AMPLIFY

Beyond Dismissal: Recognizing and Preventing Perceived Medical Gaslighting in Urgent Care

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Financial Disclosure

- Dr. Geria serves as a clinical advisory for BD medicine.

Recognizing and Preventing Perceived Medical Gaslighting in Urgent Care

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- Define perceived medical gaslighting and distinguish it from intentional misconduct
- Identify urgent care scenarios at high risk for perceived dismissal
- Apply micro-communication strategies to reduce patient distrust
- Recognize operational contributors to perceived gaslighting
- Develop system-level interventions to mitigate risk

Why This Topic Matters Now

Rising patient reports of feeling “not heard”

Consumer-driven urgent care expectations

Short visit times + high expectations

Limited continuity and incomplete records

Social media amplification of dissatisfaction

What Is “Medical Gaslighting”?

Intentional gaslighting (rare)

Deliberate manipulation to make someone doubt reality

Perceived gaslighting (common)

Patient feels dismissed, minimized, blamed, or not believed

Perception drives experience—even when care is clinically appropriate

Why Urgent Care Is Vulnerable

- 12–20 minute visits
- Limited access to prior records
- No longitudinal relationship
- High expectations for tests, antibiotics, imaging, referrals
- Throughput and documentation pressure

The Trust Equation

- Trust = Competence + Transparency + Validation
- Urgent care often excels at competence
- Trust erodes when validation and transparency

BMJ Qual Saf.; AHRQ

High-Risk Clinical Scenarios

Low-risk chest pain

Pediatric abdominal pain

Persistent fatigue / nonspecific symptoms

Headache with normal neuro exam

Negative rapid testing with persistent symptoms

Requests for imaging or antibiotics when not indicated

SCENARIO #1: CHEST PAIN

- 34F, chest tightness x3 hours
- Normal vitals, normal ECG, no risk factors
- Clinician: “Probably anxiety. You’re fine.”
- ***Result: patient feels dismissed; distrust escalates***

AHRQ; BMJ Qual Saf.

Validate: “Chest pain is scary.”
Explain what was ruled out (dangerous causes)
Clarify risk: “Extremely low risk today.”
Safety-net: return precautions + follow-up

SCENARIO #2: PEDIATRIC ABDOMINAL PAIN

- “It doesn’t look like appendicitis.”
- “Kids get stomach aches.”
- Minimal explanation
- ***Result: parent unconvinced → ED visit***

AHRQ; UCA Reports

- Explain: exam is reassuring today
- Describe typical evolution over 12–24 hours
- Name specific red flags that change concern
- ***Offer a clear re-evaluation pathway***

CASE SCENARIO #3:
VIRAL URI + NEGATIVE TESTING

- 45M, 3 days congestion; COVID/Flu/Strep negative
- Patient requests antibiotics
- **Trigger phrase to avoid**
  - “It’s just viral.” (often heard as “You’re overreacting.”)
- Reframe
  - “These tests rule out serious bacterial causes.”
  - “Antibiotics won’t shorten this.”
  - “Here’s what helps + when to recheck.”

- **Avoid**
  - “It’s just anxiety.”
  - “There’s nothing wrong.”
  - “Your labs are normal.”
  - “You don’t need that test.”
- **Replace with**
  - “Here’s what we ruled out.”
  - “Here’s why this test wouldn’t change management.”
  - “Here’s what would change my concern.”

Documentation Matters

Risky charting

"Patient anxious."

"Reassurance given."

Safer charting

Document rationale + shared decision-making

Document specific red flags and return precautions

Document patient understanding

- Door-to-door time and throughput pressure
- Staffing ratios and surge management
- Incentives tied to volume over quality
- Limited documentation time → briefer, more defensive communication
- Lack of follow-up pathways (messaging / revisit slots)

- Negative reviews and patient-experience scores
- Repeat visits and ED leakage
- Higher complaint volume and reputational harm
- Malpractice exposure (especially in missed diagnosis narratives)
- Staff burnout and turnover

- Sit down (when possible)
- Ask: “What worries you most?”
- Reflect: “I hear that you’re worried about ___.”
- Explain what was ruled out and why
- Give specific return precautions
- Offer a re-evaluation pathway

- Rushed clinicians explain less and validate less
- Defensive communication increases when clinicians feel blamed
- System stress amplifies perceived dismissal
- Prevention requires both individual skill and system support

- Train communication as a clinical skill
- Align throughput expectations with safety and trust
- Support documentation workflows and time
- Build reliable follow-up access (messaging, revisit slots)
- Reward quality and patient understanding—not just volume

- Rapid testing to reduce ambiguity
- POCUS as visual validation (when appropriate)
- Clear printed/digital visit summaries
- AI-assisted documentation for clarity and completeness
- Secure messaging for follow-up questions

Cultural Reframe for Urgent Care

Urgent care is not

A triage tent

An antibiotic dispensary

A throughput machine

Urgent care is

A risk-stratification engine

An acute diagnostic center

A frontline trust builder

- Most perceived gaslighting is unintentional
- Urgent care structure amplifies risk for dismissal perceptions
- Communication micro-adjustments change outcomes
- Operational alignment is essential
- Trust protects patients, clinicians, and organizations

- Speed without empathy erodes trust.
- Empathy without clarity erodes safety.
- **Urgent care must deliver both.**

References

- AHRQ: Patient Safety Culture resources
- BMJ Quality & Safety: diagnostic error and communication literature
- JAMA/Internal Medicine: patient experience and communication studies
- Levinson et al.: communication and malpractice literature
- NRC Health: patient experience measures (if used)

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