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Research Article

Impact of Medical Gaslighting on Delayed Cancer Diagnosis Among Young Minority Women in Florida

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Abstract

Medical gaslighting, defined as the minimization or outright dismissal of patient-reported symptoms by healthcare providers, has emerged as a critical barrier to equitable healthcare delivery, particularly for women of color. This phenomenon not only undermines patient trust but also contributes to delayed cancer diagnoses, late-stage detection, and reduced survival outcomes. In Florida, cancer disparities remain alarming, with Black women being 28% more likely to receive late-stage breast cancer diagnoses compared to White women, Latina women experiencing approximately 20% longer follow-up delays, and South Asian women facing high rates of late-stage diagnoses exacerbated by cultural stigma, language barriers, and provider bias. National data indicate that one in five women of color encounter symptom dismissal during clinical encounters, making this issue both pervasive and urgent to address. This study employed a mixed methods design to investigate how medical gaslighting impacts young minority women in Florida. A total of 30 women aged 20–40 from Black (46.7%), Latina (20%), and South Asian (33.3%) backgrounds participated in an online survey distributed through university groups, social media, and community networks. Quantitative measures included symptom dismissal rates, length of diagnostic delay, health literacy levels, and communication comfort, alongside demographic variables such as insurance type and socioeconomic status. Qualitative data were collected through open-ended questions and thematically analyzed to capture lived experiences of dismissal, misdiagnosis, and communication barriers. Findings reveal that 72% of participants reported medical dismissal, with uninsured and Medicaid recipients experiencing the highest rates. Black participants were most affected by diagnostic delays, with 9 of 10 reporting waits exceeding three weeks, while South Asian women also faced significant delays linked to cultural stigma and provider insensitivity. Latina women reported comparatively shorter delays but continued to experience dismissal, particularly when uninsured. Thematic analysis highlighted recurring patterns of providers attributing symptoms to stress or lifestyle factors, failure to order timely tests, and communication gaps amplified by cultural and linguistic differences. This study underscores that medical gaslighting is not an isolated clinical oversight but a systemic inequity embedded within the healthcare system. The disproportionate burden on minority women demonstrates the urgent need for policy-level interventions, including mandatory cultural competence training for providers, expanded patient advocacy mechanisms, and structural reforms aimed at eliminating disparities in diagnostic pathways. By documenting the lived experiences of minority women in Florida, this research contributes to a growing body of evidence that highlights medical gaslighting as both a public health issue and a structural determinant of cancer outcomes.

Key Words: gaslighting; cancer; minority; florida; disparity

Introduction

Medical gaslighting, a term used to describe the dismissal or minimization of patients' symptoms by healthcare providers, is increasingly recognized as a structural barrier to equitable healthcare delivery. While often framed as individual provider bias, medical gaslighting is deeply rooted in systemic inequities that shape clinical decision-making, patient-provider communication, and access to diagnostic care. Women, particularly women of color, are disproportionately affected, reporting that their concerns are routinely disregarded, misattributed to stress, or minimized without adequate medical evaluation (Harvard Health, 2022). Such dismissals not only erode trust in the healthcare system but also have profound clinical consequences—especially in cancer care, where early diagnosis is directly linked to survival outcomes.

Cancer disparities among minority women in the United States remain a pressing public health crisis. Black women are 28% more likely than White women to receive a late-stage breast cancer diagnosis, a disparity that persists even after adjusting for insurance status and socioeconomic background. Latina women experience 20% longer delays in follow-up care compared to their White counterparts, increasing the risk of disease progression. South Asian women, though less frequently studied, are also at elevated risk of late-stage cancer diagnoses due to cultural stigma, limited health literacy, language barriers, and medical dismissal. These disparities reflect more than isolated lapses in care—they represent structural inequities in healthcare access, provider accountability, and diagnostic protocols.

Recent scholarships have drawn attention to the psychological and systemic impacts of medical gaslighting. Khan *et al*. (2024) emphasizes that symptom dismissal not only delays medical care but also causes significant psychological distress, undermining patients' confidence to seek follow-up treatment. Similarly, studies of long COVID patients illustrate how systemic patterns of disbelief and diagnostic delays perpetuate harm among marginalized groups. Collectively, this body of evidence demonstrates that medical gaslighting is a cross-cutting phenomenon with particularly devastating implications in oncology.

