Review Article

We didn't start the fire…or did we?—a narrative review of medical gaslighting and introduction to medical invalidation

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Contributions: (I) Conception and design: All authors; (II) Administrative support: All authors; (III) Provision of study materials or patients: All authors; (IV) Collection and assembly of data: All authors; (V) Data analysis and interpretation: All authors; (VI) Manuscript writing: All authors; (VII) Final approval of manuscript: All authors.

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Background and Objective: Gaslighting is defined as behaviors inflicted on an individual which invalidate or call into question their ability to judge their own lived experience. Research into gaslighting in other contexts, such as domestic violence, underscore its potentially damaging effects. Medical gaslighting is an increasingly used, but poorly defined issue in a progressively more complex healthcare system in the United States. Limited studies constructively evaluate this breakdown in the provider-patient relationship and no studies exist evaluating gaslighting in the care of patients with digestive diseases. This narrative review aims to add clarity to the definition of medical gaslighting, evaluate the mechanisms that perpetuate gaslighting in gastroenterology practice and offer pragmatic solutions to begin to reduce its prevalence.

Methods: Narrative overview of the literature retrieved from searches of computerized databases.

Key Content and Findings: The potential root causes of gaslighting in gastroenterology practices are multifaceted and complex, and encompass patient, provider, and systemic factors.

Conclusions: An important distinction for medical gaslighting from other forms of gaslighting is the role of intent. As such, we propose the term "medical invalidation" be added to this construct and conceptualize medical gaslighting as occurring on a continuum. Within each facet of the relationship between system, provider and patient there are opportunities to prevent and recover from the occurrence of medical invalidation/medical gaslighting.

Keywords: Medical gaslighting; gaslighting; gastroenterology

Received: 21 January 2024; Accepted: 02 July 2024; Published online: 26 August 2024.

doi: 10.21037/tgh-24-26

View this article at: https://dx.doi.org/10.21037/tgh-24-26

Introduction

This review aims to open discussion around the concept of medical gaslighting within the practice of gastroenterology. We aim to provide a starting point for future research into how gaslighting may present itself in the gastroenterology setting and generate recommendations on how to mitigate its impacts while considering the perspectives of both the patient and the medical provider. To date, no study has evaluated this phenomenon in chronic digestive diseases. As such, we draw from the extant literature on non-medical gaslighting, doctor-patient communication, physician burnout, and stigmatization. We present this article in accordance with the Narrative Review reporting checklist (available at https://tgh.amegroups.com/article/view/10.21037/tgh-24-26/rc).

Methods

A narrative review was conducted by searching representative databases for publications related to medical

Table 1 Search strategy summary

Items	Specification
Date of search	October 1, 2023 to January 15, 2024
Databases and other sources searched	PubMed, PsychInfo, Google Scholar, HOLLIS
Search terms used	"Gaslighting", "medical AND gaslighting", "gaslighting AND digestive", "gaslighting AND gastroenterology", "physician AND burnout", "physician AND burden", "patient AND provider AND relationships", "invalidation", "medical AND invalidation", "difficult patient", "patient AND frequent flyer", "irritable bowel syndrome AND stigma", "disorders of gut-brain interaction AND stigma", "inflammatory bowel disease AND stigma", "functional dyspepsia AND stigma"
Timeframe	Up to January 15, 2024
Inclusion criteria	Studies written in English, peer-reviewed, editorials
Selection process	All authors conducted the selection and consensus was reached through agreement among the authors

Table 2 Patient and provider vignette: the initial encounter

Patient perspective	Provider perspective
A) Sarah is a 28-year-old African American cis-gendered female coming to her Gastroenterologist's office for follow up after an ED visit for severe abdominal pain. At the ED Sarah was given pain medication and a basic workup, was told it was likely gas pain, and was discharged. During the visit, Sarah is seen by one of the clinic's APRNs, Chad, because her Gastroenterologist is booked for the next 3 months. Sarah is frustrated having to explain her symptoms again to someone new. She shares her ED experience, and chronic severe stomach pains, nausea, and diarrhea with episodes of incontinence. Sarah becomes tearful as she talks; the pain is bad enough she must call off work; she feels stressed she may get fired soon. Sarah explains even when the pain subsides, the uncertainty of her symptoms has put her life on hold	B) Chad quickly reads over Sarah's chart. Her colonoscopy was normal two months ago, and besides these symptoms. Sarah has no other medical problems. He sees Sarah has had complete workups done at three different hospitals, all of which have come back normal, and concludes this is likely a case of IBS-D. Chad expects it would be relieving for Sarah to know she doesn't have a severe illness and turns to Sarah: "Good news! Your tests have come back normal, there's nothing indicating anything major is going on, this is most likely IBS" and recommends Sarah take Imodium to help with the diarrhea

ED, emergency department; APRN, advanced practice registered nurse; IBS-D, irritable bowel syndrome associated with diarrhea.

gaslighting and associated constructs (*Table 1*).

