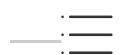


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Abstract

Background

Stereotype about Black people contribute to nurses and healthcare providers gaslighting and dismissing of their health concerns. Despite the popularity of the term medical gaslighting in mainstream literature, few studies have explored the experiences of Black women during pregnancy and childbirth.

Purpose

This paper aims to provide an in-depth insight into Black women's experiences of anti-Black medical gaslighting when accessing care during pregnancy and childbirth.

Methods

Utilizing qualitative methods, we conducted 24 semi-structured interviews

with Black women in the Greater Toronto Area. We used thematic analysis to ground the data analysis and to generate insight into Black women's experiences.

Results

Three overarching themes: 1) Not Being Understood: Privileging of Medical Knowledge Contributing to the Downplaying of Health Concerns, 2) Not Being Believed: Stereotypes Contributing to Dismissive Healthcare Encounters and 3) Listen to Us: Turning off the Cycle of Medical Gaslighting. These themes highlight ways anti-Black medical gaslighting manifests in Black women's healthcare encounters to create differential access to treatment and care.

Conclusions

Anti-Black medical gaslighting contributes to differential access to treatment and care. Improving equitable access to treatment and care must involve addressing structural and epistemic biases in healthcare and fostering a culture of listening to humanize the experience of illness.

Background

The experience of discriminatory and

prejudicial treatment towards Black people in the healthcare system is pervasive, contributing to Anti-Black medical gaslighting (AMG) ([Boakye et al., 2023](#); [Chung, 2021](#); [Del Pozo & Rich, 2021](#); [Drwecki, 2015](#); [Hoffman et al., 2016](#); [Sabin, 2022](#)). AMG is described as situations in which the symptoms and embodied experiences of Black patients are given less credibility and dismissed by nurses and health care providers ([Carter, 2022](#); [Hoberman, 2012](#)). It also involves nurses and healthcare providers imposing their interpretation via medical discourses about the pathology of diseases ([Sebring, 2021](#)). Medical gaslighting constitutes a form of abuse and manipulation that causes a person to doubt their own account despite having the embodied experience ([Stern, 2018](#); [Sweet, 2019](#)). The practice of medical gaslighting manifests in subtle and invisible ways during healthcare encounters including downplaying and attributing patients' symptoms and experiences to unrelated issues, outright dismissal of legitimate patient concerns, and instigating patients to doubt, disbelieve, and question their own experience ([Hoberman, 2012](#); [Watson-Creed, 2022](#)).

AMG is influenced by medical racism and the perceptions of nurses and healthcare

providers about Black people ([Carter, 2022](#); [Hoberman, 2012](#)). Medical racism encompasses wide-spread systemic racism, discrimination, bias, and race/ethnic based misrepresentations in medical practices targeted at Black people in the healthcare system ([Hoberman, 2012](#)). Medical racism, which emerged from the dark history of medical experimentation and exploitation of enslaved people, is continuously being reinforced in education, teachings, and practices of nurses and healthcare providers, ultimately contributing to inequitable access to care and disparity in health outcomes among Black populations ([Hoberman 2012](#); [Owens, 2017](#); [Schoenthaler & Williams, 2022](#)). The history of medical exploitation including unethical reproductive experimentation, coercive sterilization, willful negligence, and fear tactics have over the years undermined the agency of Black women when interacting with nurses and healthcare professionals ([Carter, 2022](#); [Owens, 2017](#); [Roberts, 1997](#)). AMG constitutes a broader *epistemic injustice* which [Fricker \(2007\)](#) described as the “wrong done to someone specifically in their capacity as a knower” (p. 1).

Epistemic injustice arises when prejudice results in a person (hearer) giving less or deflated level of credibility to the words or

statements made by another person (speaker) ([Fricker, 2007](#)). In healthcare, epistemic injustice shows up as medical gaslighting resulting in patients not being treated as having authority over their embodied experience, and their accounts are deemed less credible and unreliable. [Fricker \(2007\)](#) also argues that epistemic injustice may also arise “when a gap in collective interpretive resources puts someone at an unfair disadvantage when it comes to making sense of their social experience” (p. 1). This form of injustice is manifested when healthcare providers, who are in an epistemically privileged position exclude the experiences of members of a social group from epistemic deliberations and collective understanding ([Cirne, 2012](#); [Fricker, 2007](#)). Historically Black peoples' experiences are considered less intelligible owing to the belief that their experiences do not align with the dominant ways by which people understand and interpret the world of nursing, medicine, and healthcare ([Baker et al., 2008](#)).

