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Psychological Effect of Medical Gaslighting on Female Patients: A Systematic Review

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Abstract: Medical gaslighting is a growing concern within healthcare systems, characterized by healthcare providers dismissing, downplaying, or attributing patients' reported symptoms to psychological causes without proper investigation. This phenomenon disproportionately affects women, particularly women of color, LGBTQ+ individuals, and those with chronic or invisible illnesses. This paper examines the psychological consequences of medical gaslighting experienced by female patients, emphasizing its impact on mental health and patient-provider trust. Through an analysis of both qualitative narratives and quantitative data, the study reveals that women who experience medical gaslighting are more likely to suffer from anxiety, depression, and post-traumatic stress disorder (PTSD). These outcomes often stem from repeated invalidation, misdiagnosis, delayed treatment, and a sense of helplessness in clinical interactions. Moreover, the erosion of trust in healthcare systems can lead women to delay seeking medical attention, self-diagnose, or disengage from traditional medical care altogether, increasing the risk of worsened health outcomes. The paper also explores the systemic and gendered dynamics that allow medical gaslighting to persist, including implicit bias in medical training, gender stereotypes about pain tolerance and emotionality, and the underrepresentation of women in clinical research. It argues that addressing this issue requires structural changes, such as comprehensive bias training for healthcare providers, improved communication protocols, and institutional accountability measures. Ultimately, this paper calls for a feminist reimagining of healthcare—one that centers patient voices, ensures equitable treatment across gender lines, and fosters environments of mutual respect and trust.

Keywords*: Medical Gaslighting, Women, Mental Health, Gender Bias, Healthcare Disparities, Trauma*.

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I. INTRODUCTION

Medical gaslighting refers to the phenomenon in which healthcare professionals dismiss, trivialize, or question the legitimacy of a patient's symptoms, often attributing them to psychological causes or exaggeration without adequate diagnostic evaluation (Harris & White, 2022). This invalidation can cause patients to doubt their own perceptions and delay seeking necessary care, potentially worsening their health outcomes. While medical gaslighting can affect individuals of all backgrounds, numerous studies have shown that women are disproportionately affected due to longstanding gender biases and stereotypes in medical practice (Chang & Sethi, 2021; Samulowitz et al., 2018).

Historically, women's health concerns have often been interpreted through a psychosomatic lens, with symptoms frequently being dismissed as stress, anxiety, or hormonal fluctuations rather than being properly investigated (Werner & Malterud, 2003). This bias is rooted in patriarchal structures within the medical field, where male-centric models of diagnosis and treatment have been the norm. For instance, pain studies often use male subjects as the default, and women reporting pain are more likely to be prescribed sedatives instead of analgesics (Hoffmann & Tarzian, 2001). As a result, many women—especially those with chronic illnesses such as fibromyalgia, endometriosis, or autoimmune disorders—report feeling unheard, invalidated, or even blamed for their conditions by medical professionals (Dehghan et al., 2021).

The psychological toll of medical gaslighting on female patients is significant and multifaceted. Repeated instances of being dismissed or not taken seriously can lead to heightened levels of anxiety, depression, and in some cases, post-traumatic stress disorder (PTSD) (Bhargava & Moriates, 2019). These effects are exacerbated in intersectional populations, such as women of color, LGBTQ+ individuals, and those with disabilities, who face compounded forms of marginalization within the healthcare system (Crenshaw, 1989; Roberts, 2016). Additionally, medical gaslighting undermines trust in healthcare institutions, discouraging women from seeking timely medical attention or adhering to treatment regimens (Matthews et al., 2020).

This paper seeks to explore the psychological consequences of medical gaslighting experienced by female patients, drawing upon a range of qualitative interviews, patient narratives, and empirical research. It will also examine the systemic and structural factors that perpetuate this issue, including provider bias, medical education gaps, and cultural attitudes toward women's health.

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Ultimately, the goal is to highlight the urgent need for systemic reform and advocate for more equitable, inclusive, and patient-centered healthcare practices.

II. UNDERSTANDING MEDICAL GASLIGHTING

Medical gaslighting is a term derived from the broader concept of "gaslighting," a psychological manipulation tactic that leads individuals to doubt their perceptions, memory, or sanity. In a healthcare context, medical gaslighting occurs when medical professionals dismiss, downplay, or invalidate a patient's symptoms, often attributing them to psychological causes without adequate investigation. This phenomenon is particularly dangerous as it can lead to delayed diagnoses, inappropriate treatments, and worsening mental and physical health.