The evolution from gaslighting to medical gaslighting

Gaslighting is defined as a singular person, group of people, or an institution unjustifiably imposing their perspective, beliefs, or interpretation onto another person through behaviors which invalidate or call into question the authority of the other person to judge their own lived experience (1-3). As a result, the recipient of the behavior becomes destabilized; begins to doubt the reality of their experience, their ability to make judgements and in turn defers to the perpetrator as the authority (1,2). Historically, the term gaslighting was used to describe abusive behavioral phenomena among intimate partners, however more recently patients are utilizing social media and other platforms to share accounts of gaslighting by providers utilizing the term "medical gaslighting" (4). Extending this definition; medical gaslighting is defined as instances of gaslighting behavior taking place between providers/professionals, patients, organizations or groups that exist in medicine, and healthcare entities, such as hospitals. In the context of medical gaslighting, potential recipients then extend beyond patients, but also to the professionals who work within these organizations and groups (2,5). Throughout this review, *Tables 2-5* will be used to model the concepts discussed.

The dynamics of "difficult patients"

The importance of a proper doctor-patient relationship built on mutual trust and respect is well-documented

Table 3 Patient and provider vignette: communication breakdown

Patient perspective	Provider perspective
A) Sarah becomes more distraught; she can't believe this guy is acting so happy when he's basically saying they still don't know what's going on. Didn't they hear her when she said her life is on hold? "I've tried that already, Imodium does nothing for me this cannot just be IBS, the pain is unbearable!"	B) Chad becomes flustered and thinks through what else might be causing pain this intense. "Given your age, it is possible this could be related to your menstrual cycle, I could place a referral to a gynecologist, but this may just be regular period pain"

IBS, irritable bowel syndrome.

Table 4 Patient and provider vignette: a relationship fractured

Patient perspective	Provider perspective
A) "You've got to be kidding me" Sarah thinks to herself. She can't believe she is another woman whose doctor is blaming her problems on her period. "What's next is he going to suggest she lose some weight?" she thinks to herself. She turns to Chad and says, "All of you doctors are supposed to be so smart and figure this out but none of you can!" Sarah hands Chad a packet of articles she pulled off the internet on other disorders	B) Chad sets the articles down and looks at his watch. He realizes he's now 30 minutes behind with patients waiting. Feeling even more flustered and frustrated, he tells Sarah "We're already over on time I'm sorry, I can recommend a diet that has helped a lot of people with IBS, and I'll place that referral it's completely up to you if you do not want to follow up with gynecology" He walks Sarah to the door and hands Sarah a handout about the FODMAP diet. Seeing Sarah in tears, he also asks if Sarah has ever considered counseling, and recommends some local therapists
C) Sarah becomes angry and thinks, "Great another provider who thinks I'm crazy, PMSing, and I'm making this all up…maybe it's not that bad and I'm overreacting." Sarah reluctantly agrees but throws the list of therapists in the trash and starts googling new offices where she will hopefully get some real answers	

IBS, irritable bowel syndrome; PMS, premenstrual syndrome.

over the last century as a predictor of good medical outcomes and reduced physician burnout. The concept of "difficult" patients, which make up approximately 15–25% of consultations (6,7), has an evolving literature that is, unfortunately, still rife with concerns regarding language choice, stereotyping, and racial bias. Patients characterized by "psychosomatic" symptoms and those with major psychiatric illness are often deemed most difficult. As it relates to chronic digestive illness, the odds of a patient being labeled as difficult were greater for those with stomach pain, fainting, loose stools/diarrhea, palpitations, and sleep problems (8). Other difficult behaviors include the person having unmet expectations, being a high utilizer of healthcare (6) (known by the pejorative term "Frequent Flyers") (9), and the online medical information being brought to the clinical encounter (10).

A provider's emotional reactions to patients can be influenced by patient behavior, such as expressing anger or disrespect (11), but also if an illness is not responding as expected to treatment, the person has multiple somatic complaints, or the physician does not understand the presenting problem well (12). Emotional reactions by physicians, such as guilt or impatience, can affect diagnostic accuracy and treatment decisions via reduced prosocial motivation and decreased time spent on problem solving (12), which may be interpreted as gaslighting behaviors. Further, the physician's ability to respond to indirect hints or cues from the patient regarding their emotional state can impact the quality of communication and the relationship (13).