AMG may arise when Black people encounter unfair disadvantages in communicating and making sense of their experience. Communicating one's healthcare experiences requires a wide range of communicative resources,

including images, symbols, and language recognized and commonly shared within a given community like the healthcare institution ([Carel & Kidd, 2014](#)). By virtue of their years of training and expertise, nurses and healthcare providers have the power and privilege to set the standards for what aspect of a person's experience is deemed clinical knowledge and what meaning should be assigned ([Kidd & Carel, 2018](#)). Discourses around communicative encounters in healthcare are premised on scientific and objective information about health and illness, hence, the basis for validating and legitimizing patient experience ([Carter, 2022](#); [Kidd & Carel, 2017](#); [Sebring, 2021](#)). For example, the existing power imbalance between patients and healthcare providers coupled with medical racism may lead to unjust communicative encounters that delegitimize the health concerns of Black women ([Boakye et al., 2023](#)).

The phenomenon of AMG must be understood as interpersonal and professional violence that results in exchanges colored by micro assaults, insults, and a host of dignity-violations ([Carter, 2022](#)). Ultimately AMG contributes to poor patient-provider therapeutic relationship, undermines the agency and capacity of a patient to engage in

healthcare deliberations, leads to inaccurate or delayed diagnosis, longer treatment wait-times, inadequate treatment and care, and poor healthcare outcomes ([Carter, 2022](#); [Durbhakula & Fortin, 2023](#); [Reynolds, 2020](#)).

Power differential and deeply entrenched racial and gender stereotypes in medicine are fertile ground for rendering the experiences of women seeking obstetric care as irrational and hysterical ([Boakye & Prendergast, 2024](#); [Fielding-Singh & Dmowska, 2022](#)). Although everyone can experience gaslighting, the intersectionality of racial and gender stereotypes may create conditions that further expose Black women to medical gaslighting. The intersectional impacts of racism and sexism lead to unchallenged norms and assumptions about Black women, such as having a high degree of pain tolerance and being less likely to be diagnosed and treated for a certain illness, ultimately increasing their susceptibility to unfavorable health outcomes ([Carter, 2022](#)). Despite the widely circulated stereotypes about Black people in healthcare, little is known about Black women's everyday experiences of AMG.

Pregnancy and childbirth are an embodied reality ([Neiterman, 2013](#)) that allow each the authority of their own lived experience.

Being Black and pregnant increases Black women's risk of being gaslit and their health concerns called into question. Because medical gaslighting occurs in subtle ways, it becomes difficult to recognize when a patient is urgently looking for a solution to a pregnancy-related concern. In Canada, there is dearth of research in nursing and healthcare on AMG during pregnancy and childbirth which limits opportunity for collective change and action within the health care system to optimize the health and well-being of Black women. While anecdotal evidence on AMG is widely circulated over the internet, empirical works needed to inform the development of interventions to combat gaslighting in practice are very scant. Therefore, the purpose of this research is to provide insight into the experiences of AMG among Black women seeking care during pregnancy and childbirth.

Methods and procedure

A generic qualitative study ([Ellis & Hart, 2023](#)) was conducted as part of a larger study exploring Black women's experiences accessing healthcare during pregnancy and childbirth ([Boakye et al., 2023](#)). Qualitative research is relevant for exploring how individuals make meaning

/sense of their experiences and everyday interactions ([Merriam & Tisdell, 2015](#)). This design was chosen because it allowed researchers to draw on different theoretical and philosophical orientations to frame a qualitative research project ([Bradshaw et al., 2017](#)). Considering the aims of the larger study exploring maternity care experiences of Black women, the research was situated within the context of critical qualitative inquiry. This approach to research enables a researcher to illuminate the ways social marginalization and systems of discrimination impact an individual's everyday interaction and identify opportunities to promote equity ([Denzin, 2017](#)).

