

Medical gaslighting and epistemic violence: towards an ethics of recognition in contemporary clinical practice


Gaslighting médico y violencia epistémica: hacia una ética del reconocimiento en la práctica clínica contemporánea

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Abstract

Medical gaslighting, understood as a form of institutional manipulation that discredits the patient's experience, represents a structural manifestation of epistemic violence that undermines clinical trust and transforms

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healthcare into a space of cognitive exclusion. In this sense, the objective of this article is to critically analyze medical gaslighting as a form of epistemic and ontological violence based on the Kowalski case, with the aim of outlining institutional criteria and mechanisms aimed at the ethical transformation of clinical relationships. The analysis reveals three inter-related structural dynamics: testimonial discrediting, which invalidates the patient's voice; affective pathologization, which reinterprets their suffering as a sign of irrationality; and institutional rewriting of pain, which imposes an official version of the condition. It concludes that overcoming medical gaslighting requires reconfiguring healthcare practice based on the principles of epistemic justice, intersubjective recognition, and cognitive humility, which are essential conditions for restoring trust and the moral legitimacy of contemporary medicine.

Keywords: medical *gaslighting*, epistemic violence, bioethics, testimonial injustice, patient autonomy.

1. Introduction

The expansion of medical *gaslighting* within contemporary clinical practice reveals a deep fracture in the ethical and epistemic horizon of modern medicine. Beyond individual cases, it is a structural manifestation of the way in which medical knowledge, under the promise of objectivity, produces cognitive exclusion and interpretive violence against patients. The situation is paradigmatic because of a crisis of expert knowledge, as professional authority, which historically embodied scientific rationality and social trust, becomes a source of silencing and identity dispossession. Today, mistrust of patient testimony is legitimized through verification protocols, discourses of neutrality, and systems of evidence that, by subordinating lived experience to technical measurement, generate moral harm under the guise of care. In this context, the tragedy of the Kowalski case encapsulates the underlying problem: the impossibility of recognizing suffering when it does not fit into the categories of biomedical intelligibility.

The theoretical framework that allows us to understand this problem is rooted in Foucault's genealogy of power-knowledge, where modern medicine is instituted as a surveillance device that transforms the body into an object of scientific reading (1). The consolidation of the anatomico-clinical model and its subsequent expansion into techno-scientific biomedicine generated a regime of truth that privileges objective observation over the subjective narrative of suffering. In this way, modern medicalization has eroded the hermeneutic dimension of medical practice, replacing the understanding of meaning with the technical interpretation of symptoms (2). Contemporary developments in the theory of epistemic injustice (3) and the phenomenology of illness (4) take up and expand on this critique, showing that the exclusion of the patient as a subject of knowledge constitutes a form of structural violence that affects their moral and ontological agency. These perspectives converge on the idea that medical *gaslighting* is not an accidental phenomenon, but rather the logical result of a model of knowledge that associates authority with neutrality and discredits subjectivity in the name of evidence.

However, despite theoretical advances in epistemic injustice and the ethics of recognition (5,6), there remains a knowledge gap regarding how forms of medical *gaslighting* manifest and reproduce institutionally in contemporary practice. Bioethics literature has extensively addressed the dilemmas of paternalism and autonomy (7,8) but has tended to treat the problem in normative terms, without considering the ontological and hermeneutic dimension of epistemic harm. Similarly, clinical studies on physician-patient communication tend to focus on behavioral or empathic variables, omitting the structure of power and legitimacy that underlies testimonial discredit. This lack of integration between epistemology, phenomenology, and bioethics prevents us from understanding the depth of the phenomenon, which is not limited to a lack of individual empathy but involves a crisis of rationality in medical practice.

The research acquires relevance precisely in this area of theoretical and practical intersection. Critically analyzing medical gaslighting

allows us to see how medical knowledge regimes shape the conditions that make moral damage and ontological dispossession of the patient possible. The justification for this work lies in the urgent need to rethink clinical relationships as a space for epistemic co-production, in which technical knowledge and lived experience engage in dialogue on an equal footing. Faced with the technocratic tendency to reduce the medical act to data management and protocol compliance, it is necessary to recover the hermeneutic dimension of care, where listening to and believing the patient are not gestures of benevolence, but epistemological and ethical requirements.