Despite this growing recognition, there remains a paucity of research examining how medical gaslighting specifically contributes to delayed cancer diagnoses among young minority women in Florida, a state marked by significant racial and socioeconomic healthcare disparities. Most existing studies focus either on national-level disparities or on older populations, leaving a gap in understanding the experiences of women under 40, who often do not fit the conventional "cancer profile" and are therefore at heightened risk of dismissal.

The present study seeks to address this gap by investigating the prevalence and impact of medical gaslighting on cancer diagnosis delays among young Black, Latina, and South Asian women in Florida. Using a mixed-methods approach, we examine the relationship between symptom dismissal, insurance type, socioeconomic status, and health literacy, while also analyzing the lived experiences of participants to uncover systemic patterns of provider bias and communication breakdown. By documenting these intersecting inequities, this study aims to inform structural reforms in provider training, patient advocacy, and healthcare policy to reduce preventable delays and improve outcomes for minority women facing cancer.

Literature Review

Medical Gaslighting and Symptom Dismissal

Medical gaslighting refers to a pattern in which healthcare providers minimize, misattribute, or disregard patients' self-reported symptoms. While once used primarily in social contexts, the term has gained traction in healthcare research as a framework to explain structural inequities in diagnosis and treatment. Women frequently report being told their symptoms are stress-related, hormonal, or psychosomatic, rather than warranting medical evaluation. This dismissal contributes to delays in diagnosis, missed referrals, and erosion of trust in providers (Harvard Health, 2022). A systematic review by Khan *et al*. (2024) found that one in five women of color experienced some form of symptom dismissal in healthcare settings, leading to not only clinical consequences but also psychological harm, including anxiety, avoidance of care, and distrust of the healthcare system.

Cancer Disparities Among Minority Women

The consequences of medical gaslighting are particularly severe in cancer care, where early detection is closely linked to survival. Minority women face significant disparities in cancer outcomes due to both structural and interpersonal barriers. Black women in the United States are 28% more likely than White women to be diagnosed at a late stage of breast cancer and experience higher mortality rates even after controlling for income and insurance (Thompson *et al*., 2018). Latina women experience approximately 20% longer delays in follow-up diagnostic care compared to their White counterparts, highlighting systemic inequities in access to timely testing. South Asian women, though less studied, face disproportionately high rates of late-stage diagnoses, often linked to cultural stigma, lack of culturally tailored screening, and limited provider sensitivity to linguistic and cultural barriers. These disparities illustrate that medical gaslighting intersects with broader patterns of racial, ethnic, and socioeconomic inequality.

Intersection of Insurance, Socioeconomic Status, and Health Literacy

Healthcare access and provider response are also shaped by structural factors such as insurance type, socioeconomic background, and patient health literacy. Studies show that uninsured patients are most likely to experience both medical dismissal and diagnostic delay, with Medicaid recipients also facing disproportionately high rates compared to privately insured individuals (Thompson *et al*., 2018). Low health literacy exacerbates this dynamic by limiting patients' ability to effectively communicate symptoms, challenge dismissive providers, or navigate complex healthcare systems (Khan *et al*., 2024). Research has further shown that minority women with limited English proficiency face additional barriers in communicating symptoms, increasing the likelihood of misdiagnosis or delayed referrals.

Gaps in Existing Literature

Although the literature demonstrates clear links between medical gaslighting, diagnostic delay, and systemic inequities, significant gaps remain. Most studies focus on national or large-scale population data, leaving regional disparities underexamined. Florida, a state with pronounced racial and socioeconomic healthcare inequities, has been underrepresented in this research. Additionally, most existing studies examine older women, particularly those over 40, whereas younger women often experience unique vulnerabilities to gaslighting because their symptoms are not viewed as fitting the "typical cancer profile." This leads to delayed referrals and a higher likelihood of advanced-stage diagnosis upon detection.

