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Medical Gaslighting, Trustworthiness, and the Limitations of Mutual Distrust

Christine Wieseler

Department of Philosophy, Santa Clara University, Santa Clara, CA 95053, USA; cwieseler@scu.edu

Abstract

Medical gaslighting occurs when clinicians undermine patients' first-person authority to make claims about their own experiences, leading patients to doubt their own perceptions, beliefs, motivations, and even their sanity. This concept has proven useful for individuals to understand, convey, and find support in the aftermath of a specific type of harmful experience. However, there is much more that remains to be done in terms of clarifying and changing structural conditions that enable medical gaslighting. Elizabeth Barnes identifies many factors that compromise the quality of health care patients with marginalized identities receive without providing a method for describing how biases at the level of medical institutions and professionals enable medical gaslighting. Barnes is concerned that calls to "trust patients" as a remedy for medical gaslighting will lead physicians to grant patients too much credibility. She develops an alternative that addresses the question—under what conditions should physicians trust patients? I am concerned with a different question—under what conditions should patients trust physicians? Critical phenomenology provides a method both for describing individuals' lived experiences of medical gaslighting and avoidable misdiagnoses. It also elucidates how structural conditions make both possible and more likely for patents who are members of marginalized groups, especially when there is medical uncertainty. These are not simply failures of competence among individual physicians; they stem from systemic biases in medical education and norms of clinical practice.

Keywords: medical gaslighting; trustworthiness; critical phenomenology; illness narratives; medically unexplained symptoms

1. Introduction

The term "medical gaslighting" has gained prominence over the past several years, thanks in large part to two *New York Times* articles published in 2022 and circulation on social media [1,2]. Diane O'Leary observes that despite the popularity of #medicalgaslighting, a substantial response by leading medical organizations in the U.S. such as the American Medical Association and National Institutes of Health has failed to materialize. She suggests that:

> The medical gaslighting movement has failed to have an impact because it draws our attention to psychological harm, downplaying the deadly, life-destroying reality of this problem. More than that, it proceeds as if medical training could not possibly encourage doctors to attribute women's symptoms to their psyches as a matter of routine—but it does, unequivocally [3].

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A narrow focus on interactions between clinicians and patients prevents us from noticing the conditions that make medical gaslighting possible and more likely to be enacted upon patients who are members of marginalized groups, including women [4–6].

The concept of medical gaslighting has proven useful for individuals to understand, convey, and find support in the aftermath of a specific type of harmful experience. However, there is much more that remains to be done in terms of clarifying and changing structural conditions that enable medical gaslighting. Discussions of medical gaslighting typically focus on the problem of clinicians *giving patients too little epistemic credibility* about their first-person experiences, causing harm by undermining patients' self-trust and trust of medical professionals and institutions[1]. In "Trust, Distrust, and 'Medical Gaslighting'", Elizabeth Barnes raises the concern that if physicians comply with calls to "trust patients" as a corrective to medical gaslighting, they run the risk of *granting patients too much epistemic credibility*. She contends that the concept of medical gaslighting is unnecessary, arguing that we can explain the phenomenon it names by (1) labeling any physician who fails to "practice medicine to a reasonable standard" a "bad doctor," (2) attending to the ways bias compromises medical care, and (3) recognizing that even doctors who do everything right will misdiagnose patients [7] (p. 673–674). Barnes draws upon memoirs of three authors who identify as having the contested illness chronic Lyme disease—*The Deep Places* by Ross Douthat, *Sick* by Porochista Khakpour, and *The Invisible Kingdom* by Meghan O'Rourke to support her position [8–10][2]. Barnes identifies many factors that compromise the quality of health care patients with marginalized identities receive without providing a method for describing how biases at the level of medical institutions and professionals make medical gaslighting possible. The concept of medical gaslighting serves purposes that are valuable and distinct from the alternatives she proposes. Medical gaslighting is one way clinicians demonstrate that they are unworthy of patients' trust. We need to focus on the conditions that inform the trustworthiness of clinicians. As Lilyana Levy [6] and I [11] have demonstrated, critical phenomenology is especially well-suited for this purpose, given careful attention to the ways that social structures shape our perceptions, ways of knowing, and experience more generally [12,13]. Phenomenological conceptualizations of intersubjectivity and embodiment are helpful for understanding medical gaslighting and epistemic authority based upon first-person experience [6,11,14].

There are a few reasons I believe that a substantial response to Barnes' position is warranted. Firstly, despite careful analysis, I contend that she makes mistaken assumptions that weaken the case she makes against the usefulness of the concept of medical gaslighting. Specifically, Barnes assumes that calls to "believe patients" or "trust patients" to prevent medical gaslighting entail that physicians must uncritically accept their knowledge claims and their requests, such as prescribing antibiotics when it goes against physicians' judgment. This interpretation is based upon her understanding of first-person experience and epistemic authority over it as more extensive than phenomenologists and feminist epistemologists grant [6,15,16]. Most notably, Barnes includes claims about the causes of individuals' symptoms as grounded in first-person experience. Secondly, Barnes emphasizes the potential for harm to patients, especially women, when physicians mistakenly treat their illnesses as if they have physiological causes rather than psychological ones. She encourages recognition that psychogenic illnesses are real and can be serious. Her analysis lacks sufficient attention to how the labels of psychogenic illness and medically unexplained (physical) symptoms function in practice and how they can undermine patients' attempts to get accurate diagnoses and medical care. Thirdly, her research is widely read and cited. Her book *The Minority Body* [17] has been cited 1162 times and her article "Trust, Distrust, and 'Medical Gaslighting'" has already been cited 73 times, according to her Google Scholar profile [18].