Stigmatization of gastrointestinal (GI) illness and gaslighting

Medical gaslighting cannot be discussed without considering the role of disease-related stigma toward GI illness. Like gaslighting, stigma, or the identification of a person as having a mark of disgrace with associated prejudices and behaviors from others, is a deeply rooted sociological construct based on the mobilization of stereotypes and inequalities to control and oppress (14). Over the last

20 years, a consistent pattern emerged in that GI illnesses are more stigmatized than other chronic health conditions, and GI conditions that fall under the disorders of gut-brain interaction (DGBI) classification are more likely to be stigmatized than those with a clear, "organic" etiology. The first study, done in 2004, compared stigmatizing attitudes patients with "functional somatic syndromes" versus those with established organic diseases; in the case of GI illness, irritable bowel syndrome (IBS) versus inflammatory bowel disease (IBD) with no differences in stigma perceptions between these patients (15). Follow up studies find patients with IBS report more stigmatizing experiences, especially from healthcare professionals, than those with IBD. Research into stigma in other DGBI and gastroparesis show stigma from healthcare professionals is also common (16).

The term "medically unexplained symptoms (MUS)" is often used to describe DGBI, despite the existence of the Rome IV criteria. Using MUS to describe a person's condition can be considered analogous to gaslighting as it implies there is no real reason for the person's reported problems. This may, in turn, lead to stigmatization and victim blaming (17) akin to gaslighting. An unfortunate, yet common, extrapolation is that in the absence of clear test results the symptoms are psychiatric in origin. Among the stigma research in GI diseases, a predominant theme is a perception that functional symptoms are believed to be "all in the person's head " (18). Yet MUS remains in the medical vernacular even in 2023 as evidenced by multiple studies using the terminology (19-21), and despite efforts including a study in the British Medical Journal in 2015 highlighting people prefer the term "Persistent Physical Symptoms" over MUS (22). Further, inclusion of Somatic Symptom Disorder in the Diagnostic and Statistical Manual for Mental Disorders–5th Edition (DSM-5) added to this assumption if modern medical testing cannot identify the root cause, then the root cause must be psychiatric. The stigmatization of psychiatric illness is vastly studied, and this linkage of poorly understood medical phenomena to psychiatric processes parallels the processes outlined in non-medical gaslighting: your symptoms aren't real, or they're over-exaggerated, and your belief there's something wrong is not based in fact.

Physicians report frustration when working with patients with MUS while patients may withdraw from seeking medical care due to poor experiences (23,24) including feelings of invalidation (25,26), infantilization, and gaslighting (27). Unfortunately, a recent systematic review of communication training programs for physicians to mitigate some of these issues finds little evidence for their effectiveness (28). If patients engage with mental health care, exchanges regarding the "psychosomatic" nature of the physical symptoms can lead to reduced acceptance of how stress or other psychosocial concepts may exacerbate physical symptoms (23) including substantial pushback from feeling medically gaslighted (29). Recent critiques of the biopsychosocial model, often heralded as a significant advancement over the biomedical model of illness, note the role of socio-structural contributors of chronic illness is often absent in its application, further perpetuating risk for victim blaming (30,31).

Medical gaslighting *vs.* medical invalidation: the role of intent

Whether the presence of intent is a requirement to meet the definition of gaslighting is a hotly contested topic within the literature, with some authors maintaining intent does not play a key role in identifying true gaslighting behaviors, rather it is the impact on the recipient that is key to identifying the phenomena (2). Others propose intent does matter (32) and describe 'epistemic gaslighting' as a differing phenomenon from manipulative gaslighting in that epistemic gaslighting occurs when the recipient of the behavior is on the weaker end of a power differential relative to the perpetrator. The effect of being gaslit then takes place due to the impact of the power differential (32).