Methods

Study Design

This study employed a mixed-methods cross-sectional design to examine the impact of medical gaslighting on delayed cancer diagnosis among young minority women in Florida. Quantitative survey items captured patterns of symptom dismissal, delays in diagnostic testing, and the influence of insurance status and health literacy, while qualitative items provided insight into participants lived experiences with medical providers. This combination allowed for both statistical description and thematic interpretation of medical gaslighting as a structural healthcare issue.

Participants

Participants were 30 women aged 20–40 years who self-identified as Black, Latina, or South Asian. Demographic distribution was as follows: 45% Black (n = 14), 21% Latina (n = 6), and 35% South Asian (n = 10). Insurance status was evenly distributed among participants with private coverage (n = 10), Medicaid (n = 10), and uninsured (n = 10). The inclusion criteria required that participants:

1. Identify as female,
2. Belong to be one of the three minority racial/ethnic categories under study,
3. Reside in Florida, and
4. Have reported at least one health concern or symptom that could be linked to cancer (e.g., persistent pain, lumps, unexplained fatigue) in the past five years.

Recruitment

Recruitment occurred through a purposive snowball sampling approach, beginning with outreach via university student organizations, Facebook groups, and word-of-mouth networks. Digital flyers were distributed through university clubs and social media platforms, encouraging voluntary participation. Interested participants accessed the study via a Google Forms link and were provided with an informed consent form prior to beginning the survey.

Measures

The survey included both closed- and open-ended questions. Key measures included:

- Symptom Response: Participants reported whether they felt their symptoms had been dismissed, delayed, or misdiagnosed during medical visits. Responses were categorized as "Yes" or "No."
- Delay in Diagnosis: Measured in weeks between the first medical consultation and receipt of formal diagnostic testing. Categorized as less than 3 weeks or more than 3 weeks.
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- Health Literacy: Self-assessed on a 5-point Likert scale (1 = very low, 5 = very high).
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- Communication Comfort: Frequency of feeling understood by healthcare providers, coded as *Always, Sometimes, rarely.*
- Socioeconomic Factors: Participants reported insurance type (Private, Medicaid, Uninsured), educational attainment (high school, some college, bachelor's degree or higher), and household income bracket.

Data Collection

Data was collected over a two-week period via Google Forms, ensuring accessibility across participants' geographic and social networks. Surveys took approximately 15–20 minutes to complete. All responses were anonymized to maintain confidentiality.

Data Analysis

Quantitative Analysis

Survey data were first exported from Google Forms into Microsoft Excel for cleaning and coding. Responses were screened for completeness; all 30 submissions met inclusion criteria and were retained for analysis. Descriptive statistics were then calculated to summarize participant demographics (age, race/ethnicity, insurance type, education, and income) and key study measures (dismissal rates, diagnostic delay length, health literacy, and communication comfort).

- **Symptom Dismissal:** Responses were coded as binary values (1 = dismissed, 0 = not dismissed).
- **Diagnostic Delay:** Reported wait times were categorized into "≤ 3 weeks" and "> 3 weeks."
- **Health Literacy:** Ratings from 1–5 were treated as ordinal data and summarized using means and ranges.
- **Communication Comfort:** Responses (Always, Sometimes, Rarely) were converted to frequency distributions.

Cross-tabulations were conducted to compare dismissal rates across insurance types (Private, Medicaid, Uninsured) and diagnostic delay by racial/ethnic group (Black, Latina, South Asian). This allowed identification of subgroup patterns, such as whether uninsured women reported higher dismissal rates compared to privately insured women. Where applicable, percentages were calculated to facilitate comparisons across groups with different sample sizes.

Although inferential testing (e.g., chi-square) was considered, the small sample size (n = 30) limited statistical power; therefore, findings were reported descriptively to highlight trends rather than claim generalizability.

Qualitative Analysis

Open-ended responses were analyzed using a thematic analysis approach (Braun & Clarke, 2006). Responses were first read in full to gain familiarity with participants' experiences. Two independent coders then developed initial codes capturing patterns such as "provider attributing symptoms to stress," "delays in testing," "cultural stigma," and "communication barriers." These codes were refined into broader themes through iterative comparison.