Recruitment and data collection

The study was conducted in the Greater Toronto Area (GTA). Twenty-four (24) Black women 18 years or older who were either pregnant or had given birth were purposely recruited. We distributed recruitment fliers widely via social media, Black community-based organizations, and groups across the GTA. The interviews were conducted by the first author with extensive experience in designing and

conducting qualitative interviews. As part of the semi-structured interview conducted for the larger study, participants were asked the following specific questions related to their interaction and communication with nurses and healthcare providers: a) how were your health concerns perceived and interpreted by the healthcare providers and b) what do you think may have influenced the way the healthcare providers responded to your concerns, and how did that make you feel? We refrain from using the term medical gaslighting to avoid influencing the responses of participants. Additional probing questions were used to clarify and elicit further information and explanation including: *what were your experiences interacting and communicating with your healthcare provider and what challenges did you experience in communicating your concerns or symptoms?* The interviews were conducted virtually over Zoom, Google Meet, and telephone, lasted between 40–60 min, and were audiotaped. The audios were transcribed by the fifth and seventh authors and the first two authors reviewed and verified the transcripts to ensure accuracy. More than half of the participants were within the age range of 24–34 years and had a bachelor's degree. 95% were employed and all participants

interviewed identified as Black. Further details of the demographic characteristics are reported elsewhere ([Boakye et al., 2023](#)).

Data analysis

Thematic analysis was used to guide the data analysis and interpretation ([Braun & Clarke, 2021](#)). This method of data analysis was used because of its flexible application to a broader range of epistemological and methodological orientations ([Braun & Clarke, 2021](#)). The analysis was structured using the six phases proposed by [Braun and Clarke \(2021\)](#). We began by familiarizing ourselves with the data by reading and reviewing the transcripts and sorting through the data to generate initial insights. Subsequently, three members of the research team generated a list of codes and assigned the codes to the data set. We categorized similar phrases and statements into clusters to generate tentative themes. We named and defined the themes and identified the relationship between themes. Once themes were identified, further analysis was conducted to provide a broader interpretation while paying close attention to the subtle and invisible ways AMG may manifest in the context of the definitions presented above. For example, while the themes discovered

were consistent with the previous literature, through our analysis, we were able to uncover the invisible burden taken by Black women to counteract gaslighting through acts of resistance, albeit the adoption of new or oppositional gaze, ([Boylorn, 2008](#)) the learning of 'new language'. Finally, we generated narratives to describe the data interpretation and to create a compelling story on Black women's experiences of AMG. The analytical process was conducted iteratively ([Braun & Clarke, 2021](#)) and in collaboration with team members to ensure broader and collective interpretation and understanding. N-Vivo version 12 Release 1.7 was used to aid the sorting and organization of the data.

Trustworthiness

Trustworthiness was achieved through a combination of different techniques including investigator triangulation, peer debriefing, and reflexivity ([Morse, 2015](#)). To achieve investigator triangulation, three members of the research team with an interest in Black women's health and Anti-Black racism research conducted the data analysis and the entire team frequently reviewed the analytic impressions and compared our interpretation as the data analysis evolved. The research team also

has extensive training and experience in designing and conducting qualitative research including interviewing and data analysis. These experiences ensured our team worked collaboratively to generate inclusive and comprehensive interpretations with consensus. Peer debriefing was achieved by sharing our preliminary findings with two non-Black racialized colleagues to review and assess the coherence of our interpretation and the presented themes. As Black women researchers, we recognized that we may have similar experiences as our participants which may impact how we approach the interviews and data analysis. To ensure reflexivity, the research team not only documented any preconceived ideas and thoughts as the data collection and analysis evolved, but also engaged in the team debriefing sessions.