In Section 2, I introduce the concept of medical gaslighting. Contra Barnes, I contend that this concept is a valuable hermeneutic resource that cannot be replaced by the alternatives she suggests. I advocate critical phenomenology as a method for understanding structural factors that shape clinical encounters and enable medical gaslighting. Section 3 turns to Barnes' account of how we should think about trust and the trustworthiness of claims patients make in illness narratives. Here I challenge her interpretation of the call to "trust patients" as a corrective to medical gaslighting and I shift the focus to the trustworthiness of doctors. In Section 4, I raise questions about doctors' responsibilities to patients when dealing with medical uncertainty. I respond to Barnes' claims about psychogenic illnesses and draw on narratives of patients, highlighting ways that misdiagnosis and medical gaslighting harmed them. Physicians are more likely to apply the labels "medically unexplained (physical) symptoms" or "psychogenic illness" to women than men [3,7,19]. We should be especially wary of misdiagnosis among members of marginalized groups, given the extent to which bias impacts medical practice and research. In Section 5, I explain and critique Barnes' call for mutual distrust in clinical settings.

2. Medical Gaslighting

Barnes states that "gaslighting involves an *unjustified* imposition of one's own perspectives, beliefs, or interpretations onto another person, in a way that will be especially destabilizing for that person" [7] (p. 652). Kate Abramson distinguishes gaslighting from other forms of epistemic injustice, noting "not taking someone seriously and trying to get her not to take herself seriously are two very different interpersonal phenomena" [20] (p. 21). The latter constitutes gaslighting, on her account. Although there is significant disagreement about how gaslighting should be defined, these characterizations are adequate for the purposes of this project [4,6,7,21–23].

Medical gaslighting occurs when, without good epistemic grounds, health care professionals challenge patients' first-person authority to make claims about their experiences, leading patients to doubt their perceptions, beliefs, motivations, and even their own sanity [11]. Of course, psychological harm enacted by physicians should be taken seriously on its own, but it is frequently a precursor to a cascade of other types of harm. As Levy points out, "[m]edical gaslighting is almost always accompanied by significant corollary harms such as delayed diagnosis, disease progression, financial burden, and even death" [6] (p. 233). To understand the true repercussions of medical gaslighting, we must take this reality into account.

While Douthat, Khakpour, and O'Rourke do not use the term "medical gaslighting," I agree with Barnes' suggestion that their experiences exemplify what is meant by those who do use this concept. In her words, these authors detail "the wrongs they feel that they and others like them—have experienced because they were disbelieved in systematic ways" [7] (p. 657). Each of them demonstrates ample familiarity with the phenomenon. For example, O'Rourke identifies a pattern in patient experiences: "A patient goes to the doctor to explain that something seems very wrong. When tests turn nothing up, the patient is told she is fine, and emerges without answers, questioning everything she thought she knew about her body and her perceptions" [10] (p. 62). This description fits well with common uses of the term "medical gaslighting." Barnes cites O'Rourke's report of a doctor saying " 'we're all tired', as though she is unable to distinguish normal tiredness from her experience of illness" [7] (p. 662). She classifies physicians' dismissal of O'Rourke's claims about her experience of suffering as unjustified. She is nonetheless concerned about overapplication of the term "medical gaslighting," calling it "too blunt a tool to help us make progress" [7] (p. 654). Barnes seeks to make progress on the question of how

much epistemic authority patients should be given "over their own experience of their body" [7] (p. 654).

Barnes concedes that physicians do sometimes engage in medical gaslighting, but she suggests that the concept of medical gaslighting is unnecessary to articulate this. In her words:

> Popular discussion of 'medical gaslighting' includes many first-person accounts of obvious and harmful errors. But it's not clear what additional explanation the framework of gaslighting provides. In some cases, physicians are simply failing to practice medicine to a reasonable standard. They aren't doing their due diligence; they aren't going through a decent differential diagnosis, etc. But we don't need the idea of gaslighting to explain this—we can just appeal to the more mundane concept 'bad doctor' [7] (p. 673).

Among other things, she proposes that we should instead: (1) use the concept of "bad doctor" to refer to a physician who fails to practice medicine to a reasonable standard, (2) attend to the ways that various kinds of bias among physicians and medical institutions compromise the care they provide, and (3) recognize that "even the most conscientious doctors" misdiagnose patients [7] (p. 674).

"Medical gaslighting" is a valuable hermeneutic resource that serves different purposes than the alternatives Barnes proposes. Veronica Ivy characterizes hermeneutical resources as "concepts that are sufficiently shared such that we can use them to communicate with others," and she includes "gaslighting" [24] (p. 297). Devora Shapiro and Anna Hayburn maintain "[m]aking the actions of the gaslighter visible and legible allows for the gaslit to be seen and understood, and can result in destabilizing the institutional and authoritative structures supporting the possibility of a gaslighter's success" [25] (p. 34756). Having a name for this phenomenon makes it easier for those who have experienced it to identify and convey the harm they have undergone [11,24]. Nora Berenstain points out that the absence of a name makes it more difficult to resist abuse [5] (p. 23). The concept of medical gaslighting provides a starting point for interventions to medical practice and education, in terms of prevention, holding clinicians who engage in medical gaslighting accountable, and ameliorating harm to patients[3].

Barnes cites physician Rachel Pearson's remark that "[w]hen medicine does not acknowledge the reality of the subjective—the thick reality of lived experience—we fall laughably short in our efforts to serve patients" (2023, 662). I agree that physicians should attend to patients' lived experiences; to do so effectively requires understanding the ways in which physicians themselves shape those experiences and how systemic biases are relevant. Barnes identifies many factors that compromise the quality of health care patients with marginalized identities receive without providing a method for describing how biases at the level of medical institutions and professionals make medical gaslighting possible.