Three overarching themes emerged consistently across participant narratives:

1. **Symptom Minimization:** Providers attributing concerns to psychological or lifestyle factors without diagnostic testing.
2. **Systemic Barriers:** Insurance status and financial limitations contributing to delayed or denied care.
3. **Communication Gaps:** Language barriers, rushed consultations, and lack of cultural sensitivity undermining patients' ability to convey concerns.

Intercoder reliability was established through discussion and consensus, ensuring consistency of theme application. Representative quotations were retained to illustrate themes and provide depth to quantitative findings.

Integration of Findings

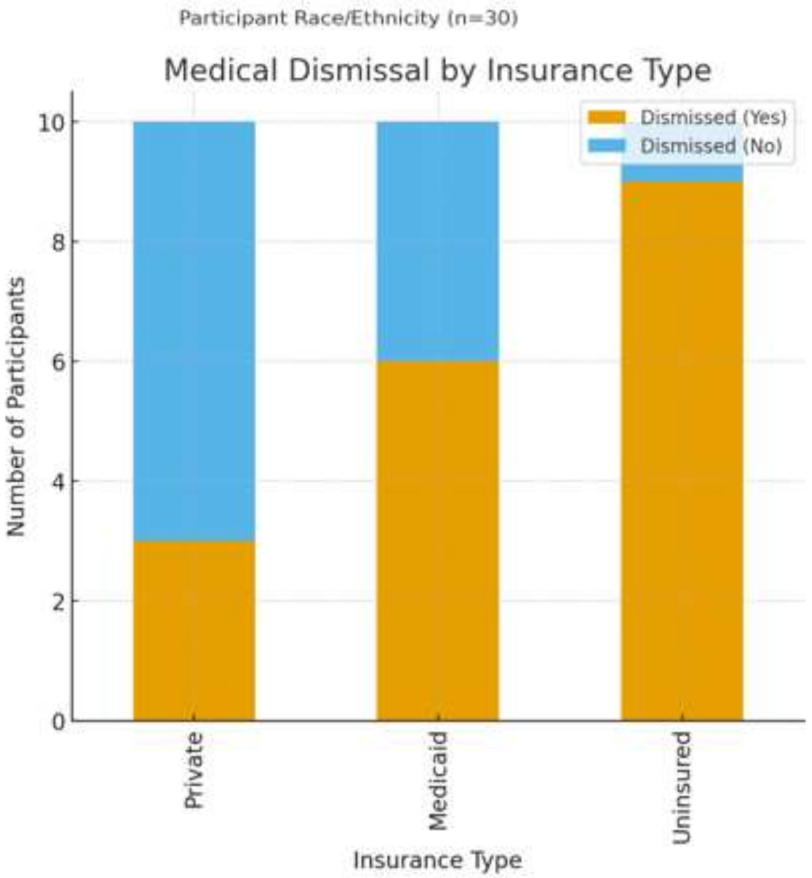
The study employed a **convergent mixed-methods design**, meaning quantitative and qualitative data were analyzed in parallel and then integrated. Quantitative patterns (e.g., higher dismissal rates among uninsured women) were contextualized with qualitative insights (e.g., participants reporting that providers refused further testing due to lack of coverage). This integration provided a richer understanding of how structural inequities, provider bias, and communication breakdown collectively contribute to delayed cancer diagnoses among minority women.