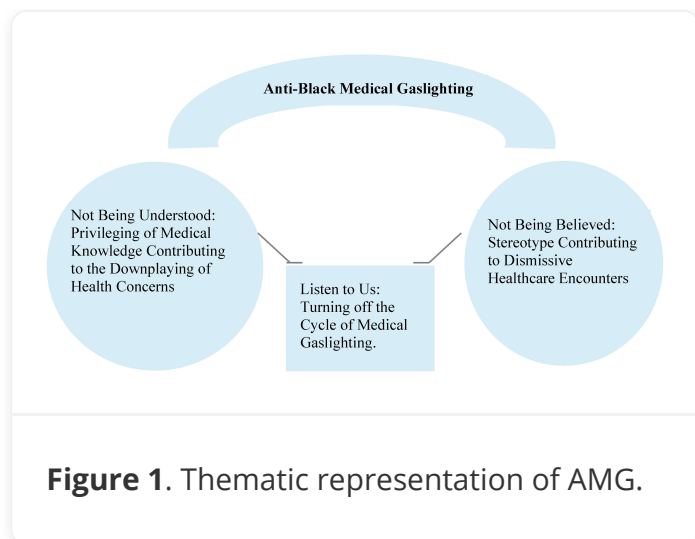
Ethical consideration

Research ethics approval was granted by the Research Ethics Board of the Toronto Metropolitan University (REB reference: 2022-207). All the participants were sent an informed consent form and were given a week to review the information and ask questions. Each participant provided written informed consent before the interview commenced. During the

interview, we continually sought consent from participants and entreated them to not disclose the names of healthcare providers or hospitals. The audio recordings were deleted after transcription was completed, and all identifying information was removed and replaced with a non-identifying name. We assigned each transcript an alpha-numeric code which we retained throughout the write-up.

Results

Three themes were generated to illuminate the medical gaslighting in Black women's healthcare encounters 1) Not Being Understood: Privileging of Medical Knowledge Contributing to the Downplaying of Health Concerns, 2) Not Being Believed: Stereotypes Contributing to Dismissive Healthcare Encounters and 3) Listen to Us: Turning off the Cycle of Medical Gaslighting. [Figure 1](#) provides an overarching representation of AMG to illuminate the emerging thematic components and conceptual understanding.



Not being understood: privileging of medical knowledge contributing to the downplaying of health concerns

Black women shared their struggles of having their concerns not understood and given consideration when interacting with healthcare providers. From the participants' accounts, there are gaps in how healthcare providers understood and interpreted their concerns. Their inability to articulate their symptoms in a way that fits into the dominant mode of communication led to healthcare providers judging their concerns as unreliable, less relevant, and excluded from health deliberation.

When I was trying to explain my

situation and it felt like whatever I said did not matter. My whole experience with that doctor just made me feel like my concerns were not relevant and so whatever I was saying did not really matter. Participant 9

Women felt their concerns were being delegitimized, which led to their exclusion from healthcare deliberations and decisions about their care and treatment. Participants indicated that these exclusionary practices undermined their agency, leaving them in situations where they had to struggle to 'prove' the legitimacy of their concerns.

It is just like our concern is basically irrelevant and I just think that it's unfair, like no one should be treated like that at all. I had to go to the doctor so many times just to vouch for myself. I mean I had to prove myself because doctors do not take Black women's concerns seriously and they do not understand the Black woman's point of view. Participant 21

The lack of acknowledgment and

understanding of Black women's embodied experience of illness contributed to gaps in their care. Another participant explained her concern was downplayed and deemed irrelevant.

I think in healthcare in general Black women are not taken seriously and it is like they [nurses/healthcare providers] do not understand us...I do not know how many ways or how many times I explained my condition to these people ... I think it is about being a Black woman and pregnant all those intersectionality is just ignored, your concerns downplayed and not taken into consideration. Participant 19

Participant 24 also shared her experiences of how her concerns were downplayed and trivialized by healthcare providers.

I think as a Black pregnant woman every time I tried to explain my concerns, the healthcare providers were always like you are fine, you're healthy, you are okay, you're a healthy young person, your pregnancy will be fine, it's probably mom's nerves. So, it kind

of made me distrust my guts.

Participant 24

Trivializing their concerns contributed to self-distrust and doubt, affecting their judgment and capacity to recognize impending signs requiring immediate attention and care. Other participants also recounted that although healthcare providers considered their concerns, it was deemed inconsistent with the accepted standards and thus excluded from consideration.

They went through the symptoms list, and they were like I do not think it's what you are saying. And they did not give me the attention I deserved when I'm telling them that these are the issues because they're just going through their generic symptoms list instead of giving me the actual attention that I needed or deserved at the time.

Participant 23

Black women indicated that healthcare providers were so attuned to biomedical terminologies even when they presented with a life-threatening complication, it was perceived to be clinically insignificant. Many participants felt the failure of

healthcare providers to listen and give clinical significance to their concerns contributed to improper diagnosis and increased their risk of worse outcomes. Participant 5 poignantly shared the impact of not being understood.