Some argue the use of gaslighting in medical practice is not entirely accurate. Jedick notes there are "three sides to every story" and the use of medical gaslighting acknowledges only one perspective (33). It does not acknowledge the physician as a human with their own thoughts and emotions. Jedick further notes the use of this term does not allow for improved relations or a path towards mutual understanding between patient and provider (33). Jedick proposed a more appropriate term would be medical "miscommunication". Durbhakula and Fortin (4) also argue it is lack of quality communication that often contributes to the perception of medical gaslighting, citing for example, insufficient explanation from a physician as to why they are not prescribing antibiotics for virus or efforts to avoid exposing patients to unnecessary testing. These authors note "patients who feel heard, understood, and cared-for will not feel gaslighted." Barnes (2) highlights the overapplication of medical gaslighting lacks the nuance of understanding "places where trust is appropriate and places where it is not" citing for example, that trusting a patient's subjective experience is important, while at the same time acknowledging that physicians are not required to trust a

patient's interpretation of the etiology of their disease.

While the impact of power differentials is certainly a key contributor to gaslighting occurrence, there are additional facets to consider. As opposed to taking a side on whether intent must be present or not to consider a behavior gaslighting, we instead propose a new term *medical invalidation*. Like the differentiation between overt aggression and microaggressions, in which we can clearly see the distinction between the intent of the behaviors while acknowledging the common feature of harm, we define medical invalidation as instances of gaslighting behaviors that take place without the intent of gaslighting, or even with well-meaning intentions. The results of medical gaslighting and medical invalidation are the same: the recipient is left feeling destabilized, and in doubt of their ability to make judgements. However, by naming the difference in intent, opportunities to hold accountability, act towards prevention, and engage in relationship repair become visible.

To be clear, medical invalidation is not harmless. Rather, the purpose of introducing this term is to acknowledge the humanity present in the practice of medicine. Although there will always be exceptions to the rule, providers as a whole act with the intent to uphold their oaths as helpers and healers. Healthcare systems are composed of human beings who in their nature and despite the best of intentions make human errors. Our hope is by taking a closer look at medical invalidation we may strike a balance of identifying contributors to medical invalidation at multiple levels, prevent its occurrence, and leave space for repair all while remaining compassionate to the realities of human nature.

Medical gaslighting/invalidation are complex phenomena, but their occurrence can be broken down (*Figure 1*). At the top of the power differential lies overarching systems: insurance providers, administration, and organizations the patients and providers fall within. These systems place pressures both on providers and patients, which may influence provider and patient interactions and behaviors. A power differential also exists between providers and patients. Providers serve as the ultimate gatekeeper to medical tests, treatments, and diagnoses that often lead patients to defer to the provider as the expert, and patients may experience concerns of how they are perceived by their provider. Providers hold the expertise and competence to speak to the etiology of patients' suffering while patients hold the competence and expertise to speak to the experience of their suffering and the seriousness of suffering is shared by both. When patients or providers attempt to take the expertise and competence of the other, this is when conflict and ultimately medical gaslighting or medical invalidation can occur. For instance, when providers attempt to impose their beliefs of how a patient is experiencing their pain, or when a patient insists their pain is the result of a specific diagnosis.

Gas on the fire: the contributors to medical invalidation and medical gaslighting

Organizational pressures

Symptoms of burnout affect over half of physicians in active practice, and approximately 29% of physicians have clinically significant depressive symptoms, 24% generalized anxiety, and 4–16% post-traumatic stress disorder (34). These statistics beget the question of "why?" In 2023, there are at least 8 key, and often competing, stakeholders in US healthcare: (I) patients, (II) providers, (III) hospitals/healthcare systems, (IV) payers/insurance, (V) employers, (VI) government, (VII) billing clearinghouses, and (VIII) pharmacies/pharmacy benefit managers. As such, in their day-to-day work providers are faced with financial stressors, decreasing autonomy, increasing regulatory oversight, pressures to reduce face-to-face time with their patients, barriers to self-care, and barriers to maintain work-life balance. The culmination of these factors, in turn, increases providers' vulnerability to engaging in invalidating or gaslighting behavior. Although burnout is often viewed from a pathogenic perspective as something to be treated through individual skill attainment, burnout must also be viewed as an outcome of systems that are developed, beginning in medical education, and fostered over the course of providers' careers (35).

A common challenge faced by providers is the negotiation between maintaining the patient-doctor relationship, protecting patients from potential harm of medical overuse, and acting as stewards of limited healthcare resources (36). Nearly every physician professional organization calls upon providers to exercise resource stewardship. With every medical decision made, providers are authorizing the use of medical resources and must weigh the value of the service against the patients' needs, preferences, and circumstances. Further, the widespread implementation of the relative value unit (RVU) incentive-based compensation model, linking physician compensation to weighted work units, has fueled the impersonalization of medicine in the United States (37,38), likely increasing incidents of medical gaslighting. The conflict between consideration of cost and

meeting patients' needs is demonstrated in the literature in which a recent survey showed while 85% of physicians agreed "trying to contain cost is the responsibility of every physician" two-thirds also agreed they "should be solely devoted to their individual patients' best interests even if that is expensive" (39).