The practical implications of this analysis are projected onto the institutional, educational, and professional levels. In the clinical setting, recognizing medical gaslighting as a structural phenomenon requires the incorporation of experiential knowledge into diagnostic and therapeutic processes, as well as the creation of appeal mechanisms that guarantee epistemic justice (9).

In the field of training, medical education must integrate the phenomenology of suffering and the ethics of care as central components of professional competence, overcoming the technical reductionism that privileges efficiency over understanding. At the institutional level, there is an urgent need to review registration and evaluation systems that, by rendering the patient's voice invisible, perpetuate the structural discrediting of their testimony. Such transformations would not only reduce harm but also reorient medical practice toward a deliberative rationality based on epistemic respect and moral reciprocity.

The problem of medical *gaslighting* is also linked to broader contemporary challenges related to the digitization of knowledge and the crisis of legitimacy in the biomedical professions. The rise of algorithmic medicine, the fragmentation of the clinical encounter, and the pressure of management models oriented toward economic results have exacerbated the disconnect between professionals and patients (10). In this context, the figure of the physician as the guarantor of truth is strained by new forms of technological mediation

that, while promising diagnostic accuracy, tend to dehumanize the experience of care. This scenario requires rethinking medical ethics not only as a normative code but as a reflective practice that recognizes interdependence and shared vulnerability as the cornerstones of the therapeutic relationship (11,12).

Within this framework, the objective of this article is to critically analyze medical *gaslighting* as a manifestation of epistemic and ontological violence in contemporary clinical practice through the Kowalski case, in order to outline criteria and institutional mechanisms aimed at the ethical transformation of the clinical relationship. The contribution of the study lies in offering a theoretical articulation that combines epistemic justice, the phenomenology of suffering, and relational bioethics to propose a reformulation of medical practice centered on intersubjective recognition and the reconstruction of clinical trust. Ultimately, the research aims to strengthen the foundations of a more reflective and just medicine, capable of reconciling scientific rationality with an ethical understanding of human suffering and restoring the moral sense of healing as an act of encounter, not domination.

2. Medical *gaslighting*: power, knowledge, and authority in clinical practice

A deep understanding of medical *gaslighting* requires placing it within the historical framework of the relationships between power and knowledge that shape modern medicine. Along these lines, medical knowledge became established in the 18th and 19th centuries not only as an enterprise of knowledge, but also as a device of social control, by medicalizing existence and transforming the body into an object of technical observation (1). This epistemological shift, from a medicine centered on the patient's word to one centered on the objective observation of the body, established a cognitive hierarchy in which the doctor's voice gained supremacy over the patient's lived

experience. This asymmetry gave rise not only to diagnostic and therapeutic practices, but also to structures of authority that shape what is considered true or legitimate within the clinical field.

From a critical perspective, the theory of epistemic injustice offers analytical tools for understanding how this hierarchy translates into the systematic exclusion of the patient as a subject of knowledge. Such exclusion manifests itself when the patient's testimony is devalued by identity-based prejudices or by a lack of conceptual resources to express their experience (3). In clinical practice, this dynamic translates into a pattern of testimonial discredit where the patient's word loses weight in the face of technical knowledge, especially when the person belongs to historically marginalized groups or suffers from conditions that challenge the dominant diagnostic framework (13).

Complementarily, contemporary medical phenomenology broadens the understanding of the problem by considering illness not as mere biological dysfunction, but as a transformation of the patient's being-in-the-world (4). The experience of illness involves alterations in corporeality, temporality, and intersubjectivity that can only be understood from the first person. Denying this perspective constitutes not only an epistemic error but also a form of ontological violence, as it implies disregarding the subject's lived reality and depriving them of their ability to make sense of their suffering. Discrediting the patient's account interrupts their process of narrative reconstruction, depriving them of an essential dimension of their identity and autonomy.