Feeling misunderstood and like not being taken seriously is just a lot of psychosocial impact. It is very stressful. You know inherently it is going to cause negative outcomes, whether it's before or after. And you are feeling alone, isolated, especially just going through the process of having a child and not feeling understood when traveling and navigating a system...you really have to stand up for yourself and then when you stand up for yourself, they look at you to be aggressive or you're being defiant.

Black women felt alienated for not being understood by healthcare providers. While women described resisting and advocating for themselves, they also felt that such attempts resulted in nurses and healthcare providers perceiving them as defiant and aggressive, further stereotyping them and leading to dismissive healthcare

encounters.

Not being believed: stereotypes contributing to dismissive healthcare encounters

Prejudice and widely circulated race-based stereotype about Black people have contributed to Black women's health concerns being treated with less credibility by healthcare providers. Black women recounted that racist beliefs about Black people having a higher pain tolerance were widespread in the healthcare system. A woman shared her experience.

Everywhere in the medical field, I find that there's some sort of prejudice when it comes to Black women, because they think we are supposed to handle a lot more pain than other races. They think that we are actually capable of handling pain more. So, if you tell them, you are in pain, they don't believe it and they don't think you're actually telling the truth and that you shouldn't be feeling pain. And I think that is very unfair. Race really does influence how they think about our pain, the

prejudice is there, it is very evident
in the way they treat us.
Participant 10

Prejudice resulted in many healthcare providers doubting or disbelieving Black women when they complained of pain. Other women also described how that same deeply held bias about Black women's pain tolerance contributed to the delay in receiving urgent and appropriate treatment.

And I feel like there is a lot of stigma and stereotypes around Black women's pain tolerance... we are not getting responded to as fast as they should. It is just common in healthcare, those stereotypes about Black women can tolerate pain more than others, is affecting our care.
Participant 5

The participants' accounts reflected how prejudice and bias led to inequitable access to pain management. Some women discussed that healthcare providers undermined their credibility and perceived them to be exaggerating their pain, despite the severity of their health concerns. This was reflected in one participant's accounts

when she said:

As Black women, our pain is treated differently in childbirth. The doctors are treating us differently. They do not take our pain or whatever situation seriously. It is like we are lying about our pain, or we are exaggerating our pain...my epidural ran out, and the machine was beeping for at least for 45 minutes, nobody came in. I was pressing the call bell, nobody came in. Participant 11

Participant 23 also expressed her concern about the disparity in pain treatment when she indicated that *“there is this assumption that Black women do not feel pain and should not be treated but if I was a White woman, I would get better preferential treatment and have my concerns or needs taken seriously”*. Other participants also shared their experiences about nurses and healthcare providers perceiving them as hysterical, failing to recognize their pain and provide appropriate care.

I'm in a lot of pain during labour and I needed some help. I'm in a situation where things are really

bad, and they see me like I am screaming or being hysterical. I think the reaction is like they don't believe me. I tell them I'm actually in a lot of pain, this hurts and they dismiss it, and they literally think my pain goes over my head.

Participant 23

There was an expectation that Black women were not supposed to express emotions when experiencing pain. Pain-associated emotions were deemed irrational despite the life-threatening nature of their conditions, resulting in neglect and failure to provide the necessary care. A participant shared her experience of being neglected, despite the severity of her symptoms.

I had preeclampsia and I told the OB [Obstetrician] and nurses something inside me is shutting down. I told them, I feel like I'm dying. And then I need you to fix it. Like I need you to look it up. I need help, something is very wrong, and I just need you to believe me. I think that wasn't enough to kind of compel them to act a little sooner than they did.

Participant 20

The persistent and deliberate attempt to dismiss and ignore Black women undermined their confidence and placed them in precarious situations such that even when they were in severe pain or had serious concerns, they remained silent and endured the suffering.

I feel like it puts us in a very awkward position. When you are actually in pain, you don't like asking for help because they look at you like you're weak and you're lying, and the second thing is you're not supposed to feel pain and you're supposed to be able to handle this. Participant 10

In attempting to assert their confidence and ensure healthcare providers believe them, some women described altering their self-report/health testimonies using medical language to express their concerns to nurses and healthcare providers. Participant 2 described how she sourced information from the internet to ensure she was able to communicate intelligently with healthcare providers.

