The toxic power dynamics of gaslighting in medicine

Sarah Fraser MSc MD CCFP

Early in the black-and-white movie *Gaslight,* the protagonist (played by Ingrid Bergman) sits alone in her bedroom. As she stares at a dimming gas-fueled lamp, confusion sets in. Did the light just dim on its own? Much later in the film, she questions this again, but this time screaming, convinced she is losing her mind. This film, and the play on which it is based, gave rise to the term *gaslighting*—a form of psychological abuse. Within the culture of medicine, gaslighting is a phenomenon I have both observed and experienced as a generalist. By recognizing gaslighting in medicine, this form of bullying can be brought to an end.

Set in London in 1880, *Gaslight* tells the story of a man who pushes his new wife to doubt her own sanity through a series of manipulative tactics. Among these cruel and subtle torments, he gradually dims their home's gas-fueled lights while vehemently denying doing so, causing his wife to question her own perception of reality. Gaslighting is when someone in power uses manipulation to make another person doubt his or her own judgment, or even sanity. The concept first gained traction as a construct in the psychological literature during the 1960s, and it pervades domestic and professional spaces to this day. For some who have experienced it, the feeling can be worse than physical abuse.[1]

Gaslighting between medical professionals

While I am writing about gaslighting between medical professionals, I do not wish to monopolize the term for this context. *Gaslighting* as a term has critical and established use describing abuse toward victims of intimate partner violence and patients. However, the term also deserves a place within the culture of medicine. As a woman who is also a family physician, I have been gaslit multiple times by colleagues in professional settings. Until recently, I did not have the right words to describe this aggression, nor did I understand the roots of its resulting disorientation. The tools to address it were outside my reach. As a generalist, when I interact with specialists, it is normally a positive and productive experience facilitated by mutual trust and respect. This made it all the more shocking when my specialist colleagues have used their status as an expert to try to convince me of something I know to be false or not in the best interests of my patients.

Let me walk you through a recent encounter that left me feeling uneasy and small. Worse, I doubted my own skills and the reality in front of me. While working as a hospitalist, a sick patient's imaging came back with concerning findings near the end of my workday. The specialist had been consulted by the emergency room physician early in the morning, but he had not yet seen the patient. I followed up with the specialist via a phone call later that day to review the worrying results.

On the phone he was quick to interrupt me, telling me he was "very, very busy." He was audibly frustrated; I was told I was disturbing him during a dictation. Thrown off base, I stumbled to justify my reason for calling. The specialist continued to cut me off, condescending in tone and dismayed at being disrupted "all day."

And so the gaslighting began. Within 1 minute, he had established a power dynamic: his time was more important than mine—my concern was nothing but part of the rabble lighting up his phone all day. He had established that the issue I was calling about was nonurgent before I could even state my case. Immediately, he created the grounds for me to doubt my judgment in calling.

Soon after, as I was sitting writing my notes, the same specialist came to see the patient and provide his clinical impression. After wrapping up the discussion about the patient, I braved to tell him that his communication with me earlier in the day had been inappropriate and disrespectful. Expecting dialogue and apology, I sat back in my chair and waited. What happened next was unexpected. The specialist asked me how long I had been out of residency. I answered him, grappling in my mind with an instinct to lie and present as older than my years. His response was "It gets easier." He advised me that I need not remind him to come see his patients, nor tell him how to do his job.

It was only much later, after active reflection and discussion with some trusted friends, that I realized this encounter had nothing to do with my medical abilities. By ignoring my statement regarding his disrespectful treatment of me and questioning my qualifications, the specialist established a pecking order and demanded that I fall in line. For the rest of the conversation, I had no choice but to try to clamber up this hierarchy or risk sliding farther down. By dismissing my concerns about the patient and advising me not to tell him how to do his job, he implied that he doubted my judgment and pushed me to do the same. Experiences like the one I just described do not happen to me often, especially now that I am practising staff. But when I'm gaslit, it sticks with me.

The power struggle

Previous definitions of medical gaslighting have been used with respect to physicians gaslighting their

patients. In particular, gaslighting has been used by physicians to dismiss women's health problems,[2] enforcing the misogynist stereotype that women are irrational and "hysterical," a prejudice that dates back centuries. Even Hippocrates believed that the womb traveled throughout the body causing hysteria, a psychological diagnosis that was only removed with the updated *Diagnostic and Statistical Manual of Mental Disorders,* 3rd ed, in 1980.[3]

Indeed, gaslighting is entrenched in power structures. As women, we often lack the cultural, economic, and social capital to effectively gaslight men.[1] Patriarchal power structures are still alive and well in medicine and are only exacerbated by intersecting issues of age, social class, and race. The most striking and easily identifiable context might be the gaslighting of a younger, racialized, woman, non-specialized health care worker. The same inequalities that make her a target also make her powerless to call out this behaviour, putting her at risk of unjust scrutiny. Although anyone in a position of power can be a perpetrator, all of the physicians who have gaslit me during my medical career so far have been specialist men.

Gaslighting can be differentiated from other forms of bullying in medicine because it does not involve public humiliation, specific threats, or blatant insults. Gaslighting is more subtle than that. More private. This makes it all the more dangerous because it can remain invisible. While it might not result in full-blown delusions or distortions of memory, as with the dramatic portrayal in *Gaslight* or in violent relationships, this abuse can have lasting effects on the self-esteem and mental health of medical trainees and physicians alike. Lack of confidence is frequently cited as a reason women do not pursue leadership positions in health care.[4] To what extent has this issue been exacerbated by gaslighting?

Shining the light on gaslighting

In the case of my recent interaction, I recovered relatively quickly because I recognized the experience for what it was and had the confidence and resilience to stand up for myself. Later that evening, the specialist called me to apologize, stating that he had been feeling overworked and overwhelmed. He said he didn't mean to upset me. I can envision another situation though, where a preceptor gaslights medical students over successive months, and how this might erode the students' confidence to a point where they question the very core of their abilities and validity as physicians.

While the apology modestly lessened my anger, it didn't fix what happened. The positive side is that this experience did prompt me to finally label this harm. Perhaps we can invent a new word to describe gaslighting within the medical community itself or in the workplace more generally: *Medlighting? Professional gaslighting?*

As general practitioners, we rely on our specialist colleagues for support. We should not be treated as subordinate to specialists with the use of dangerous psychological tactics—just as we should not treat other members of the health care team this way. I hope sharing my experience can start a conversation about gaslighting in medicine and help bring this detrimental dynamic out of the shadows.

Dr Fraser is a general practitioner and Editorial Fellow for *Canadian Family Physician.*

Competing interests
None declared

References

1. Sweet PL. The sociology of gaslighting. *Am Sociol Rev* 2019;84(5):851-75. Epub 2019 Sep 20.
2. Noe Pagán C. When doctors downplay women's health concerns. *The New York Times* 2018 May 3. Available from: **https://www.nytimes.com/2018/05/03/well/live/when-doctors-downplay-womens-health-concerns.html**. Accessed 2021 Mar 29.
3. Tasca C, Rapetti M, Carta MG, Fadda B. Women and hysteria in the history of mental health. *Clin Pract Epidemiol Ment Health* 2012;8:110-9.
4. Glauser W. Rise of women in medicine not matched by leadership roles. *CMAJ* 2018;190(15): E479–80.

Can Fam Physician 2021;67:367. DOI: 10.46747/cfp.6705367

Artist: Ben Yong MD CCFP, Edmonton, Alta, and Yellowknife, NWT