Manne, 63).

Overall, Manne's account focuses on societal power rather than the psychology or motives of a particular gaslighter and holds that "misogyny primarily targets women because they are in a man's world, rather than because they are women in a man's mind, where that man is a misogynist" (Manne, 64). Adopting an ameliorative account of medical gaslighting is important for similar reasons. Patients often experience their doctors gaslighting them through manipulation tactics such as silencing, dismissing, or blaming symptoms on PMS, stress, or anxiety. When patients speak about their experience of being gaslit by their doctors, they use language that implies the psychology of the doctor plays an important role in their gaslighting experience. However, given that medical gaslighting is incredibly common, a psychological explanation conjures up an unlikely outcome - that most doctors are gaslighters and psychological manipulators. Looking to other societal factors instead of psychological
explanations aids in identifying a finer and more likely explanation. Alternatively, cases described as gaslighting because the patient experienced dismissal may be incorrectly categorized as medical gaslighting when, in fact, their symptoms did not warrant any further analysis and were harmless. In this way, developing a more precise analysis of medical gaslighting from the perspective of its victims is crucial.

Criteria 4 – Identify moral ramifications.

The fourth criterion for developing an adequate account of medical gaslighting is identifying its distinct moral wrongs. Addressing the moral ramifications of medical gaslighting involves an examination of its inherent moral wrongness, encompassing how medical gaslighting both entails and inflicts serious harm upon the well-being of its victims. In most cases of reported gaslighting, patients report feeling harmed somehow. Similar to general accounts of gaslighting, patients also report feeling crazy, frustrated, anxious, confused, or depressed and may even experience life-altering circumstances such as a misdiagnosis. Karen Stollznow, Ph.D., writes in "'It's All in Your Head': The Dangers of Medical Gaslighting" that medical gaslighting is "traumatizing for patients, causing confusion, self-doubt, and helplessness, which, ironically, can lead to anxiety and depression" (Stollznow, 4). Developing an accurate account of medical gaslighting requires acknowledging the resulting trauma and asking, "How, exactly, does medical gaslighting harm patients?" "Are patients the only victims of medical gaslighting?"

Understanding and identifying distinct moral wrongs associated with medical gaslighting is essential for accountability as it holds doctors and, importantly, medical institutions liable. Accountability allows for a more targeted and just response to instances of medical gaslighting.
Further, it brings awareness to the unethical medical practices that induce harmful effects on patients, patients whose lives are at stake, and their agencies undermined.

Criteria 5 – Identify policy implications.

The fifth criteria for developing a philosophical framework of medical gaslighting is to identify policy implications. Although I will not have sufficient space in this paper to develop the specifics of which medical policies should be improved, I find it necessary to touch on them for future development. For instance, an account of medical gaslighting will identify areas where changes or improvements are needed, such as in medical training, patient-provider communication, or institutional procedures. Further, it can aid in developing preventative measures that might involve changes in medical education, medical experimentation, protocols for handling patient complaints, or strategies for improving patient-provider relationships.

Essentially, once we (1) accurately define medical gaslighting as a distinct medical phenomenon, (2) identify root causes, (3) address medical gaslighting from the perspective of its victims, and (4) call attention to the moral wrongs associated with medical gaslighting, we can then begin to address the natural next question, "What now?" How do we go about advocating for systemic change? What would healthcare without widespread medical gaslighting look like, and how do we achieve it? Patients deserve access to quality medical care where they feel heard and their symptoms addressed; doctors deserve to medically treat patients in an environment that better nurtures their talent and intelligence for addressing the host of medical issues that plague patients. Doing so, however, requires acknowledging the complexity of medical gaslighting and attempting to pave a way forward.
III. Analyzing General Accounts of Gaslighting

While no well-developed philosophical theory addresses medical gaslighting, scholars have defined more general accounts of gaslighting. In developing my account of medical gaslighting, it will be useful to explore more prominent general accounts of gaslighting to understand better which qualities of gaslighting, generally explained, are also involved in medical gaslighting. Recognizing specific features of general gaslighting that are also present in medical gaslighting will further reveal that general accounts of gaslighting cannot fully explain cases of medical gaslighting, elucidating its uniqueness. The following will aid in gaining conceptual clarity on the necessary features and characteristics of medical gaslighting.

Below, I will outline and critically analyze two different accounts of gaslighting. First, I evaluate Kate Abramson’s account of gaslighting, which focuses on the psychological nature of the phenomenon, paying particular attention to the associated moral wrongs. Then, I present and evaluate Carla Bagnoli’s account of gaslighting, which offers a robust account of gaslighting in which gaslighting is explained as maintaining power through domination. Finally, in preparation for presenting my account of medical gaslighting in section IV, I take stock of what each account offers. During this process, I evaluate which features of gaslighting, as presented by Abramson and Bagnoli, also apply to cases of medical gaslighting. However, we will find that neither account can fully explain the distinct manifestation of medical gaslighting.

Abramson’s Psychological Account

In "Turning Up the Lights on Gaslighting," Kate Abramson defines gaslighting as a form of "emotional manipulation" that aims to make someone believe that their reactions, memories,
beliefs, and perceptions are not just incorrect but completely baseless, to the point where they could be seen as irrational (Abramson, 2). This can be done consciously or unconsciously by the gaslighter. A central aim of gaslighting involves the gaslighter charging the victim with being crazy or paranoid, leading to a loss of their \textit{sense of self as a moral agent} (Abramson, 8). Abramson suggests, "When gaslighting succeeds, it drives its targets crazy in the sense of deeply undermining just these aspects of a person's independent standing" (Abramson, 8). Driving someone to the point of losing their sanity and sense of self takes time. So, gaslighting is not simply an isolated interaction; instead, it occurs often over multiple incidents, usually involving multiple individuals who either act as gaslighters or support or collaborate with the gaslighter.

Importantly, Abramson's definition of gaslighting focuses on how it is often manifested in a sexist manner. Specifically, women are more commonly targeted by gaslighting than men, and men tend to engage as gaslighters more frequently (Abramson, 3). Further, gaslighting can be sexist in several other ways: (1) it often occurs when a woman protests against sexist or discriminatory behavior; (2) specific manipulative tactics employed in gaslighting rely on the target's internalization of sexist norms; (3) successful gaslighting can reinforce the very sexist norms the target was resisting and the manipulator relies upon, and (4) gaslighters sometimes aim to preserve specific sexist norms through their conduct. For Abramson, gaslighting can display sexism in different combinations of the above or not exhibit it at all – although it more often exhibits them than not.

If we understand gaslighting as emotional manipulation that seeks to "destroy another's independent perspective and moral standing" (Abramson, 13), we can better understand why Abramson views gaslighting as involving a particular kind of moral wrong. Abramson claims
that gaslighting is morally wrong because to regard someone as "crazy" is to regard them not as a person with moral agency but as an "object of treatment" who is not worthy of making moral demands (Abramson, 13). To gaslight a victim is to treat them less as a member of a moral community and more as an object without any personhood or identity, which is morally wrong.

For Abramson, gaslighters employ methods such as commanding language, re-entrenching (to further solidify one's defensive position or viewpoint), and manipulation. Specifically, gaslighting involves the following moves: (a) a victim is targeted, (b) the victim is framed as paranoid, (c) the gaslighter engages in dismissive language and re-entrenching tactics, and, finally, (d) the victim is manipulated until they lose their moral agency and personhood. In addition to erasing a person's independent perspective, it is also vital to recognize the detrimental psychological impact of successful gaslighting on a victim. As Abramson argues, the final stage of successful gaslighting leaves a victim prone to severe depression, requiring professional psychological assistance. While this is a profound harm, Abramson suggests that it also provides a reason for hope: if a person can mourn the loss of their former self, it indicates that they have not entirely lost themselves. Their depression is not simply the result of the torturous gaslighting they have faced but a reasonable emotional reaction to what they have endured. Thus, it serves as the first step toward their recovery and can even be characterized as a form of resistance.

To summarize, critical features of Abramson's account of gaslighting include:

1. Gaslighting is emotional manipulation that leans heavily on the psychology of the gaslighter.
2. Gaslighting is usually sexist in that women are more often targets of gaslighting behavior.
3. Gaslighting aims to extinguish any possibility of disagreement.
4. Gaslighting tactics happen over a period of time, which develop and cause a victim to question their sanity and
5. Gaslighting is morally wrong as it seeks to destroy someone as a moral agent.
Bagnoli’s Account of Domination

Carla Bagnoli rejects a purely psychological or structural account of gaslighting and offers an alternative take in her "Normative Isolation: The Dynamics of Power and Authority in Gaslighting." In her view, the objective of gaslighting is domination, and its effectiveness hinges on a person's compliance or acquiescence, often resulting from a diminished sense of self-worth (Bagnoli, 146). For Bagnoli, gaslighting is built by "multiple and reinforcing strategies that induce rational acquiescence" (Bagnoli, 146). A victim's agreeability, or lack of objection, is necessary for gaslighting to succeed, and agreeability comes at the cost of one's loss of self-respect, agency, and moral standing. Such effects are incredibly damaging, constituting gaslighting involving moral wrongs, including deception, emotional abuse, manipulation, and isolation. Also, a gaslighter uses two main strategies: (1) manipulating evidence and (2) using a victim's fear of being isolated from their community to strip them of their autonomy, which has deeply alienated effects.

Through her investigation into the nature of gaslighting, Bagnoli defends four central claims about gaslighting. First, gaslighting is a complicated moral situation in which an individual(s) wrongs another while believing their actions are justified and valid. Second, gaslighting tends to generate a co-dependent relationship, capable of transforming one's ability to reason authentically. Thirdly, the role of third parties is critical to the success or failure of gaslighting techniques. Third parties can validate, reinforce, and act as accomplices. Yet third parties also can witness and step in, potentially aiding a victim of gaslighting. Third parties can be one or more people, and this further validates Bagnoli's claim that a victim's fear of isolation from their social sphere aids in their acquiescence to gaslighting techniques. Finally, Bagnoli argues that
Gaslighting should be conceived of as a "multifocal structure" instead of a monadic or bipolar one (Bagnoli, 147). That is, although gaslighting enacts discriminating social injustice such as sexism, structures themselves cannot use gaslighting techniques. Instead, structures rely on personal and emotional relationships to enforce power and authority.