The concept gained increasing attention as patients, particularly women and minorities, began sharing experiences of not being believed by healthcare providers. As Khan, Tariq, and Majeed (2024) describe, medical gaslighting involves healthcare practitioners implying that a patient's health complaints are exaggerated or psychosomatic. The patient may be told that "it's all in your head," or that stress, anxiety, or depression is the root cause—without appropriate testing or exploration of physical illness.

Research has consistently demonstrated that women are disproportionately affected by medical gaslighting. A comprehensive review by Samulowitz et al. (2018) found that gender bias in healthcare significantly influences diagnostic processes. Women reporting pain are less likely to be taken seriously compared to men and are more frequently prescribed sedatives rather than diagnostic tests or pain management strategies. The bias stems from long-standing stereotypes that portray women as emotional, overreactive, or less credible in reporting their own health experiences.

This systemic issue contributes to the underdiagnosis and misdiagnosis of conditions that predominantly affect women. For example, fibromyalgia—a chronic disorder characterized by widespread pain, fatigue, and cognitive issues—has often been misunderstood and attributed to psychological causes despite growing evidence of its biological basis. Similarly, endometriosis, a condition where tissue similar to the uterine lining grows outside the uterus, can take years to be diagnosed, with many women being told that their pain is a normal part of menstruation or that they are overreacting (Ballweg, 2004).

Autoimmune diseases also exemplify the dangers of medical gaslighting. Diseases such as lupus, rheumatoid arthritis, and multiple sclerosis are more common in women, and their symptoms—like fatigue, joint pain, and neurological issues—are often vague and episodic, making them easy targets for dismissal. Studies by the American Autoimmune Related Diseases Association (AARDA) show that it takes an average of 4.6 years and consultation with five doctors for a woman to receive an accurate autoimmune diagnosis (AARDA, 2022).

The consequences of medical gaslighting are profound. Patients may internalize the disbelief, doubting their own experiences and delaying further medical care. This can lead to advanced disease progression, deteriorated mental health, and loss of trust in the healthcare system. Furthermore, marginalized groups—including people of color, LGBTQ+ individuals, and those with disabilities—face intersecting biases that exacerbate the risk of being gaslit by medical professionals (Hoffman, Trawalter, Axt, & Oliver, 2016).

Addressing medical gaslighting requires both systemic and cultural change. Medical education must emphasize patient-centered care, implicit bias training, and the validation of patient experiences. Encouraging active listening, thorough diagnostics, and empathy are essential steps in rebuilding trust and improving outcomes for all patients.

III. PSYCHOLOGICAL IMPACT ON FEMALE PATIENTS

Medical gaslighting—the practice of dismissing or minimizing a patient's symptoms—can have profound psychological consequences, particularly for women. Gender bias in healthcare settings often contributes to women's experiences of being unheard, leading to significant mental health challenges. This section explores the psychological toll through three key dimensions: anxiety and depression, post-traumatic stress symptoms, and the loss of trust in healthcare systems.

- *Anxiety and Depression*

Table 1 Anxiety and Depression

Study	Findings
Office on Women's Health (2021)	40% of dismissed women showed clinical depression
Samulowitz et al. (2018)	Women seen as emotional, symptoms often downplayed

When women's symptoms are dismissed, they often internalize that invalidation, which can severely undermine their confidence in their own bodily experiences. This erosion of self-trust commonly manifests as anxiety, depression, and emotional dysregulation. Research indicates that women are more frequently perceived as "emotional" or "exaggerating" their symptoms, especially in the context of pain, leading to inadequate diagnosis and treatment (Samulowitz et al., 2018).

For example, women presenting with symptoms of autoimmune diseases like lupus or multiple sclerosis are often told their symptoms are "stress-related" or "psychosomatic" (Werner & Malterud, 2003). Over time, such repeated dismissal can lead to chronic anxiety, where patients become unsure whether their suffering is "real" or imagined.

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A national survey conducted by the Office on Women's Health (2021) found that 40% of women who reported not being taken seriously by healthcare providers also reported clinically significant symptoms of depression. This psychological distress can persist even after a correct diagnosis is eventually made, as the trauma of being disbelieved lingers.