On an empirical level, Maya Kowalski's situation allows us to clearly observe how such mechanisms work. The patient suffered from complex regional pain syndrome, a condition characterized by intense suffering and pathophysiological mechanisms that are not yet fully understood (14). The epistemic ambiguity inherent in the condition, combining limited objective manifestations with extremely subjective pain, led to a medical reinterpretation that transformed her testimony into suspicion. The institutional decision to attribute the symptoms to maternal manipulation operated as a double epistemic

injustice, simultaneously disqualifying the patient's voice and pathologizing family support. This response was not based on new evidence, but on professional prejudices about the reliability of young patients or women with high emotional expressiveness.

On a more structural level, the concentration of epistemic authority in the figure of the physician is expressed in the control of the communicative agenda, the unilateral determination of the relevance of information, and the imposition of clinical interpretations that are presented as objective truths (9). Although this asymmetry may have a technical basis, it becomes an instrument of domination when the professional systematically disregards the patient's experience. At the same time, the institutionalization of protocols and recording systems focused on the measurable reinforces the exclusion of the subjective. Consequently, evidence-based medicine, when interpreted in a reductionist manner, can become a mechanism of epistemic marginalization that invalidates knowledge that cannot be translated into quantifiable data (15).

As techno-scientific rationality imposes itself as a model of knowledge, medicine runs the risk of losing its hermeneutic dimension, which allows us to understand the patient as a narrative whole situated in a unique life horizon (2). The mechanical application of algorithms and clinical guidelines tends to eclipse the interpretation of meaning, an indispensable element in addressing cases that escape rigid diagnostic categories. In this context, medical practice becomes dehumanized by replacing the encounter with the person with an instrumental reading of the sick body.

Institutional mistrust of patient testimony is exacerbated when protection protocols, such as those designed to detect child abuse or Munchausen syndrome by proxy, are applied with a presumption of suspicion. In such cases, the precautionary principle becomes a punitive device that reverses the burden of proof, forcing families to prove their innocence.

In the case of Maya Kowalski, the forced separation from her mother was more a response to the dissonance between reported pain and clinical findings than to verifiable evidence of abuse, which

led to a serious deterioration in her physical and psychological condition (14).

On the other hand, the epistemology of testimony emphasizes that the knowledge of others constitutes a legitimate source of truth and that rationality requires accepting accounts in the absence of well-founded reasons to doubt them. This principle is particularly relevant in the clinical relationship, where the patient has irreplaceable access to their own experience. Systematically questioning this epistemic authority is tantamount to undermining the conditions of possibility of medical knowledge and accurate diagnosis (13). The patient is not simply a transmitter of symptoms, but a collaborator in the construction of clinical knowledge.

Consequently, the epistemic violence that characterizes medical *gaslighting* is perpetuated under a discourse of objectivity and care that legitimizes the exclusion of the patient in the name of their protection. Under this rhetoric, the medical institution exercises a biopower that defines the boundaries between normal and pathological, between credible and illusory, between what deserves attention and what is dismissed as invention. Such an operation, protected by scientific authority, not only disciplines bodies but also shapes subjectivities by imposing a single legitimate version of reality (1).

An analysis of the dynamics of power and knowledge that underpin medical *gaslighting* reveals that its impact extends beyond the epistemological realm, penetrating the moral core of clinical practice. This observation leads to the need to examine the specific ethical implications of such asymmetries, particularly in relation to the fundamental principles of contemporary bioethics, whose violation reveals the extent of the moral damage that epistemic violence produces within the therapeutic relationship.

3. Bioethical transgressions: autonomy, beneficence, and justice in crisis

The evaluation of medical *gaslighting* in light of bioethical principlism reveals interdependent transgressions of the principles of autonomy,

beneficence, non-maleficence, and justice, whose violation reveals the depth of ethical damage that permeates clinical practice. However, understanding these violations requires going beyond the formal application of principles to examine how the relational foundations of medical ethics are eroded and the therapeutic relationship is transformed into a space of structural subordination.

