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The Phenomenology of Humiliation: Feeling Injustice in Healthcare

In this paper, I show how humiliation, as a moral emotion, is a pervasive yet neglected dimension of medicine, health, and ethics discourse. Although often conflated with shame, humiliation names a distinct self-conscious emotion: not an internalized sense of personal failure, but a relational harm imposed by others and institutions that undermines dignity and self-respect. Recently, medical humanities and ethics literature have attended extensively to shame and stigma, yet humiliation remains under-explored, despite its salience in patient accounts of dismissal, disrespect, and degradation. I begin why it helps to have conceptual distinction between humiliation and shame, showing how humiliation is an externally inflicted injury rather than a private moral lapse. Drawing on my ethnographic and phenomenological research in India and Zurich, in this conceptual paper, I illustrate how humiliation surfaces in health care encounters and spaces, where patients, especially those who are marginalized, are silenced or disregarded. I show humiliation is diagnostic and has inherent moral insights and reveals injustice. Thus, in this paper, I argue reclaiming humiliation as a moral and phenomenological category opens new ethical and analytic possibilities: it calls for reimagining medicine as a relational practice grounded in dignity, recognition, and justice—one that acknowledges those once humiliated not as passive sufferers but as moral agents whose emotions reveal the truth of injustice.

I Introduction: Contextualizing Humiliation

"They treat us like dogs with rabies."[1]

"I used to smoke about forty cigarettes a day. No wonder I became ill. I hate myself for not quitting the day I was diagnosed with asthma. Now I am reduced to zero, and I am the one to blame. When you are old and ill and have COPD, you do not count anymore (M 70)."[2]

"So [the nurse] showed me how to [inject], but she was so mean about it. She was not accommodating. She said I should know how to do it myself. They treated me like crap and I know it was because I was Native. We all know because of the look - there's a look. When you need the medical care we put up with it. We shouldn't have to."[3]

"Where else can people like us go? We don't have money, so we get what we always get" [4]

These quotes, drawn from diverse contexts and studies, disclose the subtle and overt ways in which self-conscious emotions arise in healthcare encounters. Each evokes an affective and moral injury that exceeds physical suffering, the sense of being rendered small, invisible, or unworthy. Yet what kind of emotional and moral experience is at stake here? One can name and categorize such experiences as shame, stigma, and humiliation, and I believe context and social category of the person who is the at receiving end plays a key role in ways we understand these emotions and social attributions. Shame and humiliation are self-conscious emotions in that they involve an awareness of how one appears to oneself and others; yet the direction of that awareness differs profoundly.

One may feel ashamed without being humiliated, as in moments of moral failure or self-reproach that remain private. Conversely, one may be humiliated without any sense of personal failure, when degradation is imposed from without. In humiliation, the injury does not arise from a recognition of one's own inadequacy but from the actions, words, or omissions of others that deny one's standing as a person worthy of respect. This distinction is crucial for understanding the moral texture of healthcare encounters. Patients may be humiliated not because they have failed morally or medically, but because they are treated in ways that betray the respect due to them as persons, spoken to with condescension, ignored in pain, or rendered invisible by institutional indifference. Such moments do not evoke shame in the patient so much as a sense of violation, of being wronged. In this sense, humiliation belongs not to the realm of personal morality but to that of social and political realm; it signals a breakdown in the moral fabric of institutions and relationships, particularly healthcare professional and patient relationship.

If humiliation marks the denial of a person's basic respect and dignity, then attending to its phenomenology allows us to identify the subtle and systemic ways that medical institutions and individuals may, even inadvertently, undermine one's self-respect and dignity. In the quote, "They treat us like dogs with rabies," the speaker's suffering is not about internal moral failure but about being positioned outside the moral community, denied recognition. As mentioned in my earlier work [4], Kumar, a sanitation worker who had undergone hernia surgery at a government hospital, once said, "Where else can people like us go? We don't have money, so we get what we always get." In his words, humiliation takes the form of erasure—the pain of being unseen, of not counting. His voice carried a quiet resignation, a sense of inevitability. The care he received was free yet stripped of respect; for Kumar, this was simply how things were for people like him—for those from poor and lower-caste communities. The Tamil phrase, அவமானம், (avamanam), humiliation, captures not just the emotional sting

but the moral and social degradation that being disregarded entails. These experiences disclose humiliation as a relational and political affect, one that signals how power and recognition are distributed in the clinic and healthcare spaces.