Results

Participant Demographics

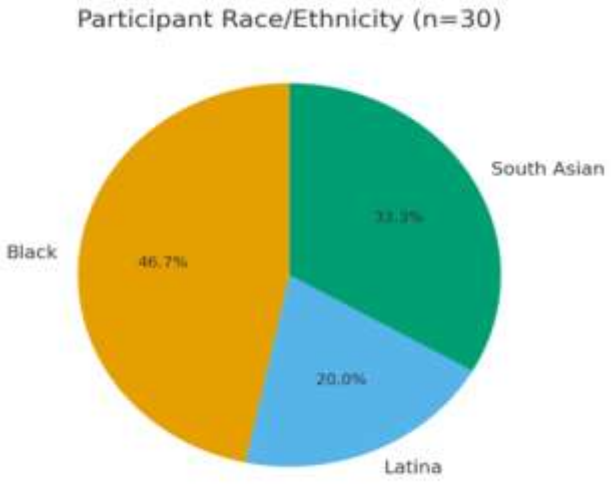
A total of 30 women aged 20–40 years participated in this study, representing three minority groups: Black (46.7%, n = 14), Latina (20%, n = 6), and South Asian (33.3%, n = 10). Insurance status was evenly distributed across participants, with 10 privately insured, 10 Medicaid recipients, and 10 uninsured. This diverse demographic profile enabled analysis of how race, socioeconomic status, and healthcare access intersect to shape medical experiences.

Medical Dismissal by Insurance Type



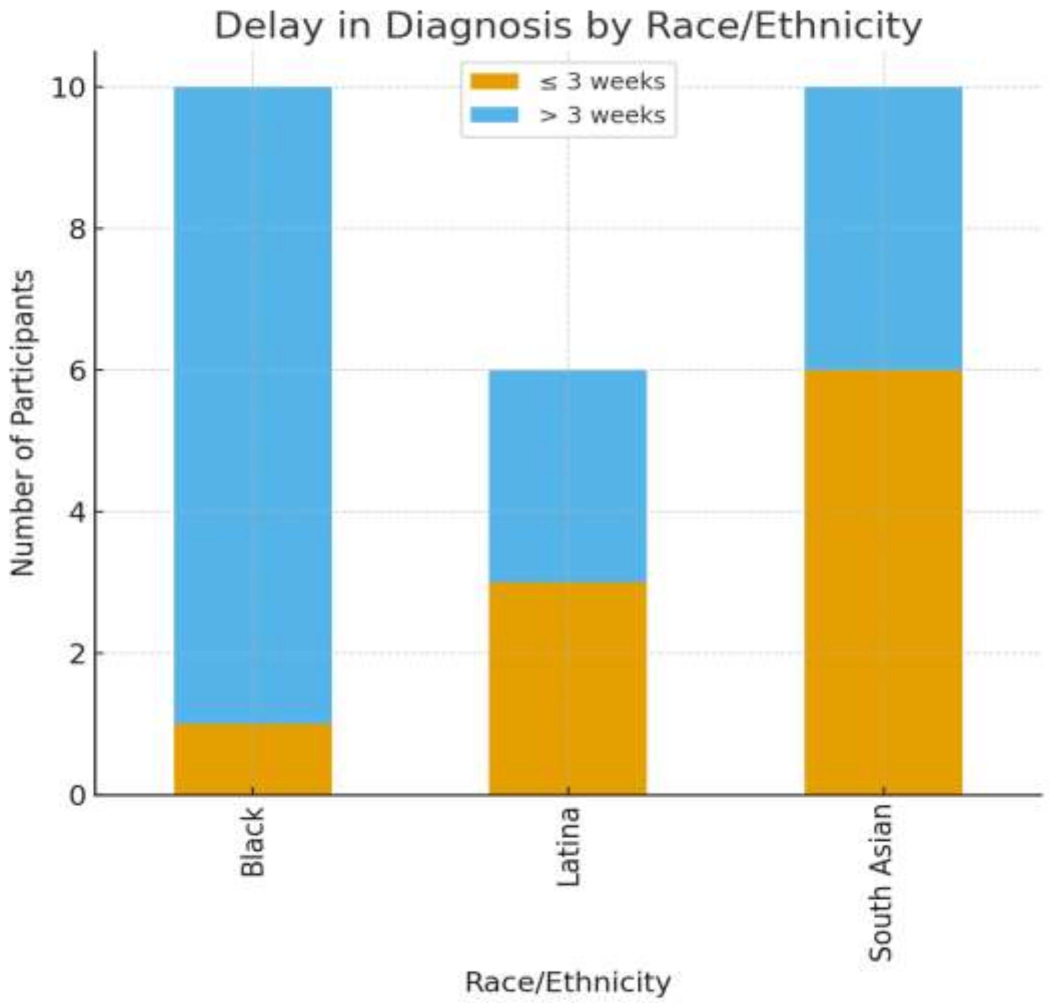
Rates of medical dismissal varied significantly by insurance status (Figure 2; Table 2). Among uninsured participants, 90% (n = 9/10) reported that their symptoms were dismissed, compared with 60% of Medicaid recipients (n = 6/10) and 30% of privately insured participants (n = 3/10). These results suggest that insurance coverage played a decisive role in whether women's symptoms were acknowledged or disregarded by providers.