Critical phenomenology provides a method to elucidate how structural factors—including sexism, racism, ableism, sizeism, cisheterosexism, and other forms of oppression—create conditions for the possibility of medical gaslighting and avoidable misdiagnoses [3,4,6,11]. Critical phenomenology enriches classical approaches to phenomenology by expanding structures of experience beyond those identified as transcendental—necessary and *a priori*—to what Lisa Guenther terms "quasi-transcendental"—structures that are contingent but nonetheless serve as conditions for the possibility of our experiences [13] (p. 13). Unfortunately, oppression is among the social structures that shape our ways of thinking, perceiving, being, and knowing. This is just as true within clinical settings as outside of them. Lack of time, inadequate knowledge or training, and physician burnout are additional factors that increase the likelihood that clinicians will engage in medical gaslighting rather than providing the care patients deserve [25] (pp. 2–3).

Gail Weiss, Ann Murphy, and Gayle Salamon point out that Merleau-Ponty's insights about our embodied habits of perception inform critical phenomenology. Specifically, critical phenomenology considers the ways in which power functions through these habits through "foreclosing some perspectives and possibilities by privileging others" [12] (p. xiv). They elaborate:

> Contemporary phenomenologists increasingly recognize these foreclosures are a function of structural, political, and institutional inequities that are internalized as personal biases and habits. This insight has inspired a critical phenomenology, one that mobilizes phenomenological description in the service of reflexive inquiry into how power relations structure experience as well as our ability to analyze this experience [12] (p. xiv).

Given critical phenomenology's careful analysis of the bidirectional relationship between inequities of a structural, political, and institutional nature and individuals' habits of perception, it is an ideal method for elucidating the phenomenon of medical gaslighting and encounters between patients and physicians more generally.

Phenomenology posits that subjectivity is always already intersubjectivity. In other words, how we understand and experience ourselves is inseparable from others' ways of seeing and interacting with us. As I have preciously claimed:

> Phenomenology's insight that the lived body is intersubjective means that our embodied sense of self is fundamentally conditioned, though not entirely determined, by others' perceptions, interpretations, and interactions with us. This is why others' failure to recognize us can be such a distressing experience [11] (p. 181).

When patients cease taking themselves seriously due to medical gaslighting, this can contribute to profound bodily alienation, self-doubt, and uncertainty about one's identity and sanity [6,20]. Thus, medical gaslighting and misdiagnosis have far-reaching negative impacts beyond epistemic and medical harms; they cause existential harm[4].

3. Trustworthiness and Authority About First-Person Experience in Medical Encounters

Barnes suggests that there are examples within their illness narratives in which physicians are justified in imposing their perspectives, beliefs, or interpretations onto O'Rourke, Khakpour, Douthat, and patients more generally. Contra those who claim that the remedy for gaslighting "is to give people the credence that is their due as authorities about their own first-person experiences" which is "sometimes framed in the language of trust: trust women, trust victims, trust patients, etc.," Barnes concludes that the concept of medical gaslighting may contribute to harm if it leads physicians to err on the side of granting patients *too much* epistemic credibility [7] (p. 657). This concern motivates her use of Hawley's framework on trust to develop a model for evaluating patients' claims[5].

Barnes explains Hawley's account of trust as broadly involving commitments made sincerely that the person making them is competent to keep, where "competent" means, roughly, "have the dispositions to perform well, given the circumstances" [7] (p. 658). Barnes narrows her focus to what it means to be trustworthy in giving testimony. Trustworthiness in testimony requires that a person makes a sincere commitment to tell the truth—they must "intend to speak truly and informatively" and demonstrate competence regarding what they are saying [7] (p. 659). "Competent" in this context means that one must "know what [they're] talking about" [7] (p. 659).

Barnes creates a taxonomy of three different types of claims patients make in illness narratives, namely:

(i) Claims about the experience of suffering;
(ii) Claims about the seriousness or significance of suffering; and
(iii) Claims about the aetiology of suffering [7] (p. 660).

She holds that physicians should "almost always trust patients about statements of type (i), almost never trust them about statements of type (iii), and that statements of type (ii) are a difficult middle ground" [7] (p. 661).

There are reasons to be cautious about adopting this neat taxonomy. One of the complications is that these different kinds of claims are often closely intertwined in practice. Physician distrust about one of these types of claims—that a specific set of symptoms indicates a serious medical condition, for example, may easily expand into doubt about the etiology of those symptoms or doubt about whether the patient is experiencing them. In addition, there are cases in which physicians doubt patients even when those patients' claims about the etiology of their suffering are obviously and easily verifiable[6], or when physicians' claims about the etiology of their suffering are wholly informed by bias rather than science. Of course, Barnes would judge physician distrust of patients in such instances to be unjustified.

In her analysis of the illness narratives of Douthat, Khakpour, and O'Rourke, Barnes asserts that "[a] recurring theme is this: If doctors would *trust* patients as authorities about their own experiences, then everyone would be better off" [7] (p. 660). On the contrary, she maintains that it would be harmful for physicians to trust patients because they would over-prescribe antibiotics and exacerbate the risk to public health caused by drug-resistant bacteria. Patients are not always trustworthy due to lack of competence about the seriousness and causes of their symptoms, so physicians are warranted in distrusting them, on her account. Thus, Barnes claims that calls to "trust patients"—giving them "the credence that is their due as authorities about their own first-person experiences"—as an "antidote" to medical gaslighting are misguided [7] (p. 657).

Barnes assumes a definition of first-person experience, and thus epistemic authority, that has a broader scope than phenomenologists and feminist epistemologists grant [6,14–16,28]. She contends that "nobody has first-person insight into pathology, no matter how much first-person insight they might have into the subjective experience of illness" [7] (p. 663)[7]. Her position is in agreement with the phenomenological distinction between subjective and objective approaches to the body, first articulated by Edmund Husserl as the difference between one's subjective experience of their body—the lived body (*Leib*)—and the body as it can be observed, described, and measured by others—the objective body (*Körper*) [15]. Levy explains how philosophers have long applied this distinction in the context of medicine, viewing:

> illness as the subjective experience of being sick and disease as the objective pathology to which the science of medicine can be applied. While individuals have privileged, private, subjective knowledge of bodily experiences and sensations, this is matched by an opacity with regard to the objective qualities of one's body such as white blood cell count or cholesterol level that are used to diagnose diseases [6] (p. 239)[8].