In relation to autonomy, it is clear that medical *gaslighting* nullifies it at its root by undermining the patient's epistemic competence, understood as the ability to know their own experience, make reasonable judgments about their condition, and actively participate in decisions concerning their care. When the medical institution invalidates this capacity and reduces the patient's voice to emotional noise or a symptom interpreted from outside, informed consent becomes an empty formality, incapable of guaranteeing genuine deliberation (9). The loss of autonomy is not limited to the individual sphere, as it also affects the family environment, where lay knowledge and affective care are delegitimized in the face of technical authority.

In Maya Kowalski's situation, the nullification of autonomy took many forms. The distrust of her testimony about pain implied a denial of her cognitive ability to describe her own body and, simultaneously, a pathologization of the maternal figure, considered emotionally unstable and manipulative. The suspension of medical custody, decided without family consent and based on the presumption of irrationality, consolidated the replacement of parental judgment by institutional imposition (14). This approach reactivated the medical paternalism that contemporary bioethics had attempted to overcome by affirming that the patient's well-being cannot be defined without reference to their values and preferences (7). As a result, medical practice ceased to be guided by respect for self-determination and instead reproduced a tutelary logic that legitimizes the exclusion of the patient and their family in the name of protection.

On the other hand, the principle of beneficence, conceived as the duty to promote the well-being of the patient, is distorted when the professional imposes their interpretation of the good without

considering the experience of the other. Genuine beneficence requires deliberative dialogue that incorporates the patient's experiential knowledge as a legitimate source of understanding of suffering. In the absence of such exchange, the act of care is degraded into an authoritarian exercise that can cause harm under the guise of protection. In practice, the suspension of the analgesic treatment that provided relief to Maya was justified on the grounds of preventing pharmacological risks, without recognizing that uncontrolled suffering represented greater harm and that the measure contravened her own testimony about the effectiveness of the treatment. The result was clinical and emotional deterioration that transformed the supposed beneficence into a form of covert maleficence (14).

The violation of the principle of non-maleficence takes on a singular gravity here, since the harm caused is not limited to side effects or technical errors, but involves moral, psychological, and ontological damage. Being treated as a malingerer or delusional, having the reality of one's pain denied, and losing control over vital decisions lead to identity disintegration and moral trauma.

The persistent denial of subjective experience is equivalent to a form of psychological abuse that destroys confidence in one's own perception and fragments the continuity of the self (6). The Kowalski family tragedy, with the mother's suicide and the profound deterioration of Maya's physical and mental health, highlights the destructive potential of such institutional violence when exercised with the legitimacy of expert knowledge.

In turn, the principle of justice reveals the structural dimension of the problem. Medical *gaslighting* is not distributed randomly, but falls most frequently on women, patients with chronic or poorly understood illnesses, racial minorities, and vulnerable socioeconomic groups. This asymmetry highlights the persistence of institutionalized biases that determine which testimonies are considered credible and which are dismissed as irrational or emotional (6,16). Procedural justice is also compromised, as victims of epistemic discrediting often lack effective channels to appeal medical decisions or challenge

misdiagnoses. In the Kowalski case, the intersection of gender, age, and family position amplified vulnerability, consolidating a pattern of institutional injustice that stripped the patient and her mother of all agencies within the clinical process.

However, the analysis cannot be limited to identifying violations of principles, since moral damage exceeds the normative dimension and affects the very essence of the clinical encounter. Medical ethics is not limited to the application of abstract rules, but involves a fiduciary relationship based on trust, empathy, and recognition of the other as an end in itself (15). When the professional assumes exclusive authority over the truth of another's body and ignores the voice of the sufferer, medicine ceases to be a moral practice and becomes a technology of control. Medical *gaslighting* thus embodies the degradation of care into domination, the replacement of dialogue with imposition, and the loss of the ethical sense that should underpin all therapeutic intervention.

A review of the bioethical transgressions associated with medical *gaslighting* shows that the violation of the principles of autonomy, beneficence, and justice not only causes moral harm but also a deeper disintegration that affects the constitution of the subject. Understanding this dimension requires moving from normative to ontological analysis, exploring how the institutional denial of the patient's testimony destroys their narrative identity and fragments their experience of self.