According to a focus group study (39), providers frequently experience patients making specific requests for tests and treatments, behaving in a mindset like customer service where the provider is the employee who should be meeting the customers' requests. While some requests may be beneficial, many requests come from advice given from the media, the internet, and the advice of friends or family. Although physicians are encouraged to practice cost-conscious care, when unnecessary testing would not yield out of pocket costs for the patient it becomes more difficult for providers to express their cost concerns as justification for turning down a test or treatment. Providers instead discuss the practical reasoning behind their decision, whether the test or treatment will help, or the potential harm to the patient. Even when reasoning is in the patients' best interest, declining specific requests often results in conflict. Turning down a request may be perceived by a patient as medical gaslighting or medical invalidation, when in fact this is an instance in which the patient has begun to infringe on the providers' role as the expert in etiology and treatment.

Providers are also facing increased burnout from ever increasing time spent managing clerical burden due to the electronic health record (EHR). As a result of EHRs, providers are spending a disproportionate amount of time on documentation, order entry, billing, and inbox messages (40). A study of ambulatory care providers shows providers spend approximately 50% of their workday on EHR, with 1–2 hours completed outside of work (41). It is not surprising then that most medical professionals report that EHR negatively affects their work-life balance, and studies support this showing an association between EHR use and burnout among providers (42,43). The explosion of resources dedicated to "big data analytics" and "artificial intelligence" to further streamline healthcare operations will likely increase pressure for providers to document even more data within the EHR (44).

This corporatization of medical services contributes to a focus on institutional identity and opportunity for institutional betrayal (45). Unfortunately, administrators within healthcare institutions may leverage gaslighting behaviors, including explaining away concerns and labeling anyone who continues to push back on policies as irrationally overreacting to normal, everyday operations (46). This is especially true for women, or racial and ethnic minority professionals (47). As trust is depleted in the institution, providers feel lost in the churn of the "system", and can feel depersonalized and bitter. As such, institutional leaders are critical stakeholders when addressing the issue of medical gaslighting and invalidation.

How we prevent igniting the fire

Because medical gaslighting and invalidation can involve numerous factors involving the provider, patient, medical system, and broader culture, there may be no way to completely prevent these experiences entirely. There are several strategies to reduce the risk of igniting this fire, however, which are described below.

Believing the patient

Providers can reduce the risk of medical invalidation by communicating they believe the patient's subjective experience of their symptoms. Healthcare professionals may at times encounter situations where the severity of patient presentation of symptoms may appear to exceed the norm. While it is possible a patient may exaggerate symptoms (often out of a desire to be taken seriously), most patients are accurately describing their subjective experience. Communicating you see the patient is suffering and their GI symptoms are having a significant impact on their quality of life is a helpful place to start to convey you are listening and taking their concerns seriously (48).

Thoughtful communication about the gut-brain axis

Patients often describe the numerous unhelpful messages received in the past regarding conditions such as IBS, including "It's all in your head", "It's just stress", "You're doing this to yourself". These statements are commonly experienced as medical gaslighting. Due to the significant impact of the gut-brain axis on GI functioning, many symptoms or conditions may be exacerbated by stress. However, using statements described above are not likely to be received well by a patient who is suffering. When providers suspect a patient may be suffering from a DGBI, offering a discussion of the nuances of the gut-brain axis using medical language, and how this can contribute to symptoms patients experience despite lack of positive test findings,