Like Abramson's account, the moral wrong(s) of gaslighting plays an essential role in Bagnoli's view. For Bagnoli, "gaslighting is best understood as a compound relational wrong aimed at securing domination" instead of destroying one's sense of self (Bagnoli, 154). Gaslighting involves a set of multiple moral wrongs, including but not limited to deception, emotional abuse, manipulation, and isolation, and is not reducible to any just one. Bagnoli provides two main reasons in support of this claim. First, gaslighting does not solely target the victim's credibility or undermine their status as a knower. Instead, gaslighting's goal is to establish dominance through the victim's compliance and is not aimed at merely distorting the victim's knowledge or credibility (though that is also involved) and involves a deeper manipulation of their sense of moral authority. Essentially, a victim is manipulated to believe that their gaslighter is superior, and the victim, through manipulation, rationally justifies their loss of credibility (Bagnoli, 154). Secondly, because gaslighting is aimed at a victim's acquiescence, this constitutes a moral violation of respect towards another person. As Bagnoli describes, a person's acquiescence is crucial because, unlike in cases of coercion, submitting oneself requires one to accept "being disqualified as a self-authenticating source of claims, gaslighting does not simply alter the victim's reasons but changes the way she values herself" (Bagnoli, 155). A victim, then, loses their power to make claims and thus cannot demand respect from others, leading to a loss of sense of self and moral agency.
An essential feature of Bagnoli's account is the deeply alienating effects that a victim experiences due to gaslighting techniques, particularly those of blaming and shaming. According to Bagnoli, blaming and shaming are alienating in "two mutually reinforcing ways" (Bagnoli, 161). First, shaming involves the threat of feeling marginalized from one's community as it involves the feeling of humiliation and potential exposure of one's faults. Second, the effects of feeling embarrassed or shamed can prompt self-withdraw from one's community. The use of blame and shame ultimately makes the victim doubt themselves, affecting their ability to justify their thoughts and actions, resulting in compliance. The gaslighter thus portrays the victim as rational and justifies the gaslighter's abusive tactics. The gaslighter "disqualifies her and exposes her as lacking full normative standing" (Bagnoli, 163). Bagnoli claims this unique dynamic is thus co-reactive rather than "static or episodic" (Bagnoli, 163). The nature of gaslighting creates a continuous cycle of emotional response. The resulting alienating effects on victims progressively isolate them from themselves and their community.

To summarize, critical features of Bagnoli's account of gaslighting include:

1. The aim of gaslighting is domination, and its condition for success is a victim's acquiescence.
2. Gaslighting is a multifocal phenomenon; it is not strictly social or interpersonal and relies on third parties/bystanders to ensure its aim.
3. Main tactics include manipulation of evidence, emotional abuse, and isolation.
4. Gaslighting is compounded by multiple moral wrongs that lead victims to alienation from themselves and their community.

**Taking Stock**

I have now summarized both Abramson and Bagnoli’s general accounts of gaslighting. At this point, I ask, “Can either Abramson’s or Bagnoli’s account of gaslighting provide the basis
for an adequate account of medical gaslighting?" To answer this question, I will analyze the features of each account, using an example of a reported case of medical gaslighting, along with empirical evidence regarding widespread medical practices, to determine whether they adequately theorize it. By clarifying which features of medical gaslighting can and cannot be explained by a more general account of gaslighting in this way, I will set the foundation for developing an adequate account of medical gaslighting.

A. Abramson

Example case, Grace, 27:

Grace visits her doctor for ongoing pelvic pain. Upon visiting her primary care physician, her doctor tells her that the pain is "just PMS symptoms" and perfectly normal. She is sent home with some ibuprofen pain medication. Having had pelvic pain for many weeks, Grace re-visits her doctors and expresses concern, stating that the pain indeed does not "feel like period cramps or PMS." The doctor, dismissing her symptoms, says she is young, healthy, and should not worry. She is sent home again. After continuing to experience pelvic pain for months along with new-onset bloating and weight loss, the woman continues to see her doctor over many weeks and gets similar responses, "You are stressing yourself out; try to do some relaxation exercises" or "It is most likely anxiety. Your lab work is all normal. Here is a prescription for Xanax." After a year of appointments with multiple doctors and specialists and being coerced into thinking her symptoms are "nothing to worry about," Grace's partner finally demands an MRI (at the resistance of her insurance company) and is eventually diagnosed with aggressive cervical cancer. By this point, Grace is mentally and physically exhausted. Being bedridden with pain and fatigue, she has been unable to keep up with her social life and feels alienated from her community and herself. Feeling alone and ashamed that it took her so long to speak up and get a clear answer, she now struggles with depression and the devastating news of her cancer diagnosis.

With this case of medical gaslighting in hand, I will evaluate Abramson’s account of gaslighting. Again, the features of Abramson’s account of gaslighting are summarized as follows:

1. Gaslighting is emotional manipulation that leans heavily on the psychology of the gaslighter.
2. Gaslighting is usually sexist in that women are more often targets of gaslighting behavior.
3. Gaslighting aims to extinguish any possibility of disagreement.
4. Gaslighting tactics happen over a period of time, which develop and cause a victim to question their sanity and
5. Gaslighting is morally wrong as it seeks to destroy someone as a moral agent.

Now, which of Abramson's characteristic features of gaslighting pertain to the above example of medical gaslighting? Upon initial examination, the features of Abramson's account of gaslighting that seem to apply to the example of medical gaslighting are: (2) gaslighting is often sexist, (4) gaslighting happens over a period of time, and (5) there is a deep moral wrong associated with gaslighting behavior, as victims often experience feeling crazy, leading to a loss of sense of self as well as depression. However, I will show that each of these features would need further revision if they were to accurately explain medical gaslighting, and thus are insufficient as they stand. I will elaborate on each below.

*Abramson's Feature 2 - Gaslighting is often sexist.*

Sexism in the medical industry is known to be a widely accepted occurrence. A study published in *The Journal of Women's Health* found that women are twice as likely as men to be diagnosed with a mental illness when their symptoms are consistent with heart disease. In the above example, Grace is targeted as a woman seeking medical care. She is served with condescending responses to her pain, such as "It is just PMS." Grace's concern for her symptoms is ongoingly dismissed, with her lab results often used as evidence that everything is "normal." Sexist norms are involved here, such as the notion that pelvic pain equals period cramps or PMS symptoms. As Abramson argues, the manipulative tactics employed in gaslighting rely on internalizing sexist norms. Between the empirical evidence that shows women are less likely to

receive timely care than men and the assumption that Grace's pain is automatically associated with PMS, it may seem that the above example of medical gaslighting does serve sexist ideologies.

However, while Abramson touches on how gaslighting employs sexist tactics, an *intersectional*\(^5\) approach is more appropriate to define medical gaslighting. When assessing the oppressive social structures in place, it is crucial to recognize that there is much more complexity to medical gaslighting that hinges on many mutually reinforcing structures that have developed and strengthened over time, not just sexism. For example, racial biases run rampant in the medical industry, and black women are disproportionately more affected by medical gaslighting than white women. A study published in the scientific journal *Proceedings of the National Academy of Sciences* found that half of medical trainees believed false stereotypes about black women – such as their having higher pain tolerances than white women\(^6\). Doctors are more likely to dismiss black women's symptoms based on racial biases. Therefore, Abramson's feature that gaslighting is sexist needs revisions based on intersectional frameworks to identify cases of medical gaslighting accurately. Consequently, her feature, as it stands, is insufficient.

*Abramson's Feature 4 – Gaslighting happens over a period of time.*

Gaslighting tactics take time to deploy, and a victim loses their sense of self over a period of time. Having repeatedly voiced her pelvic pain concerns to her doctor, Grace continued to be

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\(^5\) The concept of intersectionality, a term coined by Kimberlé Crenshaw, describes how individuals are affected by intersecting systems of advantage or disadvantage. Oppressive systems of inequality based on gender, race, ethnicity, sexual orientation, gender identity, disability, and class, among other forms of discrimination, intersect to create unique dynamics and effects.

dismissed and sidestepped multiple times over the year. Abramson acknowledges that
gaslighting rarely (if ever) can be identified as a one-off event. However, this is due to the
psychology of the gaslighter. If a gaslighter's aim, according to Abramson, is to make a victim
feel crazy, then it is unlikely to happen in one interaction.

This is not the case in medical gaslighting. The psychology of doctors is not what makes
medical gaslighting span over a period of time. Many conditions take time to diagnose due to
institutional formalities. Due to the time it takes for a patient to be correctly diagnosed, patients
may lose their sense of self over this period. For example, in medicine, patients rarely get treated
for a complex health issue in one visit unless they see their doctor for a routine checkup. Often, a
primary doctor is seen first for an initial consultation, followed by testing or lab work the
primary doctor sees fit. Then, specialists (such as an ear, nose, and throat doctor (ENT),
cardiologist, or neurologist) are seen depending on the lab results. Getting diagnosed and treated
with most medical issues takes time. In particular, complex medical issues may present as
autoimmune disorders (MS, Chron's, Lupus), chronic pain disorders (fibromyalgia, trigeminal
neuralgia), endometriosis, and many types of cancer. According to the American Autoimmune
Related Diseases Association, an average diagnosis timeline is 4.5 years.

Further, according to the Journal of Obstetrics and Gynecology, it can take 4-11 years to
be diagnosed with endometriosis (Agarwal et al., 355). Thus, while general gaslighting and

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7 There are exceptions, such as emergencies. For example, appendicitis, physical injuries, or childbirth are often treated immediately.
8 https://autoimmune.org/breaking-barriers/
medical gaslighting happen over time, they do so for different reasons. Therefore, Abramson's explanation of this feature inadequately describes medical gaslighting.