4. Identity dispossession and fragmentation of the patient

The depth of the damage caused by medical *gaslighting* is particularly evident in the dissolution of the patient's ontological and narrative integrity. Personal identity cannot be understood as an immutable substance, but rather as a narrative construction that is configured through the organization of the past, present, and future projections

into a coherent web of meaning (17). Such a narrative structure is indispensable for sustaining psychic continuity in the face of the onset of illness, since suffering and bodily alteration threaten to fracture the coherence of the self. The possibility of narrating the experience of illness and obtaining social validation of that narrative is therefore an essential component of existential coping, without which the patient is suspended in a symbolic void that hinders the understanding of their own existence.

In this sense, medical *gaslighting* destroys narrative capacity by systematically denying the validity of the patient's experience. When the medical system discredits the patient's testimony, it produces not only epistemic injustice, but also narrative violence that deprives the subject of the ability to make sense of their suffering and obtain recognition of their experience. Such denial takes on a devastating character because the narration of illness is not an accessory gesture, but an ontological necessity linked to the maintenance of agency. Transforming pain into a narrative allows the continuity of the self to be reconstituted and a horizon of possibility to be projected beyond the crisis, a process that is a basic condition of resilience (18).

According to this logic, when the medical institution rejects the patient's narrative, labeling it illusory or fraudulent, it forces the patient to inhabit an existentially unsustainable position. The most immediate and tangible experience of their life, their own pain, is returned to them as fiction or misperception. The tension between knowing that one is suffering and being declared an impostor generates identity dispossession, understood as the loss of the ability to sustain a coherent narrative about oneself and the meaning of one's experience (19). This fracture of epistemic confidence in one's own perception not only compromises the relationship with the health-care system but also erodes self-understanding and practical agency in everyday life.

From the perspective of medical phenomenology, illness is conceived as a radical transformation of being-in-the-world that reconfigures the essential dimensions of existence: corporeality, which

becomes the object of constant attention; temporality, which is reorganized around treatments and symptoms; spatiality, which is restricted to clinical and domestic contexts; and intersubjectivity, which is altered by stigma and dependence (4). Such an ontological transformation requires recognition by others, especially those who hold interpretive authority over the medical experience. When that recognition is denied, the patient becomes trapped in a form of existential alienation where their suffering finds no witness or shared language, deepening their sense of isolation and derealization.

The case of Maya Kowalski exemplifies these dynamics with particular harshness. Her complex regional pain syndrome profoundly altered her relationship with her body, limited her functional autonomy, and transformed her life horizon. The institutional interpretation of her symptoms as the result of maternal psychological manipulation implied a denial of the reality of that transformation, imposing an external narrative that delegitimized her experience. By declaring that her pain was fabricated or induced, she was denied the status of an epistemic and moral subject. The implicit demand to accept this medical reinterpretation forced Maya to live with an unbearable contradiction: recognizing her suffering while health authorities publicly denied it (14).

According to recognition theory, individual identity depends on the intersubjective confirmation of three dimensions: affective recognition that affirms the intrinsic value of the subject, legal recognition that confirms their status as a rights holder, and social recognition that validates their abilities and contributions (5). Medical gaslighting simultaneously violates all three, as it involves emotional rejection, denial of rights, and cognitive degradation.

The patient is reduced to an object of suspicion, their testimony is interpreted as delusion or manipulation, and their moral value is questioned. Such denial of recognition causes moral harm because it destroys the subject's confidence in their own legitimacy, generating persistent feelings of shame, helplessness, and self-contempt.

The psychological effects of this denial have been widely documented in the literature on interpersonal *gaslighting*, which describes

symptoms of anxiety, depression, disorientation, and dissociation as typical responses to sustained manipulation (20). In the medical context, these consequences are intensified by the institutional authority that surrounds the professional voice, making it difficult for the patient to sustain an alternative interpretation of their reality. Physical vulnerability and dependence on care exacerbate this asymmetry, transforming the therapeutic relationship into a structural form of legitimized abuse.