Table 5 Patient and provider vignette: an alternative path

Patient perspective	Provider perspective
A) Sarah makes an appointment at a hospital in the next town over and is given a 1-hour new patient appointment with Dr. Beeleaf. When she speaks to the receptionist, she is told the office will take care of all prior authorizations and will request her records be sent over. The receptionist reassures Sarah they will work together to figure this out and Sarah already begins to feel more relief. Sarah arrives to her visit with Dr. Beeleaf and is brought into the office	B) Not long before Sarah made her appointment, the hospital had made numerous changes in their departments to support patients and providers. The GI department hired a full-time psychologist, and nutritionist. They were also given funding for additional support staff and their entire team was provided with training to understand the whole-person perspective of GI symptoms including the role of the mind-gut connection. Additionally, changes were made to providers' schedules which allowed for one-hour new patient appointments and reductions in over-booking providers. As a result of these changes demand for care increased. Instead of placing the burden of this demand on the providers, the hospital instead released funds to hire additional physicians. Dr. Beefleaf sits down, faces Sarah, and listens as Sarah recounts her medical history and experiences. "I'm so sorry all of this is happening, Sarah. I have no doubt your symptoms and pain are real and I'm hopeful we can get some solutions. I'm curious, though, when your symptoms started was there anything big going on in your life? Any changes or stressors?"
C) "So, wait, I'm causing this because I can't handle my stress?" Sarah asks	D) "No, that's not what I'm saying at all. Let me be clear you did not cause any of this. Stress can just be a factor that makes these symptoms worse and so that's something we want to address while we also treat you medically. As people we aren't just physical or mental, our mind and our body influence one another and so we want to make sure we are addressing both. We have a psychologist on staff in our practice for this reason and if you're okay with it I think it would be helpful to meet with them to talk through what you've been experiencing. While they work with you, I will also be running tests and working on medical interventions that can help."
E) Sarah thinks about this, she hadn't been asked before, but she realizes her symptoms began around the same time her company was conducting layoffs and her mom was in an accident with a drunk driver. She tells this to Dr. Beeleaf	F) "Okay, that makes sense, and I'm not in any way saying the stress you were under were the sole cause of your symptoms, but we do know stress can influence physical symptoms." Dr. Beeleaf goes on to explain the role of the mind-gut connection. As Dr. Beeleaf is explaining, Sarah recalls other times she experienced more severe pain and noticed it did tend to happen when she was stressed or anxious
G) Sarah takes a sigh of relief and agrees with Dr. Beeleaf's plan. She makes an appointment with the clinic's psychologist and nutritionist and leaves the appointment feeling she is in good hands with this clinic and this team. Over time Dr. Beeleaf also tells Sarah she suspects Sarah has IBS-D and recommends options to help Sarah with her symptoms. Sarah, knowing and trusting Dr. Beeleaf follows her advice, continues to work with the psychologist and in a few months, she is starting to feel much better	

GI, gastroenterology; IBS-D, irritable bowel syndrome associated with diarrhea.

is recommended (48). Acknowledgment that present-day medical testing has limitations in objectively visualizing or quantifying neurological gut function can also help patients embrace these concepts. These actions can assist patients in understanding their condition and increase trust that their provider is taking their concerns seriously. They also clarify the rationale for why working with providers such as a GI psychologist or dietitian are valid treatment options and are recommended as part of comprehensive GI healthcare. Jedick highlights the importance of how this approach is handled, noting "*it's critical that the physician come to the encounter as a partner and coach rather than a cold disciplinarian when suggesting lifestyle modifications or discussing a patient's behaviors as an etiology to disease*." (33).