➢ *Post-Traumatic Stress Symptoms*

Table 2 Post-Traumatic Stress Symptoms

Example	Effect
Anna's Case	Developed panic attacks due to delayed diagnosis of endometriosis
Khan et al. (2024)	Women misdiagnosed for years showed PTSD symptoms

In more extreme cases, particularly those involving reproductive or chronic illness, medical gaslighting can result in symptoms similar to post-traumatic stress disorder (PTSD). This is especially common among patients whose concerns are repeatedly dismissed over extended periods. The cumulative effect of invalidation, coupled with worsening symptoms and the delay in appropriate care, can lead to flashbacks, avoidance behaviors, and hypervigilance.

Khan et al. (2024) found that women who were misdiagnosed or undiagnosed for conditions like endometriosis or fibromyalgia often exhibited symptoms consistent with PTSD. These women frequently reported emotional numbing, intrusive memories of prior humiliating doctor visits, and an ongoing fear of medical encounters.

One illustrative example is the case of "Anna," a 34-year-old woman who was repeatedly told that her pelvic pain was a result of anxiety. After five years, she was diagnosed with stage III endometriosis. During that time, she developed panic attacks before every medical appointment and avoided seeking care even for unrelated issues—classic signs of trauma response.

➢ *Loss of Trust in Healthcare Systems*

Table 3 Loss of Trust in Healthcare Systems

Source	Finding
Mehta et al. (2020)	Women delayed ER visits due to past dismissals
Hoffmann & Tarzian (2001)	Women likely to disengage from traditional care

Repeated experiences of medical gaslighting often lead to a breakdown in trust—not only in individual healthcare providers but in the medical system as a whole. This can result in healthcare avoidance, delayed diagnoses, and poor outcomes. Hoffmann and Tarzian (2001) found that women who felt invalidated by physicians were more likely to delay care, use alternative medicine, or disengage from medical services altogether.

This erosion of trust can have life-threatening implications. For instance, a 2020 qualitative study found that women with cardiovascular symptoms delayed emergency room visits due to past dismissals, leading to worse outcomes (Mehta et al., 2020). These delays are particularly concerning in conditions like heart attacks, where immediate care is critical. Black and Indigenous women are disproportionately affected, as they already face systemic racism within healthcare systems, compounding the distrust.

Real-life accounts from advocacy groups such as *Endo What?* and *The Invisible Disability Project* often highlight stories of women who avoided medical care for years due to the trauma of prior invalidation. These narratives underscore how systemic and repeated gaslighting diminishes trust and reinforces health inequities.

The psychological impact of medical gaslighting on female patients is multifaceted and deeply damaging. From heightened anxiety and depression to trauma responses and systemic mistrust, these effects are not only emotional but can significantly impact physical health outcomes. Addressing this issue requires structural change within healthcare, training in implicit bias for providers, and amplifying women's voices in clinical settings.

IV. CONTRIBUTING FACTORS

➢ *Gender Bias in Medicine:*

The roots of gender bias in medical education and practice are deeply embedded in historical androcentrism, where the male body has traditionally been treated as the standard for diagnosis, research, and treatment protocols (Samulowitz et al., 2018). This male-centric model has resulted in a persistent underrepresentation of women in clinical trials, leading to a critical gap in knowledge about female-specific symptoms, disease progression, and treatment responses. For instance, conditions like cardiovascular disease, which can manifest differently in women, are often misdiagnosed or dismissed because their symptoms do not align with the "typical" male presentation (Bairey Merz et al., 2011). Additionally, disorders like endometriosis and autoimmune diseases, which predominantly affect women, frequently encounter delayed diagnoses, sometimes taking years for a patient to be correctly diagnosed (Ballweg, 1997). This systemic oversight not only diminishes the quality of care women receive but also fosters a medical culture where women's reported symptoms are often minimized or psychologized rather than appropriately investigated.