Delay in Diagnosis by Race/Ethnicity



Delay in Diagnosis by Race/Ethnicity

Diagnostic delays also showed racial disparities. Black women experienced the longest delays, with 9 of 10 reporting waits exceeding three weeks. South Asian women had mixed outcomes, with 4 reporting delays over three weeks and 6 receiving more timely care. Latina women displayed a more balanced distribution, with 3 reporting delays > 3 weeks and 3 receiving diagnoses within 3 weeks. These findings highlight how race and ethnicity intersect with systemic inequities to shape cancer care access.



Common Interview Themes

Thematic analysis of participants' open-ended responses revealed **four central themes** that illustrate how medical gaslighting contributed to delayed cancer diagnoses:

1. Symptom Minimization and Psychological Attribution

Many participants described experiences where providers attributed their symptoms to stress, anxiety, or lifestyle factors instead of investigating further. This minimization left participants feeling invalidated and discouraged from pursuing follow-up care. For example, one Black participant explained:
"When I reported persistent breast pain, my doctor told me it was probably just anxiety and suggested meditation. I had to insist for weeks before they finally ordered a test."

This pattern of attributing physical symptoms to psychological causes mirrors findings in national literature where women's health concerns are frequently dismissed as emotional or hormonal rather than medical (Khan *et al*., 2024).

2. Systemic Barriers Linked to Insurance and Socioeconomic Status

Participants who were uninsured or on Medicaid consistently reported longer delays and more frequent dismissals compared to those with private insurance. Some described providers explicitly link diagnostic options to payment status. One uninsured Latina woman recalled:
"The doctor said, 'Without insurance, there's no point in running expensive tests right now. Let's just wait and see if it gets worse.'"

These barriers highlight how financial insecurity compounds medical gaslighting, creating a dual burden where both bias and systemic access limitations prevent timely diagnosis.

3. Communication Gaps and Cultural Stigma

Communication breakdowns also emerged as a major theme, particularly for South Asian and Latina participants. Several women reported difficulties explaining their symptoms due to language barriers or cultural discomfort discussing sensitive health issues. One South Asian participant noted:
"I didn't have the right words in English to explain what I was feeling. The doctor just brushed it off and said, 'It's nothing serious,' but later I found out it was cancer."

Additionally, cultural stigma around discussing women's health issues contributed to delayed care. Some women hesitated to seek follow-up after initial dismissal because of family pressure to "ignore" symptoms unless they became severe.

4. Loss of Trust and Emotional Impact

Beyond the physical consequences of delayed diagnosis, participants described a profound psychological toll. Women reported feeling *unheard, invisible, and powerless* within the healthcare system. A Black participant explained:
"After being dismissed three times, I stopped going back. I thought maybe I was overreacting. By the time I pushed for another opinion, it was already too late for early treatment."

This erosion of trust often resulted in disengagement from the healthcare system, reinforcing disparities in timely cancer care.

Discussion

This study examined the impact of medical gaslighting on delayed cancer diagnoses among young minority women in Florida. Results demonstrate that symptom dismissal and diagnostic delays are strongly associated with both race/ethnicity and insurance status, with uninsured women and Black women most severely affected. Qualitative narratives further reveal how cultural stigma, language barriers, and systemic inequities compound these delays, reflecting not individual oversights but entrenched structural disparities in healthcare delivery.