In Maya Kowalski's experience, the prolonged denial of her reality culminated in a tragedy that goes beyond the clinical sphere. The death of her mother, the result of psychological distress caused by institutional stigmatization, shows how medical *gaslighting* can have lethal consequences when practiced without checks and balances or review mechanisms. At the same time, Maya's physical and emotional health deteriorated severely during the months of forced separation and therapeutic suspension, demonstrating the interaction between psychological damage and somatic aggravation (14).

The temporality of trauma induced by medical *gaslighting* shows that its effects extend beyond the initial episode. The loss of confidence in one's own judgment and in the good faith of the healthcare system generates a form of moral iatrogenesis that hinders the future search for care. Patients who have suffered institutional discredit tend to develop avoidance, self-censorship, and mistrust behaviors that compromise their access to timely treatment (6). Such erosion of the relationship between patient and system constitutes cumulative social harm, as it perpetuates health inequalities and undermines the ethical legitimacy of medicine as a care-oriented practice.

The impact is not limited to the individual but extends to their relational network. In Maya's case, the pathologization of the maternal bond destroyed the emotional structure that sustained her coping process. The disintegration of the family, mediated by state intervention, amplified the suffering and introduced a collective dimension to the damage. The illness ceased to be a shared experience and became a field of institutional conflict, which suppressed the emotional support essential for recovery.

Narrative identity, as conceived in hermeneutic philosophy, requires an audience that listens to, believes, and confirms the subject's story (17). When the medical environment refuses to play that role, it deprives the patient of recognition and abandons them in their vulnerability. Such abandonment constitutes a serious moral failing, because the essence of medicine lies precisely in the presence of solidarity in the face of suffering. The fiduciary commitment of care demands recognizing the other as a subject of experience and not as a mere object of clinical observation (7). To deny this recognition is to renounce the ethical core of the profession and betray its most basic promise: to accompany, listen to, and believe the patient in their pain.

The examination of the identity dispossession resulting from medical *gaslighting* highlights that the damage cannot be repaired solely through symbolic recognition or individual empathy but requires structural transformations in the ways of knowing and caring. Consequently, there is a need to outline a proactive framework that articulates epistemic justice, intersubjective recognition, and the ethics of care as the foundations for reconfiguring the clinical relationship in terms of cognitive equity and moral legitimacy.

5. Towards epistemic justice and intersubjective recognition in clinical practice

The identification of medical *gaslighting* as a form of epistemic and ontological violence requires a response that transcends superficial corrective interventions and is oriented towards structural transformations of medical epistemology and the institutional frameworks that regulate healthcare practice. Overcoming this form of harm requires modifying the very foundations of the clinical relationship, rethinking the assumptions of authority, rationality, and knowledge that have historically legitimized the exclusion of the patient as an epistemic subject. The aim is not to adjust communication protocols or improve individual attitudes, but to reconstruct the ethical and

epistemic conditions of the clinical encounter on the principles of cognitive justice, intersubjective recognition, and dialogical rationality.

From this perspective, the notion of epistemic justice offers an indispensable starting point, as it allows us to understand how equity in the production and validation of knowledge implies recognizing the testimonial authority of the patient as a legitimate source of clinical truth (3). Achieving such justice requires reversing the traditional assumptions of positivist medicine, which tends to distrust the subjectivity of the patient. Instead of requiring the patient to prove the veracity of their experience, it is up to the professional to justify any doubts about their testimony with solid reasons. This reorientation involves adopting an ethic of active listening, where the patient's account is considered a constituent component of clinical knowledge and not an accessory piece of information subordinate to technical evidence.

This epistemic transformation must be embodied in verifiable institutional mechanisms. Incorporating experiential knowledge as clinical evidence involves developing methodologies that integrate the patient's perspective into diagnostic and therapeutic decisions, as well as establishing independent review bodies to act in situations of interpretative conflict. The existence of transparent and accessible appeal procedures would make it possible to correct the biases of authority that often exclude patients from deliberative processes. In addition, clinical documentation should record both objective findings and the patient's narrative, ensuring that their voice remains visible in the record and can be considered in subsequent reviews (9).