*Abramson's Feature 5 – Gaslighting is morally wrong as victims often experience feeling crazy, leading to a loss of sense of self and depression.*

A deep moral wrong is associated with medical gaslighting behavior, as victims often experience feeling crazy, leading to a loss of sense of self and depression. Many complex health issues that take years to diagnose often go unrecognized because they are, in a sense, "invisible" to the naked eye. Patients experience debilitating symptoms that often cannot be seen by a physician because they involve pain, tingling, fatigue, cognitive issues, or symptoms that come and go. Of course, this presents an incredibly frustrating experience for the patient, as doctors are often quick to reduce a patient's symptoms related to stress or anxiety and are more likely to attribute symptoms of stress or anxiety to women than men. Feelings of being silenced and dismissed repeatedly have severe psychological impacts on patients.

In the example, Grace experienced over a year of severe pain, with little sense of urgency for what she was experiencing. She feels alienated, alone, and lost throughout the long journey of doctor appointments, pain, and intuition that something is wrong, even with reassurance. She becomes bedridden with pain and fatigue, not knowing where to turn for help. She is finally diagnosed, but the damaging effects have taken hold. As a result, Grace has lost her sense of self and feelings of autonomy and has sunk into a deep depression.

While it may seem that medical gaslighting is also morally wrong for how it affects patients, Abramson's feature falls short of explaining the full scope of moral wrongness associated with it. That is, medical gaslighting does not *solely* affect patients. As I will argue
below, in addition to harming victims, medical gaslighting makes doctors susceptible to what Macy Salzberger describes as moral injury, as they may face guilt or shame for having contributed to undermining a patient's agency and are, in a sense, an accomplice to their having lost their sense of self.

I have argued that while Abramson's account of gaslighting may seem to explain three features of medical gaslighting adequately, each feature will need more clarification or revision to capture the uniqueness of medical gaslighting, thus showing that the above three features of Abramson's account fail of accurately explaining features of medical gaslighting. I now ask, "Which of Abramson's characteristic features of gaslighting clearly cannot be adopted in an account of medical gaslighting?" I argue that Abramson's remaining two features do not pertain to medical gaslighting: (1) Gaslighting is emotional manipulation that leans heavily on the psychology of the gaslighter, and (3) Gaslighting aims to extinguish any possibility of disagreement. I will elaborate below.

Abramson's Feature 1 – Gaslighting is emotional manipulation.

As summarized, Abramson claims that gaslighting is a form of emotional manipulation rooted in the gaslighter’s inability to tolerate disagreement. However, doctors generally do not employ psychological manipulation due to a feature of their psychology. Doctors want to help heal their patients, not manipulate them psychologically. A survey published by the National Library of Medicine shows that most doctors find their work meaningful and a close doctor-patient relationship rewarding⁹. Although Grace's doctor repeatedly dismisses her symptoms,

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⁹ https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4303370/
there is no evidence of personal malice or coercion on the doctor's part. Instead, the doctor is adhering to a set of medical protocols and decision-making tools that is inherently dismissive rather than partaking in psychological manipulation.

*Abramson's Feature 3 – Gaslighting aims to extinguish any possibility of disagreement.*

Doctors are inclined to be open to conversation regarding a patient's symptoms (albeit, often, short conversation), but the conversations rarely err on extinguishing any form of disagreement. While a doctor may disagree with a patient, it is not a form of medical gaslighting. Doctors have expertise and experience and can often see alternate ways of coming to a diagnosis or plan of treatment more so than a patient can. This does not mean, however, that I claim that doctors are always better equipped with knowledge about the patient's experience of their body. Instead, a disagreement between a patient and doctor need not be a feature of medical gaslighting.

I have now identified and explained that the features of Abramson’s account of gaslighting are insufficient in developing an account of medical gaslighting. While I do acknowledge that three of her features somewhat resemble characteristics of medical gaslighting, they are inadequate in explaining medical gaslighting without revision. In advancing my account

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10 A popular quote taught in medical school training states, "When you hear the sound of hooves, think horses, not zebras." This teaches doctors to assess and treat patient concerns by considering the most likely outcome rather than jumping to more serious conclusions about diagnoses that need further work. The Huntington Disease Association states, "The zebra was chosen to represent a rare disease in medicine. Doctors are taught to expect less common conditions in order to avoid patients being misdiagnosed with rare illnesses. Because of this being implemented during training, many medical professionals don't learn enough about rare diseases and can often forget how common a rare disease is. In fact, there are over 300 million people in the world currently living with a rare disease." https://www.hda.org.uk/
of medical gaslighting, I thus reject Abramson’s features of general gaslighting as they are presented.

B. Bagnoli’s Account of Domination

Moving on to taking stock of Bagnoli’s features of gaslighting, they can again be summarized as follows:

1. The aim of gaslighting is domination, and its condition for success is a victim's acquiescence.
2. Gaslighting is a multifocal phenomenon; it is not strictly social or interpersonal and relies on third parties/bystanders to ensure its aim.
3. Main tactics include manipulation of evidence, emotional abuse, and isolation.
4. Gaslighting is compounded by multiple moral wrongs that lead victims to alienation from themselves and their community.

Using another example, let us identify which of the above four features adequately explains medical gaslighting.

Example Case: Kesha, 35

Kesha, an active mother of four and triathlete, has been grappling with persistent chest pain and shortness of breath. Concerned, she visits her primary care physician seeking answers. Her doctor interrupts and says, "But you are a triathlete! You are as healthy as a horse." Kesha continues to voice her concerns but is continuously met with dismissive language, attributing her symptoms as anxiety and stress due to being a working mother. Despite Kesha's persistence that her symptoms feel different and more alarming than simple stress, the doctor repeatedly suggests relaxation techniques and encourages her to take deep breaths. Over several months, Kesha's condition deteriorates, and she sees multiple doctors, all while her chest pain becomes excruciating. She also develops secondary symptoms such as dizziness and swelling of her ankles and legs. Kesha is finally referred to multiple specialists, including a rheumatologist who, after running lab tests, insists she is healthy. Kesha has put her active life on hold and falls into a depressive and disassociated state. Frustrated, confused, and frightened, she seeks an opinion from a cardiologist who discovers a severe heart condition requiring immediate intervention after finally agreeing to run many tests. Kesha's delay in receiving proper medical attention worsened her physical health and left her with emotional anguish from her concerns' repeated invalidation and dismissal.
Upon initial examination, the features of Bagnoli's account of gaslighting that may seem to apply to medical gaslighting are: (1) the aim of gaslighting is domination by a victim's acquiescence, (2) gaslighting is multifocal and relies on third parties, and (4) gaslighting is compounded by multiple moral wrongs that lead a victim towards alienation of themselves and their community. I will elaborate on each below.

_Bagnoli's Feature 1 – Aim of Gaslighting is Domination, successful by victim acquiescence._

While there is something particularly dominating about the gaslighting experience, its condition for success in the medical realm does not hinge on a victim's acquiescence. In the above example, Kesha continuously advocated for herself, expressing concern for her symptoms. She continued making doctor appointments and following up with specialists. Doctors, while they did show their authority by deciding which tests to execute, did not dominate Kesha. Kesha did not acquiesce and instead embodied perseverance.

Compliance, however, is indeed a component of medical gaslighting. For example, Kesha was presented with test results that suggested "nothing is wrong" when, in fact, her condition was not identifiable by traditional tests. She was left to accept test results as evidence that her symptoms were not worrisome when, in fact, they were. However, accepting test results as evidence for medical normalcy is incredibly complex. Lab work and test results rely on longstanding and widely accepted modes of scientific knowledge, and they are often hard to refute in a 15-minute meeting with a doctor.

Further, Kesha (or any patient) may accept the test results as accurate yet continue to resist their physician's diagnoses or lack of diagnosis because their symptoms directly contradict test results ("These tests show I am normal, but I am in pain, which is not normal").
Acquiescence, as Bagnoli describes, is not a condition that necessitates the success of medical gaslighting. Nevertheless, I acknowledge that some aspect of domination remains. A patient feels dominated by their physician, who, in a sense, acts as an authority figure. For now, however, this feature does not adequately explain Kesha's experience of medical gaslighting, and a victim's acquiescence need not be a characteristic of medical gaslighting.

_Bagnoli's Feature 2 – Gaslighting is multifocal and relies on third parties._

In the above example, Kesha, a black woman, is met with gaslighting tactics that rely on many oppressive structures, including sexism and racism. Due to Kesha's athleticism, doctors quickly assume her health is not a concern. According to Bagnoli, while the social structures at work lay the foundation for gaslighting to exist, gaslighting must be enacted in a person-person relationship. Gaslighting manifests through interpersonal connection, but oppressive structures are needed for the phenomenology. Oppressive structures such as sexism and racism are enacted in Kesha's relationship with her doctor(s).

However, as I will more thoroughly expand in the next section, gaslighting is multifaceted and interdependent. That is, the many features of medical gaslighting rely on each other for its success. Also, many different aspects can be attributed to its existence, such as oppressive social structures, problematic development of medical sciences, and the normalization of objectification in medical care. It is not enough to explain medical gaslighting as multifocal without explaining how the different features of medical gaslighting rely on each other. However, I acknowledge that third parties play a vital role in medical gaslighting, an aspect Bagnoli touches on. Nevertheless, third parties' role in medical gaslighting is better explained by
the systematized nature of medical care. In these ways, this feature of Bagnoli's account of
gaslighting is insufficient in adequately explaining medical gaslighting.

*Bagnoli's Feature 2 – Gaslighting is compounded by multiple moral wrongs, leading a victim
towards alienation of themselves and their community.*

Filled with frustration, fear, and confusion, Kesha puts her active lifestyle on hold – a
challenging experience as a mother. Entering a state of depression and detachment, Kesha feels
unlike herself. By the time she finds answers to her condition, Kesha has suffered psychological
and physical damage due to the delay in diagnosis. Kesha, having experienced such emotional
turmoil, is led toward feeling detached from herself, her family, and her community.