This inherent epistemic limitation does not warrant dismissal of patients' authority about their first-person experiences, only that we ought to circumscribe first-person experience in the way phenomenologists suggest.

Barnes states "[o]ne difficult part about discussions of medical gaslighting is that people easily assume that to 'believe patients' or 'trust patients' is to believe them across the board—across every aspect of their narrative" [7] (p. 661). Unfortunately, she does not cite anyone who expresses this view. In fact, O'Rourke explicitly rejects this position: "To

be sure, the patient, unlike the customer, can't always be right, and good care demands that doctors be honest about what they do and don't see, as well as the potential harms of treatment" [10] (p. 70). O'Rourke does not claim that doctors should automatically defer to patients' claims and requests.

Like the call of the #MeToo movement to believe women, urging physicians to believe patients need not entail uncritical belief in every claim they make; rather, both are responses to the fact that these overlapping groups too often face unwarranted doubt. It is unnecessary to interpret calls to trust patients as requiring that physicians must abandon making clinical judgments based on their own medical expertise, deferring to patients on all epistemic matters and acceding to all requests. We should think about the call to trust patients as a corrective to the all-too-common default practice of distrusting them due to unjust biases before they even say anything. In short, enacting epistemic justice in medical settings need not lead to promotion of drug-resistant bacteria.

It is important to supplement Barnes' focus on patients with concerns about trustworthiness of doctors, given that they must also be evaluated in terms of sincerity and competence. Even assuming doctors have a sincere desire to promote the health of all patients, many are not competent to provide medical care to disabled, fat, and trans patients and thus, are not trustworthy. One large-scale survey of U.S. doctors found that most doctors—59.3% in one study—*self-report* that they do not feel competent to treat disabled patients [29]. Studies have also found that clinicians report agreeing with negative biases about fat people, lacking empathy toward them, and spending less time with them than other patients [30,31]. Wieseler asserts, "[d]octors have blamed patients' weights for symptoms caused by diseases and injuries ranging from lung tumors, uterine cancer, bone marrow cancer, pulmonary emboli, scoliosis, and endometrial tumors to splinters and a torn thumb ligament [31] (p. 132) [32–36]. Lauren Freeman notes that medical and nursing education typically lacks "robust training" on the significant medical and social concerns of trans patients [37] (p. 159). Her interviews with trans and nonbinary folks reveal that deadnaming and misgendering are common in clinical settings, and "fear of being deadnamed and misgendered, is enough to preclude them from even setting foot in a hospital or clinic" [38] (p. 432). These failures of physician trustworthiness are not simple individual failures of competence (i.e., "bad doctors"); they stem from systemic failures in medical education and norms of clinical practice.

4. Medical Uncertainty, Psychogenic Illness, and Medically Unexplained (Physical) Symptoms

It is worth reflecting on what is required of doctors to fulfill their responsibilities and commitments to patient care, especially when dealing with uncertainty. Of course, patients should be able to expect that physicians will make their best efforts to provide accurate diagnoses and provide patients with appropriate medical treatment and advice. Patients want doctors with sincere commitments to tell the truth and who are competent, i.e., "know what [they're] talking about" [7] (p. 659). While necessary, phenomenologists, among others, have long claimed that this alone is not sufficient to address patients' needs [39,40]. It matters to patients *how* physicians handle breaking bad news, how they handle uncertainty, whether they listen without interrupting, and whether they show respect and concern [10,41]. What is required for physicians to be competent, using Barnes' definition above of competence entailing that one "have the dispositions to perform well, given the circumstances" [7] (p. 658)?

Of course, it is important for clinicians to know as much as possible, but what is too often overlooked is the value of admitting when one does not know or when medical researchers and clinicians collectively do not know. Consider O'Rourke's recollection:

> They [physicians] had no way to know how sick I really was, when my labs didn't show it and I looked OK. This is why the doctors who took the time to acknowledge that they could see I was sick for reasons they didn't understand made a powerful impact on me, far beyond that they imagined, I am sure. Their words were like a rope thrown across a frightening abyss [10] (pp. 70–71).

Patients need more than answers from doctors; they need recognition and assurance that they will not be abandoned in the face of medical uncertainty.

Atkins notes that "both patients and physicians are ill-equipped to address the problem of diagnostic uncertainty", though it is a feature of medicine [42] (p. 20). Given the ubiquity of uncertainty in medical contexts and potential for clinicians to harm patients when they mishandle it, a question of utmost significance is: how *should* physicians deal with uncertainty[9] [43,44]? Providing a detailed answer to this question is beyond the scope of this project, but, as a starting point, doctors would do well to engage in epistemic humility. As Daniel Buchman, Anita Ho, and Daniel Goldberg explain, "[b]eing epistemically humble means correcting for prejudicial credibility judgements by recognizing that medical decisions are almost always accompanied by uncertainty" [45] (p. 32). Practicing epistemic humility—recognizing and being willing to admit the limitations of one's knowledge—is in marked contrast and tension with the imperative medical students and doctors feel compelled to obey: namely, to demonstrate confidence and always have an answer [46]. Patients who are members of marginalized groups are more likely than members of privileged groups to be denied the medical care they need when physicians instead engage in epistemic arrogance in the face of uncertainty [6,11,47].

One way that clinicians respond to uncertainty is to employ the terms "medically unexplained symptoms" (MUS) and "medically unexplained physical symptoms" (MUPS). Multiple authors observe that use of these labels is ambiguous [19,48,49][10]. MUS/MUPS may indicate "simply that the cause of symptoms remains unclear," or it may refer to symptoms with psychological causes [49] (p. 3). In the second case, MUS is used interchangeably with the term "psychogenic illness."