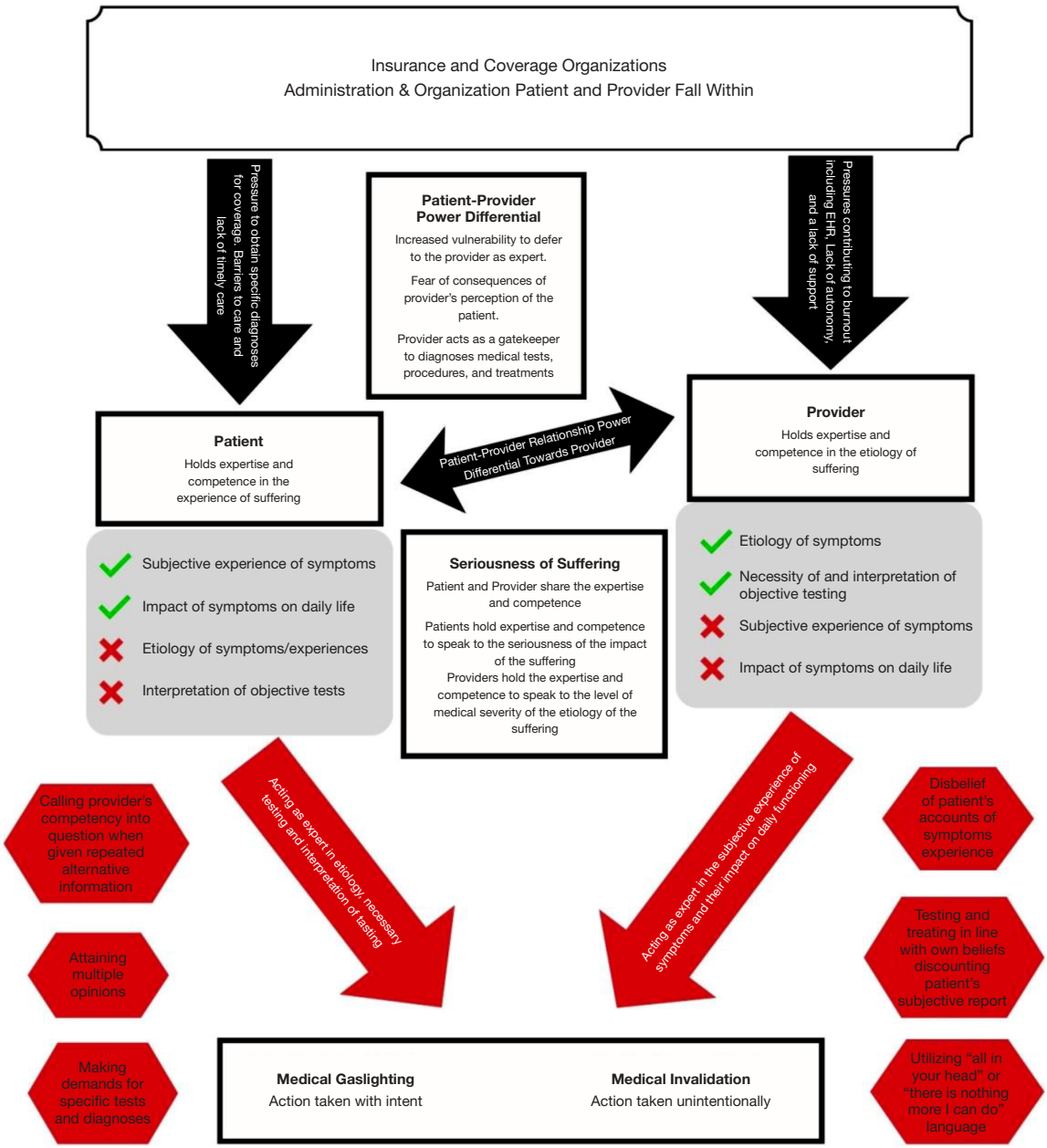

Figure 1 The breakdown of contributors to medical gaslighting and medical invalidation and differentiating these two phenomena.

Recognize the limitations of relying on heuristics and stereotypes

Medical providers are encouraged to be mindful that we all have heuristics and biases that influence our behaviors and decision making, whether they were learned through mentors in medical training or through personal experience. Being aware of these tendencies, for example, to label a patient as "difficult" based on stereotypes can allow providers to take a step back and re-assess each individual patient's situation to reduce the likelihood the provider is communicating in a manner that is dismissive or condescending (33).

Being mindful of power dynamics

The patient-provider relationship is not egalitarian in

nature. Medical providers are equipped with years of medical training and knowledge about the functioning of the human body that most patients are not (33). This can create feelings of vulnerability for the patient, since historically patients have been encouraged to defer to medical expertise. Providers should remember the patient has been living within their own body and experience all their life and holds multitudes of knowledge about their own body and lived experience. While patients may present with hypotheses about what is causing their symptoms that may not be based in empirical evidence, the willingness to listen to their perspective regarding causation is important for establishing trust. This does not imply providers are required to defer to the patients perceptions about the etiology of their symptoms, for while patients often have good insight into their own subjective experiences of health, they may not have same competence or insight into the pathophysiology of their symptoms (2).

Building trust by bolstering perceptions of competence and warmth

When meeting a new person, we consciously and unconsciously judge their levels of warmth (qualities such as empathy, kindness, and honesty) and competence (intelligence, skill, and assertiveness) as a means of identifying if that person intends to help or harm us and if that person can carry out their intents (49). In the context of healthcare, patients assess these same traits to judge whether their provider understands their illness and understands them as an individual. In an initial interaction with their provider, patients pay attention to cues indicating if a provider has the qualities to conduct relevant procedures, make accurate diagnoses, and make the best recommendations for treatment while simultaneously evaluating whether the provider recognizes and respects their personhood whose existence extends outside of their symptoms. When meeting and interacting with patients, providers can take actions to demonstrate both qualities, and by doing so they build trust in their relationships. Examples of demonstrating warmth include: engaging in active listening, empathetic statements regarding the condition, appropriate use of humor, making eye contact, greeting patients, apologizing for delays, and asking appropriate informal questions. Examples of demonstrating competence include: giving additional information about the illness in language the patient can understand, explaining medical terms, encouraging and answering questions, using a clear and confident tone, and reviewing the record prior to the appointment.