While both Abramson and Bagnoli agree that gaslighting is morally wrong, they do so in
different ways. For Abramson, the emphasis is on a victim's loss of sense of self, whereas
Bagnoli describes this loss of sense of self as particularly alienating for a victim. I agree with
Bagnoli that there is a sense in which a victim feels alienated. I also agree with Abramson that
gaslighting often leads victims to lose their sense of self. To lose one's sense of self *is* an
alienating experience. However, not all victims of medical gaslighting experience alienation
from their community. The opposite may occur, and victims may find connection, empathy, and
motivation in their community. For example, the Netflix documentary *Unrest* chronicles
filmmaker and activist Jennifer Brea and her years-long battle with getting diagnosed with
Myalgic Encephalomyelitis (ME), also known as chronic fatigue syndrome. ME is a "devastating
multi-system disease that causes dysfunction of the neurological, immune, endocrine and energy
metabolism systems" and is often misdiagnosed or written off as being in a patient's head.\(^{11}\)

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\(^{11}\) [https://www.unrest.film/](https://www.unrest.film/)
the film, Brea describes feelings of isolation and severe depression after not being taken seriously by her doctors. However, Brea finds an online community of people suffering from the same symptoms and finds motivation to continue seeking answers to her illness and encouragement to document her difficult journey.

Further, as I mentioned in the introduction, TikTok is chock-full of thousands speaking up about their medical gaslighting experiences (whether accurate or not), and many of them band together to shed advice and insight into their symptoms and experiences of medical gaslighting. Due to the widespread nature of medical gaslighting, many patients are susceptible, and while many indeed experience a loss of their sense of self, it is familiar enough to find others who will understand, listen, encourage, and motivate victims to continue their journey. Nevertheless, something is alienating about the experience of being gaslit, whether from oneself or their community. However, my account will focus more on the alienating effects of medical gaslighting as they are experienced rather than as causal outcomes. Therefore, this feature of Bagnoli’s account of gaslighting falls short of adequately explaining medical gaslighting.

I have identified three features of Bagnoli's account of gaslighting that seem to help develop an adequate explanation of medical gaslighting. However, I have shown that each feature is inadequate as presented. I now ask, "Which of Bagnoli's characteristic features of gaslighting clearly cannot be adopted in an account of medical gaslighting?" Upon appraisal, the feature that does not apply to medical gaslighting is (3) main tactics include manipulation of evidence, emotional abuse, and isolation.

_Bagnoli's Feature 3 – Main tactics include manipulation of evidence, emotional abuse, and isolation._
Similarly to my rejection of Abramson's criteria that gaslighting is emotional manipulation, I also reject Bagnoli's feature that tactics include manipulation of evidence and emotional abuse. Once again, I do not adopt the notion that doctors are inherently seeking to manipulate victims through emotional means. Doctors want to help their patients by finding solutions and explanations for their ailments. Also, doctors may use test results to incorrectly reassure patients' concerns, but they cannot manipulate evidence without breaking protocols or legal procedures.

C. What is Missing?

I have now summarized both Abramson and Bagnoli’s general accounts of gaslighting and evaluated their claims to see which also adequately identify medical gaslighting. While Abramson provides a helpful analysis for identifying psychological gaslighting in interpersonal relationships, her account does not fully explain the phenomenon of medical gaslighting. Similarly, Bagnoli offers an alternative yet equally helpful approach but does not adequately explain medical gaslighting. Further investigation is necessary.

Although I reject the features of gaslighting as laid out by Abramson and Bagnoli, my theory of medical gaslighting will take inspiration from the following features (in no particular order). Again, these features do not adequately explain the characteristics of medical gaslighting and must be revised in a way that better encompasses the complexity of recognizing medical gaslighting.

1. Gaslighting is usually sexist in that women are more often targets of gaslighting behavior.
2. Gaslighting tactics happen over a period of time, which develop and cause a victim to question their sanity.
3. Gaslighting is a multifocal phenomenon; it is neither strictly social nor interpersonal and relies on third parties/bystanders to ensure its success.
4. Gaslighting is morally wrong.
5. Gaslighting involves some aspect of dominance.
6. Gaslighting involves some aspect of feeling alienated.

Some of the above aspects influence my account of medical gaslighting, yet they will differ in essential ways. An adequate account of medical gaslighting must also explain other unique features of medical gaslighting not discussed by either Abramson or Bagnoli. The first is that medical gaslighting is inherently systemic. We need a broader understanding of which forces are at work and how they influence medical gaslighting today. This requires identifying some of the root causes that have contributed to medical gaslighting, further enabling the normalization of the phenomenon. In addition, my theory will need to explain how medical gaslighting works - or the modes in which medical gaslighting occurs in the medical industry. Finally, in continuing to meet the original criteria laid out in section II, my theory of medical gaslighting will need to be explained from the perspective of its victims rather than from the perspective or aim of a gaslighter. The following section will lay out my account of medical gaslighting.

IV. Medical Gaslighting

To develop my account, I first lay out nine characteristic features of medical gaslighting. Along the way, I clarify which features were inspired by Abramson and Bagnoli, given that the features will be amended to serve an account of medical gaslighting better. I also respond to objections along the way that aid in better understanding why I argue the significance of each feature. I conclude this section by defending my account, first by addressing a final objection, followed by arguing that my account meets the original five criteria for an adequate account of medical gaslighting.

Characteristic Features of Medical Gaslighting
Feature #1 – Medical gaslighting is a widespread and historically systemic phenomenon.

I aim to answer the following questions in this section. First, what do I mean by the claim that medical gaslighting is systemic? Second, what social or institutional structures are in place to allow for a systemic presentation of medical gaslighting? Answering these questions helps to reveal how deeply rooted medical gaslighting is and will show that until we become aware of medical gaslighting’s systemic nature, medical gaslighting will continue to thrive.

Medical gaslighting as a systemic phenomenon refers to the pervasive and entrenched nature of gaslighting within the medical care system. It is not enough to view medical gaslighting as a psychological phenomenon that occurs strictly between doctor and patient because of the frequency with which it is reported. It is not limited to isolated incidents but represents a widespread and ingrained practice within the medical system. Systemic issues are deeply rooted, persistent, and extend throughout the system. It happens between primary care providers and patients, surgeons and patients, specialty doctors and patients, nurses and patients, and other physician-patient relationships all throughout the medical system, including hospitals, clinics, and private medical centers. The systemic nature of medical gaslighting includes its pervasiveness, omnipresence, structural biases, and influence on medical training and medical protocols. For instance, a patient suspecting they are falling victim to medical gaslighting may want to switch primary care doctors. However, because medical gaslighting is widespread and inherent to medicine’s training protocols and treatment regulations, switching doctors will ultimately lead to the same treatment plan and medical gaslighting tactics.

Elena Ruiz offers a fascinating account of what she defines as cultural gaslighting, which “refers to the social and historical infrastructural support mechanisms that disproportionately
produce abusive mental ambients in settler colonial cultures in order to further the ends of cultural genocide and dispossession” (Ruiz, 1). Although Ruiz argues for the more extensive claim that gaslighting is inherent to our society, she nonetheless explains her definition of cultural gaslighting in the context of medical care (among other structural institutions), which is applicable here. Ruiz agrees that a systemic approach is helpful, as it emphasizes that gaslighting does not solely exist between provider and patient, and instead, that “tightly woven net of policies, training manuals, advisory boards, disciplinary and institutional procedures—even medical equipment—upholds the structured inattention” to the health of black women, “who continue to have the highest maternal mortality rates of any group for which metrics are kept” (Ruiz, 6). In this way, understanding that medical gaslighting is a feature that is embedded into the medical system is essential.

Further, characterizing medical gaslighting as a systemic phenomenon underscores the need for broader systemic changes within the healthcare system. Recognizing its systemic nature emphasizes identifying and addressing deeply rooted factors that allow gaslighting behaviors to persist and harm patients. In this way, we must also understand historical influences at work that built the foundations for medical gaslighting to exist and thrive.

a. Knowledge Dissemination as Exclusionary

A root cause contributing to the systemic nature of medical gaslighting is the historical exclusion of women's contributions to the sciences, rooted in a sexist and misogynist social order. Sandra Harding provides a valuable analysis of the relationship between knowledge production and gender. Harding concludes that more traditional methods of producing knowledge about the world reflect the dominant social groups that developed those methods.
Scientific practices have historically been developed to exclude the views and experiences of women, resulting in a male-dominated view of the sciences that has perpetually silenced women and women of color and continues to enable medical gaslighting to this day. Historically, women have been "systematically excluded" from doing or contributing to the sciences (Harding, 31).

Vandana Shiva states:

"At a deeper level, scientific knowledge, on which the development process is based, is itself a source of violence. Modern reductionist science, like development, turns out to be a patriarchal project, which has excluded women as experts, and has simultaneously excluded ecological and holistic ways of knowing which understand and respect nature's processes and interconnectedness as science" (Shiva, 14).

We have a gap in the process and development of modes of scientific inquiry. Historically, other ways of knowing and developing modes of science are ignored and overlooked, whether purposefully or unconsciously, need not matter. Instead, we must recognize a foundational error in how the sciences were developed, which is inherently exclusionary, biased, and lop-sided. Without adequately considering and including women who possess a deep understanding of women's bodies, it seems plausible that symptoms go undiagnosed, brushed off, or ignored, as they are poorly understood. Nevertheless, how do we aspire to understand these bodies' complexity if those who possess the most comprehensive knowledge are systematically excluded from contributing to scientific medical advancement?

Put into today's medical context, in an article published by the National Library of Medicine, "To Address Women's Health Inequity, It Must First Be Measured," Kathryn Shubert addresses the historically underfunded area of research on women's health. A lack of research

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12 "Women's health" broadly includes trans men, trans women, and non-binary people. Also, this study acknowledges the "consequences gender identity goes beyond how a person identifies, and includes multiple factors..."
on women's health "marginalizes the health risks and experiences" of women, women of color, and trans people. Some implications include biases and lack of clinical trials for developing life-saving vaccines and drugs. Also, a lack of research on women's health contributes to a lack of knowledge of how to recognize and medically treat women's bodies. For example, Carolee Lee, Founder and CEO of Women's Health Access Matters, reports:

"There's currently a stark gender gap in health research funding across the board, even when it comes to diseases that disproportionately impact women. Case in point: only 12% of Alzheimer's disease research goes to projects focused on women, even though women make up about two-thirds of all Alzheimer's patients. Cardiovascular disease is the number one killer of women in the United States, yet only one-third of patients enrolled in clinical trials are female, and just 4% of the National Institutes of Health's cardiac artery disease research budget focuses on women-only research" (Lee, 2).