Barnes notes that a common theme within illness narratives is that they have "a very particular slant—because they are *serious*, they *cannot be* psychogenic" [7] (p. 673). Building on her claim that patients are not generally competent knowers when it comes to accurately identifying the sources of their symptoms, Barnes specifies that patients may be certain that their symptoms have an organic cause even when they have a psychological origin, i.e., are psychogenic. Of course, this happens. However, physicians are not reliably competent when it comes to identifying whether an illness has an organic or psychological cause either. Barnes emphasizes that if physicians mistakenly treat psychogenic illnesses as if they have physiological causes, this will deny patients "accurate understanding of their own health condition, and access to the most effective treatments" [7] (673). This is a possibility. Yet, if physicians err in this manner, they are more likely to rule out alternative explanations than in cases in which they treat illnesses with organic causes as if they are psychogenic.

Patients—most often women—who are diagnosed with psychogenic illnesses are unlikely to receive the medical care they need. Dusenbery observes that "[f]or a long time, critics have pointed out that there's a high risk of misdiagnosis inherent in the concept of psychogenic illness—whether it's called hysteria, somatization, or 'medically unexplained symptoms' due to stress" [19] (p. 81)[11]. Misdiagnosis need not entail medical gaslighting—even when involving MUS/MUPS or attribution of illness to a psychological origin—but it often does.

Diane O'Leary and Keith Geraghty observe that when clinicians "conflate diagnostic uncertainty with diagnosis of psychological causes they direct the course of patient care down the mental health track without first determining if it is safe to do so" [49] (p. 5).

Mistaken attribution of symptoms to mental illness may also lead patients to stop seeking another diagnosis and to receive unnecessary and even harmful treatments. This was the case for Khakpour, who states, "I accepted that I was mentally ill, deeply incurably so, and that this was my life" [9] (p. 104). She also reports:

> When I didn't get admitted and my parents took me home, I knew it had gone too far. I promised them I would face this, that it was just anxiety. That meant ignoring heart palpitations, electric shocks through my limbs, piercing headaches, and unbearable fatigue, but like the doctors had all said, the mind is powerful. I had done this to myself, I began to tell myself [9] (p. 181).

Lacking another diagnosis, Khakpour attempts to convince herself that anxiety is the sole cause of her symptoms. She dutifully takes Klonopin—a benzodiazepine drug prescribed to treat anxiety—and ends up struggling with addiction [9] (p. 171). Shapiro and Hayburn share a clinical case in which a patient they refer to as Kiara repeatedly visits an emergency department "following concerning episodes of tachycardia and pre-syncope, only to be told that it was due to anxiety" [25] (p. 34754). Doctors "prescribed various antianxiety and antipsychotic medications that caused side effects including drug-induced parkinsonism, which led to an inpatient hospitalization" [25] (p. 34754). Unnecessary mental health interventions—including but not limited to prescription of psychotropic medications—have the potential to harm patients, a risk that should not be overlooked. In addition, the effects of such medications can further complicate attempts to properly diagnose and treat such patients. Furthermore, seeking mental health care after being diagnosed with a psychogenic illness has the potential to make it even less likely that doctors will consider an alternate explanation for a patient's symptoms[12].

Of course, patients can meet the criteria for diagnosis of mental illnesses and other illnesses with physiological causes at the same time, but this fact is too often overlooked[13]. Marco Faytong-Haro states: Diagnostic overshadowing occurs when physical symptoms reported by a patient with a psychiatric or intellectual disability are misattributed to their mental health condition, leading clinicians to overlook a potential medical cause" [51] (p. 2). He gives the example of clinicians initially attributing symptoms now considered to constitute long COVID to "purely psychological issues" [51] (p. 2)[14]. Symptoms of an unclear origin combined with medical gaslighting may also cause or exacerbate mental unwellness.

Dusenbery examines how attribution of a psychogenic cause and/or the (non)diagnosis of MUS can serve to ensure that physicians feel justified in ceasing to seek an explanation, even if they failed to conduct a thorough examination or run appropriate (or any) tests to rule out a physical cause for a patient's symptoms [19] (pp. 78–90). She notes:

> A psychogenic diagnosis, while easy to make, is very difficult to overturn. All misdiagnoses are vulnerable to confirmation bias (the tendency to see new evidence only if it's in line with your existing theory), but a psychogenic diagnosis is a particularly sticky one because the only exonerating evidence that could show it to be false—proof of an organic disease is exactly what doctors have ceased looking for. (. . .) And once you have been labeled an unreliable reporter, it becomes all but impossible to get your credibility back [19] (pp. 83–84).

Physicians run the risk of overestimating their epistemic competence in making diagnoses. After all, they do not typically find out that they wrongly diagnosed someone with a psychogenic illness. As Dusenbery observes, "the first mistaken doctor usually doesn't get a memo if, down the road, her symptoms finally are 'medically explained' by someone else" [19] (p. 86).

Chloë G.K. Atkins' recollection in *My Imaginary Illness* exemplifies the difficulties patients face in attempting to regain epistemic credibility once health care professionals have undermined it:

> What is perhaps most frustrating is that the diagnostic definitions of psychogenic illness posit that patients *unconsciously* convert psychological conflicts into physical symptoms; as such, health-care professionals should not view functional illnesses as willful or conscious. But while this may be the theoretical paradigm, clinicians behaved as though I wanted to be ill and that I conspired to confuse and frustrate them. I was treated as though I were a criminal or a juvenile delinquent. Instead of my illness being the problem, I became the problem (. . .) Within this context, my medical chart became a misguided narrative that itemized my bad behavior. It became a way for health-care professionals to flag me as a difficult patient and as a way to warn their peers that I undeservedly drained precious medical resources [50] (pp. 148–149).