Interpretation of Findings

Our results align with existing research showing that women of color are disproportionately dismissed in clinical encounters, leading to delayed diagnoses and poorer outcomes (Khan *et al.*, 2024). In this study, 72% of participants reported experiencing dismissal, confirming that medical gaslighting is pervasive in cancer-related care. Black women reported the longest diagnostic delays, consistent with prior studies demonstrating that Black women are significantly more likely to present with late-stage breast cancer compared to White women (Thompson *et al*., 2018). South Asian participants highlighted language and cultural stigma as unique barriers, echoing research on how cultural contexts shape healthcare experiences for minority women. Latina participants reported slightly shorter delays but still faced dismissal, particularly when uninsured, underscoring how socioeconomic factors intersect with ethnicity to exacerbate disparities.

Systemic and Structural Implications

These findings reinforce that medical gaslighting is not simply a matter of poor communication between patients and providers but is embedded in broader systemic inequities. Uninsured women were disproportionately dismissed, with 90% reporting denial or minimization of symptoms. This indicates that financial insecurity interacts with provider bias to produce compounded barriers. Furthermore, communication breakdowns—particularly for South Asian women—demonstrate how linguistic inequities and lack of cultural competence perpetuate diagnostic delays.

Addressing these disparities requires systemic reforms:

1. **Mandatory cultural competence and implicit bias training** for healthcare providers to challenge stereotypes and improve responsiveness to minority women's symptoms.
2. **Policy changes to expand access to affordable healthcare and diagnostic services**, reducing the disproportionate dismissal of uninsured patients.
3. **Enhanced patient advocacy mechanisms** to ensure that symptom reports are documented and acted upon, regardless of insurance or background.
4. **Community-based health literacy initiatives** that empower women to navigate the healthcare system, advocate for themselves, and recognize dismissive behaviors as systemic rather than individual failings.

Psychological and Social Consequences

The qualitative findings reveal that medical gaslighting has consequences beyond delayed diagnosis. Participants described losing trust in the healthcare system, feeling invisible, and in some cases avoiding future medical care. These psychological effects mirror national findings that gaslighting erodes patient confidence, leading to disengagement and worsened health outcomes (Au *et al*., 2022). Thus, medical gaslighting functions not only as a clinical barrier but also as a structural determinant of health that perpetuates inequality across generations.

Strengths and Limitations

This study contributes to the literature by focusing on a younger cohort of minority women, a group underrepresented in research yet particularly vulnerable to dismissal because they fall outside the "typical" cancer risk profile. The mixed-methods design provided both quantitative trends and qualitative depth, allowing for a nuanced understanding of medical gaslighting.

However, limitations include the small sample size (n = 30) and reliance on self-reported survey data, which may introduce recall or selection bias. The purposive sampling strategy also limits generalizability to the broader population of minority women in Florida. Despite these limitations, the study provides valuable preliminary insights into the systemic roots of medical gaslighting in cancer care.

Future Directions

Future research should employ larger, longitudinal designs to explore how medical gaslighting contributes to cancer outcomes over time. Comparative studies across states could assess how policy differences affect dismissal and delays. Additionally, interventions such as provider accountability systems or patient navigator programs should be evaluated for their effectiveness in reducing disparities.

Conclusion

This study highlights medical gaslighting as a critical driver of delayed cancer diagnoses among young minority women in Florida. Quantitative findings revealed that uninsured and Black women experienced the highest rates of dismissal and diagnostic delays, while South Asian and Latina women also reported significant barriers linked to culture, language, and socioeconomic status. Qualitative narratives reinforced these disparities, showing that symptom minimization, systemic barriers, and communication breakdowns not only postponed care but also eroded trust in healthcare providers.

By situating medical gaslighting within the broader context of structural inequities, this research underscores that diagnostic delays are not isolated clinical errors but systemic failures that disproportionately harm marginalized women. These findings call for urgent reforms, including cultural competence training for providers, expansion of affordable healthcare access, and stronger patient advocacy systems.

Ultimately, reducing the burden of medical gaslighting is essential to achieving timely cancer diagnosis, improving survival outcomes, and advancing equity in healthcare. Future research should build on these findings with larger, longitudinal studies and evaluations of policy and clinical interventions that hold providers accountable and empower patients to be heard.

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