A lack of research funding swayed toward a better understanding of women's bodies is influenced by the systemic exclusion of women from the sciences. Elizabeth Anderson argues that dominant modes of inquiry harm women because they produce theories of social phenomena that render women's activities and interests, or gendered power relations, "invisible," among other harmful consequences (Anderson, 1). The medical practices that have developed and have become normalized on a systemic level are inherently damaging because they are founded on theories that have historically ignored women – their experiences, bodies, intellect, and epistemic agency.

I have argued that the systemic nature of medical gaslighting is rooted in the historical exclusion of women's contributions to the sciences. One could object by arguing that an

such as access to resources, roles and practices, norms, beliefs, decision-making power and autonomy, laws, policy, and institutions" (Shubert, 882).
alternative to the male-dominated view of the sciences would not solve the relative gender gap. Donna Haraway suggests that feminists of science need to analyze and answer questions such as, "Do feminists have anything new to say about the vexed relations between knowledge and power?" or "Would feminist standards of knowledge genuinely end the dilemma of the cleavage between subject and object or between noninvasive knowing and prediction and control?" (Harding, 137). Haraway is skeptical that any feminist theory can deliver an unproblematic alternative to the dominant ways of knowing and that most theories would only guide us from objective to subjective and relative theories. Nevertheless, there is great importance in seeking alternatives, as the prominent modes of inquiry in the sciences are "highly incorporated into the projects of a bourgeois, racist, and masculine-dominant state, military, and industrial complex" (Harding, 138). Further, I agree with Harding's response to objections such as Haraway's – that the move towards relativism overall misunderstands feminist endeavors. Prominent feminist theorists are not attempting to swap one gender-focused viewpoint for another, like shifting from "woman-centered" to "man-centered" ideas (Harding, 138). Instead, they aim to develop hypotheses that are impartial to gender biases. While we may have to start with a gender-specific hypothesis to grasp the concept of a gender-neutral one, the objective of the feminist pursuit of knowledge is to create theories that accurately portray women's experiences. For Harding, from the perspective of feminist theory and research, traditional modes of thinking distort reality due to its male-centric bias. A more inclusive approach to the sciences is crucial and would aid in

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13 In Harding's view, "objectivism" is the assumption that objectivity must always be satisfied by value-neutrality, and 'subjectivism,' to relativism is the assumption that no value-directed inquiries can be objective and therefore all are equally justifiable" (Harding, 137).
developing the research and knowledge needed to curb medical gaslighting because women's bodies and their response to disease would be better understood. While there are many more contributing factors to the systemic nature of medical gaslighting, the above allows us to understand why it is the case that medical gaslighting is omnipresent in our medical system.

**Feature #2 – Medical Gaslighting is multifaceted and interdependent.**

The second essential feature of medical gaslighting is that it is multifaceted, with each of its many facets dependent on each other, meaning that one-factor influences or exacerbates another. Recall Bagnoli’s feature that stated gaslighting is a multifocal phenomenon – this feature failed to account for the ways the systemic nature of medical gaslighting relies on its other features. Therefore, its vital to recognize the multifaceted and particularly interdependent nature of my characteristic. For example, while medical gaslighting may emerge from and have roots in societal norms, it manifests in a relationship – doctors, while not actively committing emotional manipulation, enact the language, protocols, and regulations and enforce the medical system standards. The multifaceted nature of medical gaslighting is then reinforced by third-party involvement and systemic procedures, such as the doctor referral system\(^\text{14}\), even though most medical doctors were trained by the same or similar approaches to diagnosing the body and its physical symptoms. All facets of medical gaslighting work together, ensuring its success. Medical gaslighting involves various behaviors and attitudes from medical care providers that collectively contribute to the experience. For example, dismissing a patient's symptoms and

\[^{14}\text{Often, depending on the patient's medical insurance coverage, patients must see their primary care doctor first before being able to see a specialist for their symptoms. That is, they must receive a referral from their primary care doctor to see the necessary specialist, such as a cardiologist or neurologist.}\]
attributing their condition to psychological factors, such as stress or anxiety, include interdependent features of medical gaslighting – its systemic nature, history of exclusion, deeply rooted misogyny, and medical training protocols. When a healthcare provider dismisses the patient's symptoms and blames anxiety for their condition, it leads the patient to doubt their own experiences.

While I maintain that medical gaslighting is multifaceted and interdependent, one could easily assert that gaslighting focuses mainly on an interpersonal style of gaslighting, one that occurs between two people in a close relationship, the doctor-patient relationship. If this is true, it would be unreasonable to argue that medical gaslighting is particularly multifaceted or interdependent. In this view, the objection suggests that gaslighting could not be a systemic, multifaceted phenomenon in healthcare if gaslighting is confined to occurring in a dyadic relationship. Consequently, one would argue that my focus should be solely on the doctor-patient relationship.

To answer this, I argue that while the primary doctor-patient relationship is vital for medical gaslighting, it nonetheless depends on the broader network of doctors and legal protocols within the medical system, creating a multifaceted phenomenon. For instance, medical networks (such as Kaiser Permanente) work as a team, and patients often see multiple doctors simultaneously. For example, a patient has their primary care doctor, a gynecologist, and the many specialists their primary care doctor refers them to depending on their symptoms or lab results. In this way, doctors work together to treat the same patient, often supporting and collaborating with other doctors and, knowingly or unknowingly, contributing to gaslighting patients. Consider another example: a patient suffering from recurring migraines visits their primary care doctor, who then,
after many visits, refers them to a specialty neurologist. The neurologist does not find any worrisome evidence and thus conveys their agreement with the original primary care physician that their symptoms are normal. After continuing to experience migraines, the patient is referred to a rheumatologist, where the cycle continues.

Further, in "Gaslighting by Crowd," Karen Adkins argues that focusing on a solely "dyadic" manifestation of gaslighting "minimizes the role of others," such as those who collaborate with the gaslighter (Adkins, 77). The role that outsiders play, along with the gaslighter, is vital to the success of gaslighting and contributes to the disappointing outcome of a victim's loss of sense of self. Seen this way, the system's role in healthcare and how healthcare relies on a network of doctors, testing protocols, and Western practices undergirds and bolsters the prevalence of medical gaslighting. An entire network of medical professionals and the medical training they have received support one another in this multifaceted endeavor.

Feature #3 – Medical Gaslighting uses modes of Objectification.

Objectification is another essential feature of medical gaslighting. Patients are objectified as medical objects, and doctors are historically taught to view patients as such. Here, I answer the question, “how ought we understand the role of objectification in the context of medical institutions?”

There are many differing ideas of how we define or understand objectification, including the sexual objectification women face as “sexual objects.” However, covering a broader notion of objectification will help us understand its significance in the history of the sciences. In “What is Objectification,” Lina Papadaki assesses the significant philosophical contributions to defining objectification, specifically the works of Immanuel Kant, Katherine MacKinnon, Andrea
Dworkin, and Martha Nussbaum, to develop a working definition of objectification. Papadaki thus defines objectification as:

“… seeing and/or treating a person as an object (seeing and/or treating them in one or more of these seven ways: as an instrument, inert, fungible, violable, owned, denied autonomy, denied subjectivity), in such a way that denies this person’s humanity. A person’s humanity is denied when it is ignored/not properly acknowledged and/or when it is in some way harmed” (Papadaki, 32).

Papadaki’s definition will help us understand how, under medical care, a doctor objectifies a patient by viewing them as a medical object. Even with an incomplete account of medical gaslighting that I have shown thus far, a denial of autonomy and subjectivity exists. When a patient’s concerns about their body and its symptoms are dismissed, silenced, or brushed off, their humanity, as Papadaki defines above, is denied. A patient may not necessarily feel sexually objectified, but they are viewed as an object without agential standing. Further, Papadaki’s analysis includes the notion that objectification need not be intentional – similar to, as I argue, the way doctors may or may not be aware that they are medically gaslighting their patients due to their being restrained by regulations and treatment protocols.

The work of Michael Foucault aids in better understanding how the role of objectification is tied specifically to the medical sciences. In *The Birth of the Clinic*, Foucault explores the conditions underpinning medical experience in modern times and develops the concept of the clinical gaze, "through which the doctor comes to exercise active authority over a now objectified and passive patient in a potentially intimate diagnostic examination" (Bleakley, Bligh, 371). In the late 18th century, European medicine underwent a transformation involving a new diagnostic approach guided by the clinical gaze and the emergence of a physical and cognitive framework – the clinic itself. The clinic institutionalized practices like patient history-taking and
intimate doctor-patient examinations. This new structure shifted the doctor's focus from patients to sickness. That is, the hospital became a place to analyze cases of illness rather than assist patients. Eventually, as clinical methods progressed, criteria emerged for distinguishing normal from pathological, with health now defined as the absence of clinical symptoms (Bleakley, Bligh, 372).

Further, mirroring the cultural and societal industrialization of the times, the medical clinic became one to implement procedures that manifested efficiency above all else, the result of which is viewing the human body as a machine, an object that needs to be fixed. Seen this way, the human body is thus objectified as a medical object rather than a human with complex social and psychological dimensions (Bleakley, Bligh, 373). The body, seen as a medical object, is susceptible to being treated as such – a list of symptoms to assess and categorize; a medical object to be studied.

Alan Bleakley and John Bligh of "Who Can Resist Foucault?" argue that the clinical gaze concept is necessary but insufficient to assess modern medicine and its faults critically. However, a critical Foucauldian concept that still presents today and aids in my development of medical gaslighting is that with "the development of the medical gaze, perception shifts from complex person to identifiable disease" (Bleakley, Bligh, 373). Said differently, a doctor focuses on addressing and diagnosing symptoms, separate from a patient's experience.