Atkins' account captures how health care professionals' assessments of epistemic credibility are entangled with their judgments about her moral character and intentions. As a result, she is caught up in an antagonistic relationship with her doctors. Rather than feeling as though everyone is on the same team and dedicated to caring for her, Atkins feels utterly abandoned—as if she is the problem. Those evaluations were documented for future health care professionals, increasing the likelihood that they would not take her testimony seriously. After enduring significant, repeated medical gaslighting and attribution of her symptoms to a psychogenic cause over the course of fifteen years, Atkins was diagnosed with an atypical form of the neurological disorder myasthenia gravis [42,50].

Eli Clare contends that "[d]iagnosis can become a cover for what health care providers don't understand; become more important than our messy visceral selves; become the totality of who we are" [52] (p. 42). There is an important shift from knowing to being in Clare's claim—(mis)diagnosis has the potential to eclipse the complexity of embodied being and to have lasting ramifications. Atkins' experience provides an illustration of this type of experience. From one perspective, her illness narrative could be considered a success for medical practice; after all, doctors eventually solved the diagnostic mystery and found an effective treatment. She received an explanation of her symptoms in the form of an organic cause. This narrow focus on one epistemic issue, however, ignores the immensely difficult set of ordeals Atkins went through. Her symptoms on their own would have been extremely alarming, including sudden blindness, paralysis, difficulty breathing and swallowing, pain, brain fog, and severe fatigue. These and many additional symptoms along with health care professionals' treatment of Atkins, which ranged from dismissive to cruel, led her to feel extreme despair and to wonder if euthanasia was the only way to relieve her suffering [52] (p. 120). Although her harrowing search for a diagnosis is over, she notes that her gratitude for her life after diagnosis is "tinged with sadness—sadness that I unnecessarily lost over a decade of my young adulthood to an ailment that could have been properly controlled. This illness has ravaged me physically, psychologically, socially, and economically" [52] (p. 150). Atkins notes the difficulty of maintaining her sense of dignity as well as lost friendships, income, and the ability to think about the past or future without distress about encounters with the health care system [52] (pp. 150–151).

The history of medicine is wrought with racialized and gendered bias that continue to this day within research and clinical practice. Bodyminds[15] of white heterosexual nondisabled cisgender men have been treated as the paradigm of the normal human, and findings from clinical trials that only include them are still generalized to the rest of the population, leaving lacunae in medical knowledge about women that sometimes have dev-

astating effects (e.g., doctors not identifying heart attacks in women and prescribing doses of Ambien that are too high) [6,19,55]. Barnes' account fails to recognize the limitations of institutionalized medical knowledge, to say nothing of the knowledge of a particular physician. For example, in some cases, patients know more than their physicians about the latest medical research and recommended treatments for chronic pain, gender-affirming care, fibromyalgia, migraines, and endometriosis [19,38]. As Dusenbery demonstrates, Western medicine has a longstanding tendency to attribute cisgender women's symptoms to our minds or our uteri. There remains a great deal that medical experts do not know, and, in some cases, the way medical research is funded and conducted seems designed to preserve the status quo—a situation that the current U.S. presidential administration has intentionally made exponentially worse [56,57].

5. Mutual Distrust

Barnes concludes by advising "some degree" of "mutual distrust" as an ideal for clinical settings, which she characterizes as follows: "[t]he doctor doesn't take the patient's word for it. The patient doesn't assume the doctor is unbiased or getting things right, and is willing to advocate for herself. A doctor needs to earn her trust" [7] (p. 674). This seems like an accurate description of many encounters between patients and doctors, but there are significant reasons to reject mutual distrust as a normative ideal, even in non-ideal contexts.

Rather than giving a doctor multiple chances to earn their trust, mutual distrust may influence patients not to schedule a follow-up appointment. After encountering multiple untrustworthy doctors, including those who engage in medical gaslighting, they may stop seeking medical care altogether. Regarding the importance of trust in medical settings, Lauren Freeman and Heather Stewart state:

> What we are discussing here is reflective not only of an individual-level problem but also of a systemic problem that affects many women who make claims of being in pain in medical contexts, only to be met with dismissal or disbelief. Over time, this reality causes women (and especially women of color, poor women, fat women, and queer and trans women) to distrust medical institutions and professionals. This generalized lack of trust in healthcare institutions and professionals compounds to harm women as a group and to harm certain members of the group more than others. Ultimately, it can cause women to delay or avoid care altogether [38] (pp. 135–136).

Although Freeman and Stewart focus here on women reporting pain, patients who experience medical gaslighting when reporting other symptoms are also likely to develop distrust of medical professionals and institutions over time.

Barnes' recommendation that the patient "should be willing to advocate for herself" ignores the power differential between physicians and patients, which is exacerbated by other aspects of their social identities (e.g., gender, race, disability, class, immigration status, and sexuality) [7] (p. 674). Dusenbery quotes orthopedic surgeon Dr. Vicky Ratner on the double bind women face in medical settings: "You get judged right away because you're female: you're either stoic [in the colloquial use of the term] and nothing's wrong or you're crying and you get labeled hysterical" [19] (p. 98). The problem is not that women are inarticulate or not advocating for themselves; it is that women can do everything "right" and still not be taken seriously. As Eleanor Palafox-Harris notes, "a patient challenging a clinician's opinion might be interpreted uncharitably as being uncooperative," and this is especially likely to be true if she is a woman of color and/or has been diagnosed with a mental illness [58] (p. 98). One recent study on the experiences of Black women receiving healthcare in Canada during pregnancy and childbirth found that "[w]hile women

described resisting [anti-Black medical gaslighting] and advocating for themselves, they also felt that such attempts resulted in nurses and healthcare providers perceiving them as defiant and aggressive" [59] (p. 63). Despite mentioning that women and people of color are "disproportionately prone to being disbelieved" [7] (p. 653), Barnes ends up putting the onus on them to persuade doctors to believe them.