There has been ongoing debate in some disciplines, such as psychology, about what counts as shame and humiliation. In others, such as philosophy, few scholars see it as central to understanding of society, and struggle for recognition. In medical humanities and health ethics, it has generally remained undertheorized, often treated as a variant of shame or shame state rather than a distinct moral and affective phenomenon. This conflation has led to an absence of sustained attention to the ubiquity of humiliating experiences in discourses of patient rights, dignity, and patient-centred care. This paper addresses precisely that omission: the invisibility of humiliation in the very contexts where it most urgently matters.

During my ethnographic and phenomenological research in both India (please refer here for more methodological details: [4–6]) and Zurich (please refer here for more methodological details:[7]), which focussed on disrespect within healthcare settings, experiences of humiliation and shame recurred repeatedly, though humiliation was the dominant one. Terms such as 'avamanam' were woven into the everyday vocabulary of those from marginalized communities, revealing how deeply humiliation is embedded in lived experience, for those who are marginalized. I situate patients and family members who speak here are not passive objects but moral and epistemic agents, articulating the emotional grammars of subjection and resistance. Reading these accounts phenomenologically allows us to glimpse how experiences are made into meaning, and how individuals and communities navigate the fragile terrain between recognition and disregard. In doing so, we also begin to understand how humiliation shapes our ways of relating, to ourselves, to others, and to the institutional worlds we inhabit. I take these articulations not as incidental emotions but as significant sites of inquiry, whose close reading can deepen our understanding of the emotional and moral texture of healthcare encounters.

Given the extensive evidence of discrimination and disrespect in healthcare systems[1,8–14], where marginalized patients are often normalized into these degrading encounters, my central claim in this paper is that understanding the phenomenology of humiliation is essential to grasping the operations of injustice, power, and domination in medicine. I begin by sketching humiliation's profile and consider the role it plays in context of sites of oppression, in relation to medicine. In approaching humiliating experiences and narratives, I trace how humiliation is articulated. My aim is not only to explore the phenomenology of humiliation but to illustrate that emotion of humiliation contains affective orientation, that is, how it feels to be humiliated is related to what humiliation is about and what it reveals. As I argue later in this paper, this understanding and reflecting on the meanings these narratives reveal and allow us to theorize humiliation not by presupposing what it is, but by attending to how it appears, how it is voiced, embodied, and resisted in situated worlds.

To take humiliation seriously, then, is not merely to refine our emotional taxonomy but to uncover a dimension of injustice at the heart of medicine. Drawing on my earlier work[4–7], in this conceptual paper, by reclaiming humiliation as a distinct moral emotion, and moral and phenomenological category, I hope this would open new analytic and ethical ground: medicine must be examined not only as a site of passivity or passive agents but as a site of struggle for respect and dignity. Building on this contextual grounding, the next section briefly unpacks understanding of humiliation, and how it has been conceptualized in existing literature, particularly to shame, highlighting where their conflation obscures important moral and

political distinctions. The third section then turns to narratives from my ethnographic research in India and Zurich, outlining a phenomenology of humiliation that illuminates how the experience of being demeaned or degraded is registered in the body, shapes one's sense of self, others and institutions. Finally, I conclude by suggesting that debates around patient's dignity in medicine can benefit from taking seriously humiliation as it is vital for reimagining medicine as practices grounded in dignity and justice.

II Understanding Humiliation

Through our emotions we apprehend what has meaning for us; they are not peripheral disturbances but central ways in which the world discloses itself. Feminist epistemologists and philosophers such as Audre Lorde[15], bell hooks[16], Gopal Guru [17,18], Uma Narayan[19], and Alison Jaggar[20] remind us that emotions are not irrational distortions but epistemic resources. Emotions are intentional, they reveal the world as already laden with significance for us. Humiliation, as a form of felt recognitions, offers insight into the moral fabric of social life: it shows how injustice appears and how it feels from within structures of power. It also enables communication of moral knowledge that might otherwise remain unspeakable. As Amia Srinivasan (2018) argues, emotions make us "affectively registering or appreciating the injustice of the world", not only to recognize what is wrong, but also to sense the possibility of what ought to be right. Taking forward these conversations, I will show in this paper, humiliation as a moral emotion, illuminates not merely an internal experience or feeling but a mode of being-in-the-world: it is a felt perception of one's standing in a moral field shaped by others' recognition, and more than that it reveals the condition of our being in this moral world.