Moreover, in Under the Medical Gaze: Facts and Fictions of Chronic Pain, Susan Greenhalgh nicely applies Foucault's notion of the "medical gaze" to the current culture of medical care to explain the shortcomings and dangerous aspects of how medical professionals treat their patients. Under the medical gaze, medical doctors are taught to see a patient as a
scientific, medical object, separating a patient's mind from their bodily illness and symptoms (Greenhalgh, 16). From here, the doctor filters what they "know" to be true of scientific evidence and aims to diagnose a patient. Patients not fitting into their medical paradigm are prone to be dismissed, ignored, and gaslit. Conversely, the medical institution built on empirical evidence gives doctors the power to intervene, diagnose, prescribe, and treat how they see fit.

Considering the above, contemplate the following example of a confirmed case of patients being viewed as medical objects. Imagine, filmmaker and director of the award-winning documentary *At Your Cervix*, sheds light on the unethical medical practice of conducting non-consensual pelvic exams on anesthetized patients. The documentary depicts patients going in for routine surgeries. They are then unknowingly used as practice for medical students to conduct pelvic exams, all while unconscious and without consent. Such an abhorrent practice brings to light many problematic issues, including the role of consent. However, using patients as medical practice while they are anesthetized also clearly shows the role of medical objectification and, as I will later show, misogyny. Patients in the medical context are seen as objects to be studied, used, and examined without regard for their humanity or subjectivity. While this is not necessarily an example of medical gaslighting, it is an example that shows the environment in which medical gaslighting thrives – an environment rooted in systemic and widespread injustices.

Feature #4 - Medical Gaslighting is inherently authoritative.

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15 [https://www.atyourcervixmovie.com/](https://www.atyourcervixmovie.com/)
The authoritative nature of medical gaslighting is another feature of my account. Power dynamics play a vital role in the manifestation and success of medical gaslighting. Medical care providers' authority over patients makes it difficult for patients to challenge or question their judgments. Patients often trust their doctors and rely on their expertise, making it challenging to recognize when they are being medically gaslit. As I mentioned, the only "solution" currently to combating medical gaslighting is encouraging patients to speak up and advocate for themselves. However, the need to advocate for oneself suggests the presence of an opposing authority. So, how exactly do medical professionals hold power over their patients? Foucault's analysis of the clinical gaze is once again helpful here.

The clinical gaze gives doctors authoritative power to question and treat the patient's body. Power is not given to the patients who come for help, halting a patient's ability to successfully challenge a doctor's medical protocol. The medical professional is trained with years of knowledge and expertise, whereas a patient is not. Only with the authority of the medical professional are lab work, testing, diagnosis, referrals to specialty doctors, and access to prescription drugs possible. A patient is left at the disposal of a doctor's care. A doctor seeks (unconsciously) to uphold their authoritative position of power by enacting the maneuvers that keep patients seeking their help. Of course, this all seems reasonable in most doctor-patient relationships. Nonetheless, in cases of medical gaslighting, patients often experience a sense of hopelessness, entrapment, dismissal, or anxiety as they navigate the arduous task of persuading their doctor that something is wrong with their body, even when there is no apparent medical explanation. Thus, the development of an ongoing power struggle takes place between the patient and the authority of the doctor(s).
While I argue that the role of authority in medical gaslighting is essential, one could reason that we should trust a medical doctor's expertise on medical symptoms, and any authority a doctor conveys is warranted based on their years of experience. Naturally, this objection questions the basis on which doctors should trust their patients' testimony. My reply is as follows.

In her article, "Trust, Distrust, and 'Medical Gaslighting,'" Elizabeth Barnes questions whether doctors have an obligation to believe a patient's testimony about their body and its symptoms. Barnes argues that doctors have good reasons not to trust patients' assertions about their physical experience. Barnes is correct when she states that a popular idea about medical gaslighting is that doctors "are not treating patients as authorities over their own first-person experience and unfairly distrust them as a result" (Barnes, 12). Further, Barnes argues that doctors should believe a patient's subjective experience about their bodies; however, they have good reason to distrust a patient's testimony about objective conditions such as disease parameters. As Barnes quotes, "the idea is that individuals have introspective access to, and are competent sources of information about, the subjective aspects of their experience of illness, but not the objective causal/biological mechanisms that ground that experience" (Barnes, 20). Barnes allows that a patient may be dismissed about the severity of their suffering, but doctors are not obligated to fully trust that patient's "intuitions" or knowledge about what caused their suffering. Thus, Barnes believes doctors may dismiss a patient for good reason, and simply because a patient's testimony is not trusted does not imply medical gaslighting. While Barnes grants that there may be instances of valid medical gaslighting, most instances of medical gaslighting need not be explained by the phenomenon of gaslighting itself. Instead, Barnes argues that such
instances can amount to a "bad doctor" or a doctor who simply is not doing their job well (Barnes, 24).

I have two responses to Barnes’ claim that doctors are either "bad doctors" or are valid in their dismissal and distrust of a patient's claims regarding their body. First, the lack of definition currently surrounding what classifies as "medical gaslighting" contributes to Barnes' conclusion. However, my account of medical gaslighting will aid in identifying which instances are indeed medical gaslighting and those which are not. Second, Barnes' claim that some doctors are "bad" relies on a psychological explanation of gaslighting. The psychology of the doctor, whether lack of motivation, work ethic, or dislike of a patient, contributes to their treatment of a patient. Such a claim places blame on the doctor rather than acknowledging the more extensive, systemic, and societal issues. Unfortunately, some doctors commit malpractice, but those instances are far less common than the thousands of claims of medical gaslighting from women. While I agree that doctors must bear some of the responsibility in treating patients medically, I argue that the complexity involved in medical gaslighting absolves much of the onus placed on doctors as sole psychological manipulators who choose to harm patients.

*Feature #5 - Medical Gaslighting Serves (the Ends) of Dominant Ideologies*

Medical gaslighting aids in securing the socio-political climate in which a patriarchal and oppressive society can thrive. When I analyzed the Bagnoli’s account, I rejected her claim that gaslighting works by domination through a victim's acquiescence. However, I discerned that an element of domination was inherent in the context of medical gaslighting. My claim, then, is that the nature of medical gaslighting works to secure the dominant ideologies of a patriarchal society. Conceptually, medical gaslighting works to secure the dominant socio-political
ideologies due to the historical structures that contributed to its nature, such as problematic foundations of medical objectification, exclusion of women from the sciences, lack of research focused on women, systemic misogyny, and the authoritativeness of doctor-patient relationships. More specifically, the experience of medical gaslighting (from the perspective of its victims) serves these ideologies by reinforcing submissiveness, gender biases, and women's health stigmas and continues to marginalize those most affected by structural oppression. These, interdependent with the systemization of the medical industry (third-party justification), work together to keep dominant social systems in place. Dominant social systems include patriarchal standards and roles, racial oppression, heteronormativity, cisnormativity, ableism, ageism, and classism.

Further, sexism and misogyny are vital in serving these dominant ideologies. Once again, I take influence from Kate Manne's account of misogyny. In *Down Girl*, Manne argues that sexism is the "'justificatory' branch of a patriarchal order, which consists in ideology that has the overall function of rationalizing and justifying patriarchal social relations" (Manne, 79). At the same time, "misogyny is the 'law enforcement' branch of a patriarchal order, which has the overall function of policing and enforcing its governing ideology" (Manne, 63). Sexism works by justifying "natural" sex differences and discriminating between men and women. On the other hand, misogyny seeks to punish women for straying from their social role and related attributes.

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16 Medical gaslighting disproportionately affects marginalized individuals, such as women of color, LGBTQ+ individuals, and indigenous women, who may experience multiple layers of discrimination and marginalization within healthcare systems. This further supports patriarchal power structures that benefit the dominant group.

17 Manne's account of misogyny, and the account I employ here in context to medical gaslighting, recognizes that "misogynist forces can be distinctive for girls and women located in different positions in a social space" (Manne, 64). Recognizing misogyny as a structural force also acknowledges how women may be affected by other intersecting and oppressive forces, such as racism.
as understood under patriarchy. As understood by Manne, sexism and misogyny share a common goal: "to maintain or restore a patriarchal social order" (Manne, 80). For example, sexism justifies beliefs such as women being more emotional than men or being the weaker, kinder, and softer of the sexes. Misogyny occurs if a woman veers from the social rules of compliance or agreeableness, and she may be shamed, silenced, or called names such as "bitchy" or "aggressive."

There is plenty of empirical evidence to support the view that sexism runs rampant in medical care, having a direct impact on the way that women are medically treated. For instance, Forbes reported a study that "women are typically diagnosed 2.5 years later for cancer and 4.5 years later for diabetes – and these are not isolated occurrences. All told, women are diagnosed later than men in more than 700 diseases" (Goyeneche, 1)\textsuperscript{18}. Reasons for such delayed diagnoses in women are justified by sexist beliefs such as women being overly dramatic, emotional, or hysterical about their symptoms.

The healthcare system lies directly within our patriarchal society and accommodates misogynistic and sexist ideologies in two critical ways. First, Manne's view allows for women to partake in misogynistic behavior because women also punish other women for straying from their patriarchal roles, not just men. The fact that women are also capable of misogynist behavior explains why many women doctors act as gaslighters, not just doctors who are men. Second, Manne argues that misogyny serves to enforce dominating ideologies and punish women who veer from their societal role. Punishment may take the form of different "down girl" moves and

include (but are not limited to) silencing, shaming, belittling, condescending, sexualizing, desexualizing, shunning, name-calling, patronizing, and dismissiveness. Manne describes "down girl" moves as "dynamic, active, and forceful maneuverings. They put women in their place when they have 'ideas beyond their station'" (Manne, 60). I argue that "down girl" moves are present in the medical context and are used as medical gaslighting tactics. When a woman continues to advocate for herself after a doctor has told her that her symptoms are "normal," she is subject to experiencing punishment in the form of down girl moves, having veered from her role as submissive or obedient. She experiences patronizing language, silencing techniques, dismissive language, and actions that further her battle to receive quality care.