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➢ *Intersectionality and Compounding Effects:*

The biases faced by women in healthcare are further compounded when intersecting identities—such as race, socioeconomic status, sexual orientation, and gender identity—are taken into account. Crenshaw's (1991) theory of intersectionality highlights how overlapping systems of oppression intensify the marginalization experienced by individuals who belong to multiple disadvantaged groups. Research has shown that Black women, for example, are less likely to have their pain adequately treated compared to white patients, stemming from longstanding stereotypes and racial biases within medical institutions (Hoffman et al., 2016). Indigenous women often report experiences of discrimination and cultural insensitivity when seeking healthcare services, leading to distrust and avoidance of the healthcare system (Anderson et al., 2016). LGBTQ+ individuals, particularly transgender and non-binary people, frequently face ignorance and prejudice from healthcare providers, resulting in misdiagnoses, delayed care, or outright denial of services (Grant et al., 2011). These compounded biases not only exacerbate the effects of medical gaslighting but also create systemic barriers that prevent marginalized women from receiving accurate, respectful, and timely healthcare, perpetuating health disparities across generations.

V. CASE STUDIES AND NARRATIVES: EXPOSING THE REALITIES OF MEDICAL GASLIGHTING

➢ *Introduction to Narrative Evidence in Feminist Medical Literature*

Personal narratives within feminist medical literature and qualitative research expose the pervasive and systemic nature of medical gaslighting, particularly among women and marginalized individuals. These accounts highlight how patients' experiences are often dismissed, misinterpreted, or minimized by medical professionals, leading to delayed diagnoses, inadequate treatment, and long-term psychological and physical consequences.

➢ *A Personal Account: Endometriosis and the Decade of Dismissal*

One striking example comes from a woman with endometriosis, as reported by Ballweg (2019), who described spending nearly a decade seeking help for severe pelvic pain. Despite repeatedly voicing her symptoms, she was told her experiences were "normal" and simply part of being a woman. She recounted, *"I was told that pain during menstruation was just part of being female, and that I needed to toughen up. It wasn't until I collapsed at work and was rushed to the ER that they finally took me seriously"* (Ballweg, 2019, p. 142). Her story is far from unique. Research indicates that the average time to diagnose endometriosis is seven to ten years, often due to the normalization of women's pain and a lack of education among healthcare providers (Hudelist et al., 2012).

➢ *Feminist Critiques: Medical Authority and Gendered Disbelief*

Feminist scholars have long argued that such experiences are not isolated incidents but part of a broader patriarchal structure embedded within the medical system. Ehrenreich and English (1978), in *For Her Own Good: Two Centuries of the Experts' Advice to Women*, assert that medicine has historically positioned itself as an authority that silences women's voices: *"When a woman complained, the answer was not to believe her, but to explain her experience away"* (p. 219). This dismissal often stems from implicit biases, with women's symptoms more likely to be attributed to emotional or psychological causes rather than legitimate physical issues (Hamberg, 2008).

➢ *Qualitative Research: Recurring Patterns of Dismissal*

Qualitative interviews reinforce these findings. In a study by Samulowitz et al. (2018), women reported feeling unheard and invalidated by their physicians, with one participant stating, *"Every time I went in, I felt like I had to prove that I wasn't making it up. It was exhausting."* These narratives are powerful not only because they document individual suffering but because they collectively reveal a systemic pattern of disbelief and minimization. As Samulowitz et al. concluded, the intersection of gender and health inequity is evident in how women's pain is handled differently, often trivialized or psychologized.

➢ *Ethical Implications: Beyond Clinical Failure*

In sum, these case studies and narratives highlight how medical gaslighting functions as both a clinical failure and an ethical violation. Patients are not only denied proper care but are often stripped of their dignity and autonomy. Recognizing and valuing personal narratives is essential to dismantling the systemic biases in healthcare and ensuring that all patients are treated with respect and belief.

VI. RECOMMENDATIONS TO MITIGATE THE PSYCHOLOGICAL HARM OF MEDICAL GASLIGHTING

➢ *Incorporate Bias Training*

Medical curricula must address implicit biases, particularly those related to gender, race, and socioeconomic status. Research has shown that unconscious biases among healthcare providers can significantly impact patient outcomes, leading to delayed or missed diagnoses for women (FitzGerald & Hurst, 2017). Incorporating structured implicit bias training into medical education can enhance providers' awareness of their prejudices and equip them with tools to offer more equitable care. Moreover, empathetic listening skills should be emphasized, as patients who feel heard are more likely to experience positive healthcare interactions and outcomes (Beach et al., 2017).