Broadly, the concept of humiliation has been dominantly examined within two main disciplines: moral and political philosophy, and psychology. Philosophers often explore humiliation in relation to dignity, self-respect, and recognition [17,21–25], whereas psychologists emphasize its subjective and affective dimensions [26–30]. From a philosophical perspective, humiliation is understood not merely as an emotion but as a moral wrong, a violation of the respect owed to persons. Avishai Margalit [23] famously describes a decent society as one whose institutions do not humiliate its members. For him, humiliation occurs when someone is given legitimate reason to feel that their self-respect has been diminished. Similarly, within theories of recognition, Axel Honneth [21] treat humiliation, often interchangeably used as moral shame, as a form of misrecognition, a denial of moral standing that undermines a person and not as worthy of respect. Across these accounts, humiliation is conceptualized as a relational injury, signalling the breakdown of mutual recognition that sustains social life. Few phenomenologists and philosophers have briefly engaged with humiliation in relation to its distinction from the phenomenon of shame [31–34]. Also, philosophical and psychological discussions on humiliation in relation to dignity and resistance to oppression within different social and political contexts has been explored increasingly [17,18,22,23,35–37].

In psychological scholarship, humiliation is typically classified as a self-conscious emotion, one that involves the perception of how one appears in the eyes of others. It shares certain features with shame, anger, and embarrassment [38], yet remains distinct in important ways. Early empirical work often blurred these boundaries, interpreting humiliation as an intensified form of shame [39]. Later research, however, clarified that the two emotions differ both phenomenologically and morally. As Klein [30] notes, "People believe they deserve their shame; they do not believe they deserve their humiliation", and states if we consider it as same

is to ‘commit classic fallacy’. Shame reflects internal moral self-assessment, whereas humiliation arises when one’s dignity is violated by another,an experience rooted in power asymmetry and undeserved subjugation. Hartling and Luchetta [29]move beyond mere descriptions of facts and conditions that may be humiliating and conceptualize humiliation as “a deep dysphoric feeling associated with being, or perceiving oneself as being, unjustly degraded, ridiculed, or put down, in particular, one’s identity has been demeaned or devalued”

Subsequent psychological research has aimed to establish humiliation as a distinct affective claim[40]. It is often described as a deeply painful feeling that emerges when a person experiences themselves as unjustly degraded, mocked, or diminished, and when their identity is thereby devalued. Scholars identify three interlinked aspects of this experience: a sense of devaluation of one’s identity, the belief that such devaluation is unwarranted or illegitimate, and a dysphoric or distressing emotional state[29,30]. What is particularly significant here is the emphasis on perception and meaning-making, humiliation depends not merely on what is done to someone but on how they interpret and understand it as unfair.

Shame and stigma have been central concerns in much of the scholarship within the medical humanities[41–48]. Recently scholars have illuminated the role of shame, and humiliation is seen as a variant or cognates of shame or assumed to be part of shame family [41,42,49–51] , offering critical insights into health and medicine discourse. For instance, shame has been explored as an affective determinant of health [42], it is often defined as a negative emotion arising “when one is seen and judged by others (whether they are present, possible or imagined) to be flawed in some crucial way, or when some part of one's self is perceived to be inadequate, inappropriate or immoral” . Within this framework, the self is both judge and judged; the moral gaze is internalized.

In one of the recent works on shame in medicine, in the context of voice-hearing, Woods [50] advances the discussion of shame by drawing on Zahavi’s phenomenological account, which departs from the dominant psychological understandings. Dominantly, within psychology, shame is often conceived as a self-conscious and evaluative emotion, “shame is a consequence of a failure evaluation relative to the standards when the person makes a global evaluation of the self.[52]” In this model, the self is the object and agent of judgment; shame arises through reflection and negative self-assessment, encompassing the whole of one’s being and generating a desire to hide or disappear. Zahavi, and following him Woods, challenge this cognitively demanding conception by turning attention to the relational and embodied dimensions of shame. For Zahavi, shame is not merely the result of self-reflection but an immediate affective response to being seen by another. In this view, shame reveals our vulnerability and dependence on others for our sense of self, making us aware that our foundations lie outside ourselves. Woods extends this insight to experiences of chronic shame in contexts such as voice-hearing, showing how the self’s exposure to the gaze, real or imagined, shapes the enduring sense of being diminished in the eyes of others.

Within the medical humanities, humiliation is often treated as little more than a cognate or variant of shame [42,50], absorbed into the lexicon of shame and stigma and thereby rendered conceptually indistinct and ethically invisible. Lazare [49], for instance, observed that while shame concerns a distress about the self as “no good” or “defective,” humiliation refers to “a temporary status of the self… caused by someone else… lowering or debasing.” Yet even Lazare, after acknowledging this distinction, ultimately folds humiliation back into shame, treating the two as a single analytic category. However, this very emphasis on relational exposure marks the point at which humiliation begins to diverge from shame. Shame, as

Lewis[52] suggests, is the emotion that arises when we evaluate our own actions and conclude that we have done wrong, a self turned inward, measuring itself against its own moral yardstick. I would argue, humiliation resists this inward turn. It is not born of reflection but of interruption; not the self's judgment of failure but the world's judgment imposed upon the self. It is the moment when one's body, voice, or being is seized and defined by another or institution, when one is made visible in the wrong way. Humiliation exposes; it strips away the protective skin of invisibility and thrusts the self into the glare of another's or an institution's domination.