If misogyny upholds a system of patriarchy against other oppressive ideologies, then medical gaslighting serves those ends. Put another way, sexism and misogyny fuel medical gaslighting by continuing to stereotype and justify "differences" between men and women and enforce, dominate, and punish forms of resistance, such as patients advocating or speaking up about their concerns that go against their doctor's expertise.

While I have argued that medical gaslighting serves dominant ideologies, one may very well assert that doctors typically have the best intentions and do not intentionally engage in gaslighting, to which I agree. Usually, doctors aim to provide quality care and may not be aware of any inherent biases in the way they treat their patients. This assertion highlights the need to explain how medical gaslighting can support or reinforce dominant societal ideologies. While I also address the issue of intentionality in feature #9 below, intentionality is key to address here. I have two responses.
First, while it may be true that doctors and healthcare providers typically have good intentions, my claim rests on the notion that medical gaslighting is inherently systemic. Biases are naturally occurring and actively a part of medical protocol, no matter how well-intentioned a doctor may be. Recall, as well, the lack of research and funding that harms women – first by their exclusion from contributory scientific research and second by the inability to identify diseases in women compared to men.

Next, I do not mean to claim that medical gaslighting has an aim, as there are far too many interdependent factors to assign an aim, such as the psychological aim of a gaslighter. However, there is a way in which medical gaslighting does something. It does serve the dominant ideologies because it is built from those dominant ideologies, which ultimately have deeply harmful effects on victims. Understanding that medical gaslighting has power behind it, even without a conscious individual as a driving force, does make it challenging to recognize.

*Feature #6 – Medical Gaslighting happens over a period of time.*

I argue that medical gaslighting transcends isolated incidents, as it often unfolds over an extended period. In section III, I argued that Abramson’s claim that general gaslighting happens over a period of time was insufficient. While appearing to be a similar feature, my feature better explains why medical gaslighting is not reliant on the psychology of a gaslighter but rather systemic policies.

A patient will see their primary doctor, specialists, surgeons, referrals, or even more specialists to identify the cause of their physical symptoms. However, these appointments, referrals, and phone calls take time, which initiates the experience of a slow burn – frustrations, silencing, dismissals, and shaming that lead a patient towards ultimate psychological, emotional,
and even spiritual damage as a moral agent. Many ailments and conditions present in patients who suffer most from medical gaslighting include those that often take many years to diagnose – cancer, auto-immune diseases, chronic pain disorders, and more. Part of this comes from the misunderstanding of how diseases present in women versus men, as well as many systemic issues I mentioned above, including sexism, misogyny, and a lack of medical research on women’s health.

Feature #7 – Medical gaslighting mostly affects women and women of color.

Because I argue that objectification, sexism, and misogyny play an essential role in the manifestation of medical gaslighting, a typical feature of medical gaslighting, according to my account, is the disproportionate impact of medical gaslighting on women and women of color. Recall Abramson’s claim that general gaslighting is usually sexist. However, acknowledging the ways not just sexism, but other oppressive structures, such as racism, contribute to medical gaslighting is imperative. For example, in the article “Medical Gaslighting: When the Doctor Dismisses your Concerns,” by Batya Yasgur, Karen Lutfey Spencer, Ph.D., a professor of health and behavioral sciences at the University of Colorado in Denver, states,

“Research has shown that women, people of color, older people, non-heterosexual people, and individuals with ‘stigmatized’ conditions – like being overweight or having a mental illness – are more frequently misdiagnosed and their symptoms are more frequently dismissed...One reason is that much of the research that informs diagnosis and treatment was historically performed on white males...For example, heart problems are often misdiagnosed in women because heart disease has been regarded as a ‘male’ condition” (Yasgur, 3).

Moreover, this also has deep roots in the exclusion of women from the sciences. And, while many doctors are indeed women, it does not absolve them from enforcing the authoritative behaviors of medical gaslighting onto women patients. An explanation here lies in the idea that
modern medicine still profoundly misunderstands women’s bodies. Nevertheless, doctors continue to treat patients the only way they know how, based on their years of medical training – a training that, while impressive and highly rigorous, is still rooted in the production of male-dominated knowledge. Unfortunately, until medical training is altered to reflect such a significant flaw in gendered and racialized knowledge, medical gaslighting will continue to negatively affect women much more than men.

Further, as discussed, sexism and racism also contribute to delayed diagnosis for women and women of color, often years more than the same diagnosis for a man. Between sexist stereotypes about women’s bodies and their demeanor (they are overly emotional, hysterical) and the lack of research surrounding the recognition of how medical symptoms present in women’s bodies, medical gaslighting continues to negatively affect women and women of color.

**Feature #8 – The Rabbit Hole Effect**

I claim that patient victims of medical gaslighting enter into a state of altered reality, or what I will call the “rabbit hole” effect. Abramson described the experience of gaslighting as making a victim feel “crazy” (Abramson, 8). Bagnoli states that gaslighting summons “deeply alienating effects” (Bagnoli, 147). Essentially, both claim something similar, using different language to convey that experience. However, what Abramson and Bagnoli underestimate is that the *experience* of gaslighting is a subjective experience and may feel differently or produce different states of reality depending on the subject. So, to claim that gaslighting makes all victims feel a specific way is misguided and misses the mark on articulating the uniqueness of such a phenomenon. Instead, I argue that victims of medical gaslighting enter into a modified version of their reality – the “rabbit hole” effect. Inspired by Lewis Carroll’s 1865 novel, *Alice’s*
Adventures in Wonderland, the “rabbit hole” effect entails a victim entering into a state of altered reality, where much of what they thought they knew about themselves, their bodies, their community, relationships, and the world, comes into question. Patients may know they are experiencing pain in the abdomen, yet multiple doctors reassure them that it is simply stress. Then, a year later, it was diagnosed as endometriosis. What they think they know about their body – that they are in pain, where pain implies something wrong – is now paradoxical to the medical advice that “their pain does not imply something is wrong.” Alternatively, a patient may suddenly be overcome with medical needs, doctor appointments, and chronic issues without any concrete diagnosis and is navigating a system that is working against them when their closest friends suddenly become distant, unwilling to be able to provide comfort. While now experiencing isolation, the patient victim also experiences confusion, questioning the belief that their community of friends was loyal and unwavering.

The rabbit hole effect leaves open the idea and acknowledgment that each victim has their own unique experience as they undergo the effects of medical gaslighting. This experience is not a final destination but an ongoing process. Victims enter a state of altered reality as they are subjected to gaslighting, whether that occurs over months or years. In a sense, rather than medical gaslighting having the “final” effect of making a victim feel crazy – they start to feel some kind of way (perhaps it is crazy) almost immediately. It is important to acknowledge the ongoing subjective experience of the victim to fully elucidate the years-long trauma induced by medical gaslighting, which leads to the next and final characteristic.

Feature #9 – Medical Gaslighting is morally wrong.
An account of medical gaslighting would be inadequate without addressing its moral harms because the moral harm done is deeply interconnected to many of its central features. I argue that there are two moral harms associated with medical gaslighting that affect both patients and doctors. The primary moral harm affects patients, and the secondary moral harm affects doctors, making them susceptible to moral injury. Addressing the moral implications in this way goes beyond either Abramson’s or Bagnoli’s account of general gaslighting. First, I will explain the harms that deeply affect patients and their doctors. Then, I will explain why these harms are indeed morally wrong.

*What are the primary harms of medical gaslighting that affect patients?*

The primary moral harms that affect patients are psychological, physical, and emotional pain and suffering. However, because medical gaslighting affects victims differently, the psychological and emotional aspects range from developing anxiety, depression, OCD, trauma, and distrust. Also, because psychological and emotional suffering affects victims differently, they may range in intensity and duration – some may be more capable of overcoming their trauma sooner, while others are left with life-long psychological trauma. Further, patients also experience physical damage. Due to the time medical gaslighting takes place (months to years), patients are significantly more susceptible to being misdiagnosed. Misdiagnoses have the potential to develop into chronic issues. For example, in the previous example case, Kesha was left to navigate chronic health issues due to the medical gaslighting involved in diagnosing her heart condition. Ultimately, the pain and suffering patients experience from medical gaslighting prevents them from pursuing a life of happiness. Medical gaslighting hinders one’s ability to thrive.
What are the secondary harms of medical gaslighting that affect doctors?

Regarding the secondary moral harm done to doctors and physicians, I argue that medical gaslighting leaves doctors susceptible to moral injury. In "The moral harms of domestic violence," Macy Salzberger puts forth an account of moral injury distinct from moral harm. According to Salzberger, moral injury "refers to a kind of psychological anguish that follows from when an individual causes or becomes causally implicated in actions that we ordinarily would understand to be morally grievous offenses because of their circumstances" (Salzberger, 169). Inspired by the moral injury investigated by scholars of war - which identifies the shame, guilt, and regret that soldiers feel in the line of duty - moral injury similarly affects victims of domestic violence and, as I argue here, doctors who partake in medical gaslighting. Moral injury need not rely on whether a victim is at fault in causing another harm, which makes sense here as doctors, as I have argued, are bound by factors outside their control. To suffer from moral injury, a doctor "must feel the action or implication to be a transgression; they must somehow feel forced by their circumstances to transgress or take part in what they take to be a wrong or harmful action" (Salzberger, 175). Moral injury requires that a doctor become present to or aware that how they treat a patient is highly problematic and denotes evidence of medical gaslighting. My claim does take this into account, arguing that doctors are susceptible to moral injury rather than a broader claim stating that all doctors suffer from moral injury.

While many doctors may be aware that the medical system encourages medical gaslighting and that their training and residency programs encourage gender bias and stereotypes in medical assessments, it is not the case that all doctors are present to such discrepancies. Many doctors may argue that the medical sciences, based on valid empirical evidence, justify the way
they treat patients. In either case, whether a doctor is aware or unaware of the effects of medical
gaslighting on patients, they are nonetheless susceptible to their moral compass being injured.
Further, when they do become aware of their involvement\(^\text{19}\) in medical gaslighting, which
ultimately leads a victim to suffer an array of consequences, doctors will have to live with the
"shame, guilt, or regret that comes from knowing that they had a causal role in an action they
would ordinarily understand to be a morally grievous offense" (Salzberger, 177). That is, when
doctors are aware of or even suspect that they are contributing to medical gaslighting, it can lead
to inner turmoil due to the conflict between one's values and actions.