The paradigm of the ethics of care complements this reconstruction by placing the clinical relationship in the realm of human interdependence and shared vulnerability. Illness reveals the constitutive fragility of existence and forces us to recognize that healthcare is not merely the application of technical knowledge, but a moral practice guided by responsibility and empathy (11). Assuming this perspective requires shifting the ideal of the autonomous professional toward the figure of a relational subject who recognizes his or

her own finitude and the need for connection with others. The virtues associated with this ethic, such as receptivity, responsibility, relational competence, and contextual flexibility, redefine care as an activity situated in a horizon of moral reciprocity rather than expert mastery. This requires reforming medical education to integrate reflective and relational dimensions alongside technical knowledge, fostering listening skills, sensitivity to difference, and critical awareness of one's own biases.

In turn, the framework of intersubjective recognition offers additional normative foundations for rethinking the therapeutic bond. The clinical encounter must be structured in such a way as to guarantee the patient's affective, legal, and social recognition, which are indispensable conditions for preserving their identity integrity (5). Affective recognition implies responding to suffering with genuine presence and not with standardized empathetic simulation. Legal recognition requires respect for informed autonomy and the patient's right to participate in decisions that affect their body and life. Social recognition involves valuing their experiential knowledge and their ability to manage their own illness. This triple dimension of recognition dissolves paternalistic logic and orients the clinical relationship toward shared deliberation, in which the professional contributes technical knowledge while the patient introduces their perspective of value, their tolerance for risk, and their life priorities (6).

Communicative rationality provides another indispensable framework for understanding the discursive dimension of clinical justice. Communication oriented towards mutual understanding involves an exchange free of coercion, where interlocutors can question statements without fear of sanction and where the goal is understanding, not control (21). The practice of medical gaslighting is at the opposite end of the spectrum, as it replaces deliberation with manipulation and the search for agreement with the imposition of interpretations. Restoring authentic communication requires material and symbolic conditions that reduce unnecessary asymmetries, including the use of accessible language, adequate time for deliberation, and the profes-

sional's willingness to review their judgments in light of the patient's account. In this process, epistemic humility becomes a central virtue: recognizing the limits of medical knowledge and accepting uncertainty as a structural feature of clinical practice rather than hiding it under professional authority (12).

From a perspective rooted in the Latin American tradition, liberation bioethics introduces a critical dimension that emphasizes the need to dismantle the power structures that perpetuate epistemic subordination. Transforming medical practice requires not only individual adjustments, but also institutional redistribution of the power of interpretation over the sick body (22). This implies adopting a "preferential option" for patients historically vulnerable to gender, race, class, or diagnostic stigma biases, implementing monitoring mechanisms to detect and correct patterns of epistemic injustice. Institutional responsibility must extend beyond formal non-discrimination to the creation of material conditions that ensure effective patient participation in the design of clinical policies and protocols.

The necessary transformation also involves the field of education. Medical education has traditionally prioritized technical competence at the expense of ethical reflection and epistemic self-knowledge. Reversing this trend requires integrating content on epistemic justice, moral deliberation, and the phenomenology of suffering into medical education. Teaching experiences should encourage direct encounters with narratives of illness and promote self-criticism regarding the implicit biases that condition clinical perception (4). Scientific research, for its part, must broaden its validity criteria to include methodologies that value the patient's lived experience, avoiding reductionism that subordinates suffering to the logic of profitability or strictly biological verifiability (16).

At the same time, health policies must abandon the productivist model that rewards efficiency over listening and replace it with schemes that encourage relational quality and epistemic respect. Evaluating medical care solely on the basis of case volume or consultation times perpetuates the invisibility of the patient as a moral subject. Incorporating qualitative indicators that reflect whether people felt

listened to and recognized is an indispensable strategy for reorienting institutional culture toward genuine care. Similarly, meaningful patient participation in hospital decision-making bodies can become a counterweight to the technical monopoly of clinical power.