I tried to be Dr. Google to look into what these things were so that I could talk with some level of like

intelligence around this topic,
because I was like well, if they're
not going to believe me... it was
like learning a new language, right,
in order to kind of explain to
someone how you're feeling and
it's hard because it's like your pain
doesn't line up with what their
textbook gives. So, it did not
matter how I was explaining
myself. It just was not connected
with whatever they were doing.
Participant 2.

Black women described using a 'new
language' to express their concerns to
ensure they got the attention of healthcare
providers and to also render their
concerns credible and worthy of
consideration. Being dismissed has
devastating consequences for the health
outcomes of Black women and their
pregnancy; therefore, it is critical to respect
and value women as expert of their own
experience.

Listen to us: turning off the cycle of medical gaslighting

Participants were inherently aware that
turning off the cycle of medical gaslighting
will require healthcare professionals to

value and acknowledge Black women as legitimate knowers of their embodied experience of pregnancy. This was captured by Black woman who said *"I think that they should listen to me... it's my body it doesn't matter if you're the expert"* (Participant 14). Black women are questioning the role of nurses and healthcare providers as experts and their basis for dismissing their embodied experiences. Participants demanded that healthcare providers cultivate a culture of listening, develop testimonial sensibility to their concerns, and address both the prejudice and bias they hold about them. This approach to listening allows nurses and healthcare providers to hold their prejudice in abeyance, fostering an atmosphere that enables them to focus on the personal and embodied experience of the patient's illness. This was captured in the following excerpt.

I think that first and foremost a doctor should not be putting seeds of doubt or should be ensuring that they are listening and believing. Just believing Black women when they say like I am in pain or this doesn't feel right, or this is what I need. They also need to be open to what we tell them

and just work with that. I think part of it is also just ensuring that there is some level of awareness about those stereotypes and also understanding how that affects us. Participant 2

Several women reiterated the significance of openness and critical awareness in combating the pervasive stereotype about Black women's pain tolerance. One participant stressed that listening to the concerns of Black women and acknowledging their experiences in the care process is essential to finding solutions that are unique to their care.

I think just listening to us if we say we are experiencing some sort of thing or some kind of adversity and not dismiss us. Because if you just downplay whatever I say, and you do not listen you are not really going to find a solution to my problem. So, they should listen to us and so they find a solution just like they would help one of their own family members. Just listening and hearing us out whenever we say that there is a problem, taking it seriously, taking action and giving us solutions to

turn off the problem. Participant

21

Participants felt that listening provides healthcare providers access to the interpretive world of their experience plus vital information needed to diagnose and respond appropriately to their needs. The act of listening fosters better relational connection and engagement, promotes empathy, and humanizes their experience.

Every human being needs to be listened to because if you do not listen you can't understand what the person is experiencing. So, every human being needs to be listened to and be given the chance to tell their story, especially some who are bringing life to the world, like we even need to be listened to more because we carry another life. You know being heard makes you feel that you are a human being, you feel valued.

Participant 15

Black women also felt that creating spaces of listening in healthcare facilitates honest communication and equitable access to the exchange of information and better understanding of their pregnancy and

childbirth experiences.

Discussion

The current study illuminates the pervasiveness of medical gaslighting of Black women seeking care during pregnancy and childbirth but also provide a more comprehensive definition of anti-Black gaslighting. While the definition of AMG presented above provides a conceptual understanding, it does not adequately capture the subtle acts of resistance used by Black women to challenge gaslighting. Based on the findings of this current research, we offer a definition that encompasses the phenomenon of AMG, which we describe as the dispossession of persons whose Blackness intersects with the healthcare and results in practitioner acts of dismissing, downplaying, disbelieving, and delegitimizing their embodied and storied experiences of health and illness and ultimately differential treatment/care. It also includes the struggle and acts of opposition Black women learn and utilize to challenge AMG. Our findings show that AMG is inextricably linked to racial prejudice and privilege of medical ways of knowing resulting in Black women being unjustly discriminated against in their capacity as knowers of their health

experience.