Collaboration with the treatment team

Many patients complain their gastroenterologists have informed them "there is nothing else I can do for you" which, from a GI perspective, may indicate there are no additional tests or medications are recommended at this time. Patients often interpret this as the provider has "washed their hands of me". In fact, many patients with DGBI may benefit from working with GI dietitians, psychologists, physical therapists, and other specialty providers. In many cases, a patient may receive more benefit from working with these specialty providers rather than relying on GI specific medications alone. When medical providers suspect a patient may benefit from working with one or more of these specialists, it is important to let the patient know you will remain engaged in the coordination of care and available to answer questions, even if the provider does not feel a follow-up appointment with them needs to be scheduled at this time. By remaining the trusted medical home for patients receiving multidisciplinary care this can help to reduce concerns about provider abandonment (50).

Patient advocacy

Patients should be given the opportunity to ask questions and clarify concerns. One factor that can threaten this opportunity is limited time in a medical appointment due to the demands of the medical system. By protecting time for questions at the end of the visit (or during the visit), and directly asking if the patient has any questions, patients are more likely to feel heard and listened to. In situations where patients bring up questions or concerns that require additional time beyond what is available during that clinic appointment, scheduling an additional follow-up appointment for questions is warranted. Patients may also benefit from bringing a friend or loved one to their appointments to take notes and ask questions, particularly if patients are nervous or overwhelmed and may not feel comfortable advocating for themselves. The presence of a supportive loved one at medical appointments has been associated with improved quality of care for patients with breast cancer (51).

Provider advocacy

During an age where provider burnout is high, clinic demands often exceed what is feasible to provide quality

care, and providers feel unappreciated within their own medical systems and often must engage in debates with insurance companies in order to get patients the care they need, providers often feel exhausted and depleted, which further increases the likelihood of providing invalidating care. Providers also deserve the right to advocate for their needs individually and as a system which can help improve provider safety, reduce risk of error, and improve quality of care and patient satisfaction. Administrators need to recognize the inherent issues with the modern healthcare system and prioritize the humanity of its primary stakeholders—the clinician and the patient, rather than focusing on RVU metrics and profit margins.

Conclusions

Medical gaslighting is a complex phenomenon without simple solutions. Both patients and providers can contribute to degradation in communication that is fundamental to a trusted relationship and foment gaslighting experiences. Because the role of intent is fundamental to true gaslighting behaviors, we propose the term *medical invalidation* to be considered as a better descriptor of many occurrences otherwise deemed gaslighting in gastroenterology practice. By recognizing this distinction, remediation strategies can be tailored to the appropriate groups (those engaging in invalidation versus gaslighting) and patient interventions can facilitate self-advocacy skills and empowerment. Further, the stresses from institutional demands, burnout, increasing healthcare system complexity, and administration play an important part in understanding and mitigating the negative effects of medical gaslighting. Currently, studies assessing medical gaslighting in gastroenterology care are non-existent, and thus future studies are critically needed.

Acknowledgments

Funding: None.

Footnote

Provenance and Peer Review: This article was commissioned by the editorial office, *Translational Gastroenterology and Hepatology* for the series "Social and Emotional Impacts of Chronic Digestive Diseases". The article has undergone external peer review.

Reporting Checklist: The authors have completed the Narrative Review reporting checklist. Available at https://tgh.amegroups.com/article/view/10.21037/tgh-24-26/rc

Peer Review File: Available at https://tgh.amegroups.com/article/view/10.21037/tgh-24-26/prf

Conflicts of Interest: All authors have completed the ICMJE uniform disclosure form (available at https://tgh.amegroups.com/article/view/10.21037/tgh-24-26/coif). The series "Social and Emotional Impacts of Chronic Digestive Diseases" was commissioned by the editorial office without any funding or sponsorship. T.T. served as the Guest Editor for the series. T.T. also reports that she is a consultant for U.S Department of Veteran's Affairs (Monterrey Consultants) where she conducts disability evaluations for U.S. veterans; consultant and Scientific Advisory Board for Ayble Health which is a digital platform for dietary and behavioral interventions for digestive disease; consultant for RVO Health where she reviews medical articles for accuracy. The authors have no other conflicts of interest to declare.

Ethical Statement: The authors are accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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doi: 10.21037/tgh-24-26
Cite this article as: Fuss A, Jagielski CH, Taft T. We didn't start the fire…or did we?—a narrative review of medical gaslighting and introduction to medical invalidation. Transl Gastroenterol Hepatol 2024;9:73.