Certainly, a transformation of this magnitude will face resistance rooted in disciplinary traditions, economic interests, and hierarchical structures. Therefore, while structural changes are being consolidated, it is urgent to establish immediate safeguards to protect those who are in a situation of epistemic vulnerability. Specific clinical mediation protocols, mandatory training in the prevention of medical *gaslighting*, and appeal mechanisms with external oversight are minimum measures to contain the damage. In particularly sensitive situations, such as cases of state intervention in family custody, a higher standard of evidence is required to prevent irreversible decisions based on subjective interpretations or institutionalized prejudices (14).

The eradication of medical *gaslighting*, therefore, does not depend solely on individual goodwill, but on a comprehensive reconfiguration of the professional ethos, institutional structure, and epistemic conditions of contemporary medicine. Only practice based on cognitive justice, mutual recognition, and ethical communication can restore the lost trust between those who suffer and those who care for them, returning medicine to its original meaning of moral accompaniment in the face of human vulnerability.

6. Conclusions

Medical *gaslighting* constitutes a complex form of epistemic and ontological violence, rooted in the historical structures of power and knowledge that define modern medicine. The central theoretical intervention lies in revealing how the dynamics of institutional authority, technical language, and instrumental objectivity intertwine to silence the patient's subjective experience, generating a form of moral harm that transcends the clinical. Thus, ethical reflection on medical practice must shift from formal compliance with principles

to an analysis of the regimes of truth that shape the therapeutic relationship. When medicine disregards testimony and the recognition of otherness, it runs the risk of becoming a technology of discipline rather than a practice of care.

As a main conceptual contribution, an analytical framework is proposed that combines epistemic justice, the ethics of care, recognition theory, and communicative rationality to propose a reconfiguration of the clinical relationship. Such theoretical integration allows us to understand medical *gaslighting* not as an individual deviation, but as a symptom of a biomedical rationality that privileges objectifiable evidence over lived experience. By situating illness as an existential and relational phenomenon, the analysis proposes a medical ethic that recognizes the patient as an epistemic, moral, and narrative agent. This epistemic shift implies recognizing that clinical truth is constructed intersubjectively and that active listening constitutes a form of knowledge.

On a practical level, the implications of the study are broad. Institutional transformation requires the introduction of mechanisms that integrate the patient's perspective as a legitimate source of clinical evidence and as an active participant in deliberative processes. The incorporation of narrative methodologies in medical records, the creation of external review committees for cases of interpretive conflict, and the strengthening of medical training in relational skills represent concrete steps toward a more just medicine. In addition, health policies must reorient their incentives to value the quality of the clinical encounter over technical efficiency. Recognizing the ethical and communicative dimension of care means redefining the indicators of institutional success and promoting a professional culture based on epistemic humility and shared responsibility.

Projections for future lines of research invite further comparative study of how different sociocultural contexts shape specific forms of medical *gaslighting*. It is pertinent to explore how variables such as gender, race, class, and disability influence testimonial credibility within clinical practice. Likewise, empirical studies are needed

to evaluate the effectiveness of pedagogical interventions aimed at epistemic justice and the recognition of experiential knowledge. Complementarily, interdisciplinary dialogue between philosophy, clinical psychology, and social sciences could offer broader models for understanding the relationship between suffering, power, and knowledge in contemporary medicine.

Overcoming medical *gaslighting* requires a paradigm shift in the very understanding of medicine. Recognizing the patient as a subject of knowledge and experience is not a gesture of concession, but an ethical and epistemic requirement that restores the humanizing dimension to medical practice. Only through medicine that listens, dialogues, and accompanies will it be possible to restore trust and reconfigure the therapeutic bond as a space of shared truth. The restoration of the moral meaning of medicine will not be achieved through isolated regulatory reforms, but through a cultural renewal that conceives of care as an act of justice and knowledge as an encounter between vulnerabilities.

Statement on the use of artificial intelligence

OpenAI's GPT-5 extensive language model was used to identify and correct grammatical and stylistic errors. The command applied was: "review and correct all grammatical and stylistic errors." Subsequently, the resulting text was reviewed to ensure that it retained the tone, consistency, and intent of the original draft.

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