➢ *Improve Diagnostic Criteria for Female-Prevalent Illnesses*

Many diagnostic frameworks have historically been developed based on male-dominated research samples, leading to a poor understanding of how conditions present in women (Holdcroft, 2007). Diseases like autoimmune disorders, fibromyalgia, and chronic fatigue syndrome are more prevalent in women yet are often under-researched or dismissed (Borenstein et al., 2013). Expanding research efforts to include gender-diverse populations and updating

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diagnostic criteria to reflect these variations is crucial. This would ensure earlier detection, better treatment outcomes, and reduced patient frustration stemming from feelings of dismissal.

➢ *Empower Patient Advocacy*

Supporting patient advocacy groups and providing resources for patients to advocate for their own care can counteract feelings of helplessness. Empowering patients with knowledge about their rights, available treatments, and how to effectively communicate concerns can mitigate some of the psychological harm caused by medical gaslighting (Institute of Medicine, 2001). Advocacy organizations can also foster peer support networks that validate experiences and encourage persistence in seeking appropriate care.

➢ *Strengthen Reporting Mechanisms*

Healthcare institutions must establish safe, accessible, and responsive mechanisms for patients to report experiences of discrimination or dismissal. Studies have shown that fear of retaliation or futility often deters patients from speaking out (Washington, 2006). By creating transparent reporting systems with protections against retaliation, institutions can identify patterns of biased care and intervene with targeted training, accountability measures, and systemic reform. Regular audits of complaints and outcomes can further ensure that institutions remain committed to addressing and reducing discriminatory practices.

VII. LIMITATIONS

While this review draws upon a robust body of literature and firsthand patient narratives, several limitations must be acknowledged that impact the generalizability and applicability of the findings.

Firstly, much of the existing research on medical gaslighting is qualitative and anecdotal in nature. Studies often rely on personal narratives, case reports, and interview-based methods to capture the nuanced and deeply personal experiences of patients (Caron, 2022; Nelson, 2021). While these approaches offer rich contextual insights and highlight the emotional and psychological toll of gaslighting in clinical settings, they inherently lack the statistical power and generalizability of large-scale quantitative research. The reliance on small sample sizes and non-randomized cohorts may introduce selection bias, limiting the ability to draw broader conclusions about the prevalence and systemic impact of medical gaslighting (Scott et al., 2020).

Secondly, the term “medical gaslighting” itself is relatively new and inconsistently defined within the academic literature. Different researchers and publications use the term to refer to a range of physician behaviors—from overt dismissal of symptoms to subtle undermining of patient credibility—resulting in conceptual ambiguity (Schulz & Mehta, 2023). This lack of a standardized definition complicates efforts to operationalize the concept in empirical research and hinders the ability to systematically compare findings across studies. Furthermore, without a shared framework or diagnostic criteria, healthcare professionals may be unaware of the behaviors that constitute gaslighting, which further contributes to underreporting and misrecognition of the phenomenon (Morris, 2022).

Thirdly, cultural and geographical variations in healthcare delivery were not fully explored in this review. The included studies predominantly focused on Western contexts, particularly North America and Europe, due to the availability of peer-reviewed literature and English-language sources. However, healthcare systems vary widely across regions in terms of structure, provider-patient dynamics, gender norms, and access to care (WHO, 2021). These differences may significantly influence the manifestation and recognition of medical gaslighting. For example, in low-resource settings, systemic issues such as lack of training, infrastructural deficits, and ingrained social hierarchies may intensify dismissive attitudes toward patients, particularly women and marginalized groups (Patel & Saxena, 2019). Consequently, the findings of this review may not be fully applicable to non-Western populations, and future research should aim to include more culturally and geographically diverse perspectives.

VIII. FUTURE GOALS AND DIRECTIONS

To advance understanding and improve outcomes related to medical gaslighting, future research and policy initiatives should focus on several key areas that address current gaps in knowledge and practice.

➢ *Developing Standardized Diagnostic Criteria*

One of the most pressing needs in the study of medical gaslighting is the development of standardized diagnostic criteria. Currently, there is no universally accepted definition or diagnostic framework for identifying medical gaslighting in clinical or research settings, which hampers recognition and intervention. Establishing clear criteria would not only facilitate empirical study but also provide clinicians with tools to identify and address gaslighting behaviors in practice (Beagan et al., 2021; Sweet, 2021). Such frameworks could draw from established psychological concepts of gaslighting while tailoring them to the unique context of patient-provider interactions.