AMG of Black people stems from racist ideology and prejudice that have historically shaped and continue to influence medical practice ([Carter, 2022](#); [Hoberman, 2012](#); [Hoffman et al., 2016](#); [Watson-Creed, 2022](#)). The belief that Black people are biologically inferior, dishonest, and uneducated, is encoded in the education and practice of healthcare professionals ([Amutah et al., 2021](#); [Hoffman et al., 2016](#); [Watson-Creed, 2022](#)). For example, the belief that “black people's skin is thicker than white people's skin” (Hoffman et al., p. 4296) is entrenched in the history of medical education and practice. False beliefs and entrenched tropes may fuel gaslighting leading to Black patients not having their concerns taken seriously and attributed to different causes, being assigned lower pain scores, and not receiving appropriate treatment and care compared to their White counterparts ([Ghoshal et al., 2020](#); [Hoffman et al., 2016](#); [Knoebel et al., 2021](#)). Such complete disregard and failure to address the suffering of people, including Black women, limits access to equitable, urgent, and timely care, ultimately increasing their risk and vulnerability to adverse health outcomes and widening disparity ([Boakye et al., 2023](#)).

Illness can be a personal and subjective experience, therefore, a patient whose illness narrative does not align with the scientific and objective ways nurses and healthcare providers make sense of illness are more likely to be gaslighted. Nurses and medical professionals occupy an “epistemically privileged role of assessing which testimonies and interpretations to act upon, as well as deciding what sorts of testimonies to receive, from whom, what form they can take and so on” ([Carel & Kidd, 2014](#), p. 535). The findings of this current study also revealed that medical gaslighting resulted in Black women engaging in testimonial smothering, a situation in which a person attempts to “demonstrate testimonial competence” (p. 224) by altering or truncating their testimony to align the content of their experience with the expectation of the dominant audience ([Dotson, 2014](#)). Treating aspects of patient experience dismissively can be profoundly unsettling and creates a sense of doubt about the reality of their experience ([Carter, 2022](#); [Reynolds, 2020](#); [Sebring, 2021](#)). Medical gaslighting of Black women contributed to silencing and masking of their symptoms, thereby depriving healthcare providers of the vital information to properly diagnose and treat their pregnancy and childbirth-

related concerns. This finding supports those of earlier authors who reported that patients attempt to conceal or omit vital information about their health that they deemed would be perceived by healthcare providers to be clinically insignificant ([Kidd & Carel, 2017](#)). Medical care decisions depend on open and honest dialogue between nurses, healthcare providers, and patients. A negative care experience not only compromises the ability of Black women to communicate their health concerns but can also force them to obscure credible information that is required to provide appropriate interventions. As reported in our study, the failure to listen to Black women may result in their refusal to seek care, thus increasing their risk for adverse health outcomes.

Pregnant women are more vulnerable to medical gaslighting because their embodied knowledge about pregnancy is more likely to be dismissed or discounted ([Freeman, 2015](#)). However, being pregnant provides women the unique and intimate knowledge about their bodies that includes “learning, adapting, and performing” ([Neiterman, 2012](#), p. 372) that goes beyond biomedical and technologically mediated knowledge. While embodied knowledge and perspectives are a vital component in

making decisions during pregnancy and childbirth, medical gaslighting may contribute to the emotion of disembodiment when emphasis on scientific evidence is prioritized over the subjective patient experience. Although the Black women in our study reported labor pains and other life-threatening symptoms, their accounts were disbelieved and trivialized by healthcare providers, and in some instances, they were branded as being hysterical. As a result, many participants experienced differential access to pain management during labor including treatment for other life-threatening conditions. Researchers examining disparities in pain treatment found that racial bias and prejudice held by healthcare providers contributed to inequity in access to pain treatment among African American patients ([Hoffman et al., 2016](#); [Schoenthaler & Williams, 2022](#)).

While no evidence in our data supported the link between medical gaslighting and poorer maternal health outcomes, researchers reported that delayed diagnoses and worsening health outcomes are major consequences of medical gaslighting ([Carter, 2022](#)). This finding within the current study reveals that AMG may contribute to poorer maternal and newborn outcomes yet is rarely

acknowledged and considered in the broader interventions to address the growing maternal health crisis. Black women may choose to stay at home and suffer in silence or seek alternate care for an obstetric health issue, which may increase their risk for severe maternal health complications and mortality. Because AMG is consistent with psychological abuse, prolonged experience may contribute to internalized trauma, increased self-doubt, lead to a sense of isolation, and avoidance of the healthcare system completely, which may lead to worsening health outcomes. Being dismissive can be emotionally traumatizing and may be detrimental for one's mental health and wellbeing.