While Salzberger argues that shame and guilt are an appropriate response to moral injury,
I do not mean to claim that doctors and patients suffer from similar moral harm or that the pain
and anguish each may feel due to medical gaslighting is comparable. However, moral harm does
affect both patient and doctor. Patients should not be subject to such physical, emotional, and
psychological distress when they seek medical care, and doctors should not be required to
medically treat patients using procedures, manuals, and regulations that produce the experience
of medical gaslighting.

*The Moral Wrongness of medical gaslighting.*

Given the above moral harms, I argue that medical gaslighting is morally wrong.
Regarding the primary moral harm that affects patients, I discussed previously the role of
objectification and that in the medical realm, patients are often reduced to being seen as medical
objects. Also, I discussed Kate Manne's account of how, under patriarchy, misogyny punishes

\(^{19}\) I use "involvement" loosely here, as doctors may have little to no control over how they are taught to medically
treat their patients within systematized healthcare.
women for veering from their societal role. Moreover, when a woman speaks up and challenges
the authority of her doctor, her humanity is denied or harmed upon the enforcement of her being
treated as an object. Recall Papadaki's definition of objectification: "A person's humanity is
denied when it is ignored/not properly acknowledged and/or when it is in some way harmed"
(Papadaki, 32). Papadaki's definition is influenced by the work of Martha Nussbaum, who laid
out seven notions involved or utilized in objectifying another. Number seven on her list is
"Denial of Subjectivity," which involves the objectifier treating the "object as something whose
experiences and feelings (if any) need not be taken into account" (Papadaki, 22). To treat a
patient as a medical object involves denying their subjectivity (about their body, symptoms, pain,
experience) and thus their humanity. To deny someone their humanity – intentionally or not – is
morally wrong.

Further, regarding the secondary moral harm, I argue it is morally wrong to put doctors
and other healthcare professionals in situations where they are susceptible to moral injury.
Healthcare institutions have a duty to protect the well-being of their employees and healthcare
professionals, including doctors. Putting them in situations that risk moral injury can be seen as a
breach of this duty, as moral injury leaves them susceptible to mental anguish. Inspired by social
contract theory, I argue that healthcare professionals and healthcare institutions enter into a
contract that, while granting privileges and responsibilities to doctors, is in exchange for ethical
treatment and protection of their well-being. Putting the backbone of the healthcare industry in
situations that risk moral injury violates this social contract and is morally wrong.

Although I argue that medical gaslighting is a multifaceted and systemic phenomenon, I
do not claim that doctors aim to destroy a patient as a moral agent. I argue against a purely
psychological account of gaslighting, which derails the accusation of emotional manipulation. Nevertheless, how ought we understand the pervasive and systemic nature of medical gaslighting as a moral wrong without placing blame on a specific gaslighter? This may again call into question the role of intentionality. However, in cases of medical gaslighting, intentionality does not serve a purpose. As I have argued thus far, the historically systemic and widespread nature of medical gaslighting is in place; whether doctors intentionally choose to serve the ends of medical gaslighting or not does nothing to avoid the consequences of medical gaslighting, which include psychological damage, alienation, years-long diagnosis leading to permanent health issues, mentally and physically damaging misdiagnosis, health anxiety, OCD, and depression. Ultimately, victims are forced into the experience of debilitating confusion and ongoing health issues whether or not a doctor intentionally manipulates.

**Defending my account**

In sum, the above features of medical gaslighting, according to my account, are as follows:

1. Medical gaslighting is a pervasive and systemic phenomenon.
2. Medical gaslighting is multifaceted and interdependent. It is strengthened and upheld using third parties and system-wide protocols.
3. Medical gaslighting uses modes of objectification.
4. Medical gaslighting is inherently authoritative.
5. Medical gaslighting serves the dominant socio-political ideology.
6. Medical gaslighting happens over a period and is not a one off-instance.
7. Medical gaslighting (mostly) affects women and women of color.
8. Medical gaslighting causes patient victims to enter a state of altered reality.
9. Medical gaslighting is morally wrong.

While I argue that the above features constitute characteristics of medical gaslighting, one could contend that it is not a distinct kind of gaslighting because it cannot be explained by more...
general accounts of gaslighting, such as those provided by Abramson and Bagnoli. To address this objection, I offer two responses.

First, recall that victims have already mobilized the language of gaslighting\textsuperscript{20}. Victims recognize the resemblance of medical gaslighting to that of general gaslighting. They perceive the frustration, confusion, and harm it inflicts as resembling something like that of general gaslighting. Therefore, victims have already identified that they are victims of gaslighting. This aligns with criterion #3, which states that an adequate account of medical gaslighting should be defined from the perspective of its victims.

Secondly, as more research emerges, I acknowledge that the term "medical gaslighting" may evolve to suit the phenomenon better. However, this project's scope is focused on identifying and describing medical gaslighting as it is currently experienced. Due to this, I argue that my project sufficiently describes the current phenomenon.

Now, having discussed the defining features of medical gaslighting, I aim to show that my account satisfies the original criteria for an adequate account in section II. To review, an adequate account of medical gaslighting must meet five distinct criteria: (1) to gain conceptual clarity about the phenomenon, (2) to identify its root causes, (3) to explain the phenomenon from the perspective of its victims, (4) describe the moral ramifications of medical gaslighting, and (5) make preliminary policy recommendations designed to reduce its prevalence. I will elaborate on how my account meets each criterion.

\textsuperscript{20} See introduction for examples.
By appraising two general accounts of gaslighting provided by Abramson and Bagnoli, I showcased how general accounts of gaslighting are insufficient in identifying the features characteristic of medical gaslighting. In doing so, I identified the missing elements that allow for a better understanding of how medical gaslighting presents. In addition, I laid out and defended the nine distinct features of medical gaslighting. Identifying, explicating, and elaborating on medical gaslighting's features aligns with the criteria and objectives for achieving conceptual clarity.

Two root causes of medical gaslighting were identified in this paper. First is the historical exclusion of women from the development of the sciences. Second, sexism and misogyny lay the groundwork for medical gaslighting to thrive. Both of these root causes are deeply embedded into the framework that is medical gaslighting – both of which contribute to consequences such as the lack of funding research for a better understanding of women’s bodies and medical rules and regulations hindered by gender and racial biases.

My account also explained the phenomenon from the perspective of its victims. In doing so, I showed how a psychological account fails to accurately explain the lack of emotional manipulation from doctors, solving the complexity involved in blaming doctors, as well as spotlighting the frequency to which medical gaslighting is reported.

In section IV, I laid out the moral harms and arguments for their moral wrongness. Identifying moral implications is necessary to develop an adequate account of medical gaslighting as it brings awareness, accountability, and, most importantly, acknowledges the pain and suffering of those most affected.
I have met four of the five criteria for providing an adequate account of medical gaslighting. The final criterion is to make preliminary policy recommendations designed to reduce its prevalence. Again, meeting this criterion is crucial as it will aid in developing preventative measures and changes in medical protocols, ultimately improving medical care for all. Once I satisfy this criterion in the next section, I will have met the necessary goals and provided an adequate philosophical account of medical gaslighting.

V. Policy implications

I have argued that my account of medical gaslighting satisfies all but one of the criteria for an adequate theory. The final criterion is that an adequate account must enable us to assess policy implications confidently. One of the key takeaways from my investigation into the nature of medical gaslighting is the recognition that it is not merely a matter of interpersonal manipulation but a systemic problem within the healthcare system itself. This systemic nature, intertwined with features such as objectification, has perpetuated an environment where medical gaslighting flourishes. Once medical gaslighting is recognized as an ongoing systemic phenomenon that harms patients and doctors, we will be better positioned to ask, "What now?" "How do we move forward and improve our medical system without producing physical and psychologically harmful effects?"

Ideally, a theoretical account of medical gaslighting has the power to inform policies and practices within healthcare systems. For instance, it can help identify areas where needed changes or improvements. Based on my project here, such improvements are needed in medical training. Medical training includes gender and racial bias training, updated textbooks and
manuals, funding for research, and empathetic approaches to patient care. Institutional practices are another area of much-needed improvement, such as updating policy regulations, revising methods of diagnosing, calling for better screening protocols, and improving lab testing initiatives.

Another improvement to policy implications is to address accountability in a systematized institution. For example, private healthcare institutions should be held accountable for addressing and preventing medical gaslighting. Implementing policy improvements involves regular audits, reporting requirements, and consequences for institutions that fail to act.

While my project here is not able to dive into the policy and procedural applications as thoroughly as previous sections, I hope that my exploration catalyzes meaningful change, driving us toward a future where medical gaslighting becomes an anomaly rather than a pervasive and systemic issue, and where ethical medical practices are held to the highest standard.

VI. Conclusion

In conclusion, I have developed an account of medical gaslighting as distinct from the more generally understood interpersonal style of gaslighting. I argued that a specific kind of gaslighting occurs in medical care – "medical gaslighting" – and explicated its driving force, nature, conditions for success, and psychological effects. First, I explored the importance of developing an adequate philosophical account of medical gaslighting. Then, I analyzed and appraised two possible accounts of gaslighting, generally understood. I found that neither account accurately explains medical gaslighting. I also addressed the moral implications of medical gaslighting and argued for its moral wrongness.
Ultimately, this exploration into medical gaslighting has brought to light an issue deeply entrenched within medical care. Recognizing medical gaslighting as a distinct phenomenon is of timely precedence, as it underscores the critical need for systemic changes. Failing to address this issue allows medical gaslighting to persist, perpetuating a healthcare environment where patients continue to suffer, and doctors, often unintentionally, may unknowingly exacerbate harm and patient suffering. We must implement comprehensive reforms to build a healthcare system prioritizing well-being and trust.
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