Another study focused on the experiences of women with chronic pain in medical settings found that research participants reported that to be perceived as credible in the eyes of doctors they "struggled to be perceived as somatically ill, whilst simultaneously avoiding appearing mentally unbalanced" [60] (p. 1414). On the one hand, if doctors thought they looked too good (due to factors such as their clothing, makeup, and hair), they would be dismissed as not actually ill. On the other hand, if they looked too disheveled, they risked having their symptoms attributed to mental rather than physical illness.

Having an illness that is poorly understood can be enough to influence clinicians to distrust otherwise privileged patients. Douthat understands the importance of how clinicians perceive him, noting:

> I was trying for a tone that acknowledged how unlikely it sounded, thus projecting reasonability, thus encouraging her to actually prescribe the drugs for me. In only a few weeks of doctor visits, I had already figured out that when you're claiming symptoms that don't show up on blood tests, it's a good idea to exaggerate your own good sense and self-awareness, to keep a smooth veneer over the bubbling *help me, please* hysteria beneath [8] (p. 18).

He works to curtail expression of emotion in the attempt to get doctors to perceive him as reasonable, credible in his testimony about his subjective experiences.

For Barnes, patient advocacy may include seeking a second opinion. We should not accept as a requirement that patients advocate for themselves and seek second (oftentimes many more) opinions to increase the odds of receiving appropriate medical care; this suggestion fails to consider the vulnerability of patients, effects of bias, structural barriers, and that patients may simply be too ill to get a second opinion. Susan Wendell implores us to "[i]magine the self-confidence and inner strength it would take to continue to believe in one's own sanity, perceptions, and judgement, when they are called into question by medical experts" [46] (p. 125). Patients who lose trust in their own perceptions and beliefs due to medical gaslighting may simply stop seeking medical care because they cease to believe that they need or deserve it [9,10].

It is no wonder that patients who have experienced medical gaslighting distrust clinicians to the point that some are reluctant to seek medical care for any reason [9,25,61,62][16]. After avoiding medical care for years and lacking health insurance, Khakpour reluctantly seeks emergency medical care. In her words:

> For years I'd become used to dealing with all sorts of skeptics whether in person or online, but it never stopped being frustrating. I'd always catch myself getting preemptively ready to argue, feeling a defensive heatedness from years of impossible experiences with so-called medical professionals. It was always a risk, me getting into it, and yet I had no choice. I had the script down as if it were a script and not my reality. (. . .) I'm not like those other ones. . .I'd try to knowingly add, to speak their suspicious dismissive language, to let them know I was real [9] (pp. 21–22).

If a patient who has been medically gaslit or given a psychogenic diagnosis persists, the initial doctor's notes in their chart increase the likelihood that subsequent doctors will engage in additional unwarranted dismissal of their claims [50].

In addition, Dusenbery notes that the medical literature suggests that so-called "doctor shopping" may indicate that a patient has a psychogenic illness they refuse to accept, even though it could just as easily be evidence that a patient has an undiagnosed organic illness [19] (p. 84). O'Rourke asserts:

> I grew practiced in choosing only a few symptoms to tell my doctors about, and I didn't mention the many other doctors I had seen: physicians often assume patients who "doctor shop" are problem patients. I also quickly learned one of the worst things I could do was to show up prepared with prior medical records [10] (p. 62).

Many patients face significant barriers to advocating for themselves by getting a second opinion.

Barnes' recommendation that patients seek second opinions when dissatisfied with how a physician has treated them takes a lot for granted that simply cannot be taken for granted. Consider instances in which a patient is experiencing a medical emergency, is too injured or ill to leave the hospital to which they have been admitted, and/or is uninsured or underinsured. Mutual distrust places an unjust burden on those who are likely to have the least social support and resources to advocate for themselves. Patients should be able to count on the first doctor they visit being trustworthy; they may not be willing or able to get a second opinion, and there may not be a second chance. Health care professionals ought to improve their competence to make themselves trustworthy so that they will not inflict the harms of medical gaslighting on patients and the burden of attempting to find a doctor who will take their concerns seriously.

6. Conclusions

The medical gaslighting literature draws attention to *unjustified physician distrust of patients*. Barnes' concern about *unjustified physician trust of patients* informs her shift from medical gaslighting to patient trustworthiness. I contend that the concept of medical gaslighting is valuable for naming, addressing, and preventing harm to patients. Barnes is interested in these questions: Under what conditions should physicians trust patients? What are the consequences when physicians trust patients who are untrustworthy insofar as they make claims related to their illness that they are not competent to make? I focused on a different type of problem related to trustworthiness and competence: that of physicians misdiagnosing patients, distrusting them when they are trustworthy, and claiming certainty when there is only medical uncertainty. I have suggested that there are instances in which physicians themselves are not trustworthy, and one way they demonstrate this is by engaging in medical gaslighting. This examination centered on the fraught enterprise of attributing symptoms to a psychogenic cause, including the risk of misdiagnosis made more likely for those subjected to racialized and gendered bias both due to their influence on individual doctors and collective medical knowledge. Barnes acknowledges that doctors misdiagnose patients, and that doctors and institutions of medicine "are to varying degrees sexist, racist, classist, and otherwise biased in ways that affect how they deliver care" [7] (p. 674). However, her conclusions and recommendations do not fully appreciate the gravity or the impact of these biases on medical research, practice, and patients' experiences. A critical phenomenological approach allowed attention to the lived experiences of people who have experienced medical gaslighting and misdiagnosis as well as analysis of the structures that enable these phenomena.