Implications for nursing research, practice, and education

Addressing medical gaslighting in healthcare is critical to advancing health equity in maternal health and promoting optimal health outcomes. This begins with targeting racial bias in the training and education of nurses and healthcare professionals. Opportunities in education that dispel myths about biological differences in pain, as well as reflections to

cultivate structural humility ([Schoenthaler & Williams, 2022](#)) are key to combating AMG in practice. Identifying and highlighting structural and epistemic biases inherent in medical gaslighting is imperative to reshape how nurses and healthcare providers perceive and make sense of Black women's experiences. Because healthcare and educational systems are potential sites for producing and reinforcing racial biases and stereotypes ([Boakye & Prendergast, 2024](#)), it is of critical importance to dispel prejudice and de-emphasize the biomedical approach to evaluating Black women's health concerns. Instead, a focus on appraising and interpreting Black women's embodied experience from their perspective alongside medical knowledge is necessary to turn off medical gaslighting. Moreover, increasing the representation of Black health professionals within the healthcare system will foster an environment for Black women to feel heard and understood. Further, increasing the awareness of nurses and other healthcare professionals about the detrimental impact of AMG on the maternal and mental health outcome of Black women is urgently needed. Healthcare institutions need to hold nurses and other healthcare providers

accountable for any acts of medical gaslighting to protect and support all patients accessing and receiving care.

It is also imperative for nurses and healthcare providers to cultivate a culture of active listening and develop sensitivity to the embodied experiences of Black women. Active listening requires healthcare providers to practice 'narrative humility' ([Svenaeus, 2019](#)) and 'phenomenological sensitivity' ([DasGupta, 2008](#)). Practicing narrative humility and phenomenological sensitivity enables the hearer to suspend their prejudice and judgment about the speaker and empathically engage with them to recognize and acknowledge their concerns and respond appropriately ([Carel & Kidd, 2014](#); [DasGupta, 2018](#)). Engaging in narrative humility, will enable nurses and healthcare providers to recognize the experiences of Black women are "not merely receptacles of facts, but that every story holds some element of the unknowable" ([Dasgupta, 2018](#), p. 11). Through practicing narrative humility, healthcare providers can gain insight into patient experiences while reflecting on how their prejudice and privilege shape the act of listening and interpreting the concerns voiced by patients. This can in turn contribute to race conscious praxis

among nurses and healthcare providers.

Listening without prejudice and judgement invokes empathy and ensures that nurses and healthcare providers are open to understanding the feelings and emotions of the speakers' words but also the humanity behind the words. Listening empathically builds trust and empowers patients to divulge more information about their concerns. Being heard humanizes the patient and ensures nurses and healthcare providers understand the structural conditions that influence health and respond to the needs of patients, particularly Black women.

The major strength of this study is that it is the first to provide insight into the experiences and pervasiveness of AMG in Black women's healthcare encounters.

Limitations of this study include the exclusion of the perspective of nurses and healthcare providers. Therefore, subsequent research should examine nurses and healthcare providers' perspectives on medical gaslighting.

Furthermore, the study did not explore ways medical gaslighting may contribute to adverse maternal health outcomes. Given the consistent disparities in adverse maternal outcomes among Black women, further research is needed to examine the relationship between medical gaslighting

and adverse maternal health outcomes.

Conclusion

Black women identified AMG as a major factor contributing to differential and inequitable access to care and treatment during pregnancy and childbirth. The experiences of Black women highlight the ways in which racial stereotype and the privilege of biomedical ways of knowing contribute to unequal health care interactions and deliberations. The experiences of Black women outlined in this paper supports the need for training nurses and healthcare providers at the educational level and at their place of practice. The training should encompass not just the racial stereotypes and prejudice in both nursing/medical practice and education, but also promote a wider culture of listening with humility and humanizing the words of Black women seeking and receiving care during pregnancy and childbirth.

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Data availability statement

The data for this study is available, however, due to the personal and sensitive nature of the information, we are unable to share the data. Moreover, participants did not consent to sharing their data.

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