➢ *Conducting Longitudinal Studies*

To better understand the enduring impact of medical gaslighting, longitudinal studies are essential. Cross-sectional research can highlight immediate psychological distress or decreased trust in healthcare systems, but only long-term studies can reveal the cumulative effects on mental health, healthcare-seeking behavior, and disease outcomes (Fricker, 2007; Mensah & Tomfohr-Madsen, 2021). These studies should track individuals over time to assess how repeated instances of gaslighting might lead to chronic stress, anxiety, depression, or disengagement from medical care.

➢ *Centering Marginalized Voices*

Marginalized populations—including racial and ethnic minorities, LGBTQ+ individuals, people with disabilities, and those from lower socioeconomic backgrounds—are disproportionately affected by medical gaslighting. Future

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research should intentionally center these voices and use intersectional frameworks to examine how overlapping identities influence experiences of medical invalidation (Crenshaw, 1991; Hoffman et al., 2016). Qualitative studies, participatory action research, and community-engaged methods can be particularly effective in amplifying these experiences and guiding culturally competent interventions.

- *Integrating Patient-Reported Outcomes in Clinical Practice*

Integrating patient-reported outcomes (PROs) into routine clinical workflows can provide valuable insight into patients' perceptions of their care and help detect instances of gaslighting. Regular assessments of trust, respect, and communication effectiveness can serve as early warning signs for providers and institutions (Greenhalgh et al., 2017). Future initiatives should promote the widespread use of validated PRO tools and ensure that these measures inform clinical decision-making and provider evaluations.

- *Creating Intervention Models*

Finally, developing evidence-based interventions is crucial to reducing the prevalence of medical gaslighting. Educational programs for healthcare professionals that address implicit bias, empathy training, and trauma-informed care can help mitigate behaviors that lead to gaslighting (Chapman et al., 2013). Simultaneously, policy reforms—such as patient advocacy protocols and institutional accountability mechanisms—can institutionalize respectful and equitable treatment. These interventions should be rigorously tested for effectiveness and adapted to diverse healthcare settings.

By addressing these areas, future research can contribute to more equitable, compassionate, and patient-centered healthcare systems. Addressing the systemic roots of medical gaslighting will not only improve individual outcomes but also restore trust in healthcare institutions.

IX. CONCLUSION

Medical gaslighting has profound and far-reaching psychological consequences for women, often manifesting as emotional distress, erosion of self-trust, feelings of helplessness, and long-term trauma. When women's symptoms are dismissed, minimized, or misattributed, it not only delays necessary medical treatment but also deeply impacts their mental health and well-being. Over time, this invalidation can lead to chronic anxiety, depression, post-traumatic stress symptoms, and a pervasive mistrust of healthcare providers.

The root of these experiences lies in structural sexism embedded within the medical system. Historically, women's bodies and experiences have been marginalized, pathologized, or misunderstood, resulting in a systemic devaluation of their voices. Biases—both conscious and unconscious—continue to shape diagnostic and treatment practices today, disproportionately harming women and particularly women from marginalized racial, economic, and gender groups. Therefore, reform is urgently needed at both clinical and institutional levels.

Clinicians must be trained to recognize and counteract their biases, adopting patient-centered care practices that prioritize active listening and empathy. Institutions, meanwhile, must implement policies that hold healthcare providers accountable for discriminatory practices and promote diversity and inclusion in medical research, education, and leadership. Building a healthcare culture that respects and validates women's experiences is not a passive process; it requires intentional, sustained action.

Central to this reform is the commitment to listen to women, validate their concerns without premature judgment, and engage them as active partners in their healthcare journeys. Addressing systemic biases also involves critical examination of outdated medical curricula, funding disparities in research focused on women's health, and the lack of female representation in clinical trials.

Acknowledging the limitations of current research—such as the underrepresentation of intersectional identities and the need for longitudinal studies—highlights important directions for future inquiry. Future research should explore how race, socioeconomic status, and other social determinants of health intersect with gender to influence experiences of medical gaslighting. Additionally, developing and testing interventions aimed at reducing clinician bias, improving communication, and supporting affected patients are crucial steps toward creating a more just and effective healthcare system.

Ultimately, confronting medical gaslighting is essential to promoting equitable healthcare for all women. By recognizing its existence, understanding its impact, and committing to systemic change, both the medical community and society at large can begin to restore trust, dignity, and fairness in healthcare.

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