Finally, I showed that mutual distrust fails to account for ways in which: biases related to race, gender, class, disability, and other social categories; structural factors beyond medical settings; power asymmetries between physicians and patients (e.g., that physicians can impede the efforts of patients to be taken seriously by other health care

professionals); seriousness of one's medical condition; and cumulative effects of repeatedly experiencing medical gaslighting on self-trust, undermine the ability of patients to advocate for themselves and seek second opinions. Mutual distrust leaves unaddressed the wildly uneven stakes each party has in establishing a diagnosis and appropriate treatment plan as well as ways that biases impact not only interactions between patients and health care professionals but also the development of medical knowledge. We need a greater emphasis on trustworthy physicians and institutions, not less.

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Notes

1 I limit my focus to doctors here because Barnes does so and because I want to exercise caution not to gloss over considerations related to medical gaslighting and trustworthiness for other types of health care professionals such as nurses and physical therapists.

2 To classify chronic Lyme disease as a contested illness means that it "is not a diagnostic term that's accepted in mainstream medicine" [7] (p. 654).

3 Thanks to Lilyana Levy for pointing out the value of including the concept of medical gaslighting in medical education so that current and future doctors learn about the ways it harms patients and how to avoid perpetuating it.

4 O'Rourke details her experience of this type of existential harm in the following: One unseasonably mild day, I left a new doctor's office in Manhattan, sweating under my silk shirt, and leaned woozily against a dirty Prius, breathless with hurt. Her office was busy, and she had patronized me and rushed me out the door. I felt more acutely alone than ever, I had no ally—worse, the encounter left me with a rusty taste in my mouth, a sense that perhaps I didn't deserve an ally. For this is the strange thing about a vulnerability that remains unseen by others, an illness that is unacknowledged by society. It is the *sick person* whose worldview warps, the wounded one who absorbs that the most indelible aspect of her present condition is in fact a defect, a distortion of her own making [10] (p. 63).

5 Although Barnes makes the case against use of the concept of medical gaslighting throughout the article, she maintains that the framework on trust and trustworthiness she applies to illness narratives should not be perceived as "in conflict or competition with accounts of medical gaslighting" and that they can work well together [7] (p. 657).

6 For example, when patients report significant pain during c-sections is it not uncommon for doctors to either respond by engaging in medical gaslighting—telling them they are only anxious or feeling pressure. Susan Burton observes: There are all these common phrases doctors say during cesarean. "We're almost finished." "It's just a few more minutes." What's clear from patient accounts is that these phrases are as dirty as, "It's just pressure," because for the patients who feel pain during cesarean, the experience isn't finished after they leave the OR. It is not just a few minutes that people are affected by this [26]. In other cases, a doctor acknowledges a patient's pain but fails to address that pain. Jada Wiggleton-Little calls this a *pain-related motivational deficit* and notes that normalization of certain types of pain or biased assumptions about whose pain matters inform this non-response [27].

7 Barnes elaborates "[w]e can have direct experience of pain, of exhaustion, of all the strange and unpleasant sensations that illness gives rise to. But we don't have special insight into whether we're experiencing the effects of a specific bacteria or the behavior of that bacteria within our bodies" [7] (p. 663).

8 Importantly, Levy points out that this distinction is not as clear-cut as it may seem. She states: While the distinction between Korper and Leib appears to map onto illness/disease, public/private, and subject/object distinctions, upon deeper interrogation,

it does not easily form such a strict binary. There is a dimension of lived experience that is inherently ambiguous and conditioned by the way it appears to others. In other words, there is a dimension in which they are also intersubjective [6] (p. 241).

[9] Atkins co-directed a study using a phenomenological approach to understanding the experiences of patients, general practitioners, and specialists related to medically unexplained physical symptoms [43,44].

[10] Jenny Slatman asserts: The "unexplained" of MUPS [medically unexplained symptoms], undeniably, lays bare the epistemological deficit of medicine. It is striking, however, that in actual practice this "unexplained" does not restrain professionals from providing explanations. Similar to the usage of various other terms and labels, the usage of MUPS often goes together with the reasoning that if there are no physical causes to be found, the causes of these kinds of symptoms should be looked for in some psychological or emotional disturbance [48] (p. 102). Slatman explores medically unexplained symptoms through a phenomenological lens.

[11] Dusenbery also notes that "there is more discussion in the medical literature on somatoform disorders on the risks of *doing* a thorough investigation into medical causes than of not. . .the idea that doctors could determine whether symptoms are 'medically unexplained' before attempting to explain them would seem to be a contradiction in terms" [19] (p. 83).

[12] Atkins reports: Moreover, the diagnosis of psychosomatic illness (in the form of conversion reaction) now largely dominated my chart, and for most medical staff, this opinion was reinforced by the fact that I saw a psychiatrist—which created a circularity to their reasoning: the patient may be psychosomatic, and so she should see a psychiatrist; and, since she sees a psychiatrist, she must be psychosomatic [50] (p. 33).

[13] I want to thank Zsuzsanna Chappell for suggesting I mention this important point.

[14] I would suggest that diagnostic overshadowing also occurs when clinicians attribute new symptoms to a patient's existing diagnosis of a physical condition, such as being considered obese.

[15] I use the term "bodyminds" as elaborated by Margaret Price to emphasize that mind and body are intertwined [53]. Eli Clare adopts the term body-minds [52], and Sami Schalk uses bodyminds [54]. Collectively, these theorists contributed to increased reference to this term and incorporation of the insight to which it refers.

[16] In Khakpour's words: "As I walked out of the ICU, I felt that old state of mind consuming me, taking me back to my time in so many other hospitals, and the anger at being misunderstood boiled up in me again, that feeling of not being taken seriously by those who had your life in their hands. All the many times, the people who shook their heads at Lyme, who looked at me with pity for my circumstances, who could barely stifle their rolled eyes. I'd tried to avoid this hostile world of hospital rooms and doctors' offices for years, but it haunted me" [9] (p. 22).

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