Humiliation, then, is not the feeling that I have done wrong, but the feeling that wrong has been done to me, that my worth, self-respect and dignity has been appraised. It is an affect of being seen too much and too little at once: too much as an object, too little as a person. It is the self's encounter with power as gaze, as speech, as institutional script, a moment when dignity is not merely denied but redefined by those who hold the authority. To feel humiliated is to experience a fracture in the moral order, to confront the precarity of one's standing in the eyes of others, and to sense, painfully, that the very terms of recognition are never neutral. From earlier quote in introduction, I would say, the smoker who says, "I hate myself for not quitting... I am the one to blame," speaks from this interiorized space of moral self-assessment. Shame here is not only a feeling but also a mode of subjectivation , a way the self takes itself up under a norm of worthiness. By contrast, the others, those who say, "They treat us like dogs with rabies," or "We waited all morning. No one looked at us. I felt humiliated, like we were not even worth their time," speak from the outside of that moral frame. Their words capture not a failure of self, but a violence of disregard; not guilt, but exposure. Here humiliation emerges as the experience of being rendered lesser in the eyes of another, when recognition itself becomes a tool of hierarchy. The man who recalls being told to "wait!" with visible disdain, avamanam, names the embodied sense of being lowered, dismissed, and made small. In these encounters, humiliation is not a fleeting emotion but an event of moral dislocation. It reveals the fragile boundaries between human worth and institutional indifference. Where shame binds the self to a moral order, humiliation exposes the order's cruelty. It is the moment when one's dignity is not only denied but reconstituted by others' gaze and authority, when the self realizes that recognition, too, can be a mechanism of domination.

While shame and humiliation can overlap depending on context, person, and experience, humiliation arises specifically from being treated with disrespect. Shaming may form part of this experience, but humiliation is distinct in that the person recognizes the treatment as unjust within a particular social and political context. As a moral emotion, humiliation contributes to our moral evaluation of situations, individuals, and institutions, its object is offense. Humiliation also has a recognizable physiological profile: increased heart rate, trembling, sweating, changes in voice, bodily tension, and distinct facial expressions. Yet it is possible to experience humiliation without necessarily feeling it fully; psychological studies show that emotional and physiological responses to humiliation vary widely. Unlike shame, which tends to involve self-evaluation, humiliation entails specific judgments about injustice, wrongdoing, and offense. It reveals what matters to us, for in moments of humiliation, we recognize that someone, an institution, or a situation has acted unjustly toward us. The direction of humiliation is outward, not inward. Crucially, the common object of humiliation is injustice, often manifested through violations of hierarchy or actions that push a person downward. As a negative, self-conscious, and other-regarding emotion, humiliation exposes unjustness itself. Recognizing humiliation is therefore vital to understanding the full spectrum of affective, epistemic, and structural violence in healthcare, enabling practices that are more just and ethically responsive.

While philosophical and psychological literature and studies offer valuable insights, they remain limited in scope for discussion and phenomenology of humiliation in medicine. This silence reflects at least three intersecting limitations. First, shame research tends to privilege intrapersonal experiences over structural or systemic forms of moral wrong and treats patient's experiences as passive or agency has been taken away by theorists or researchers. Second, the field's Euro-American orientation has left little room for the exploration of culturally and historically specific forms of subjugation and resistance. And third, the separation of emotion from politics has obscured how humiliation functions as both an affect and an instrument of domination. Recognizing these omissions is crucial. To treat humiliation only as an internal emotional state, as just a variant of shame, is to overlook its social ontology,its existence as a product of relations of power, hierarchy, and exclusion. And importantly, humiliation draws attention to desire and struggle for recognition and illustrates patient's agency.

Margalit's [23] claim that a decent society is one whose institutions do not humiliate gains phenomenological depth: to live in a world where humiliation is possible is to live in a world that can make one's dignity precarious. Thus, humiliation, as a self-conscious and other-regarding emotion and affective disposition– one that is produced through power-laden encounters embedded hierarchies within particular social and political context, and sustained through the very mechanisms that dictate who is granted recognition and who is systematically denied it. Based on my earlier work, and works which reflects disrespectful experiences in health spaces, humiliation is not merely an individual or momentary experience, but an enduring affective disposition, shaping how marginalized individuals experience and navigate social, political, and institutional spaces. To examine humiliation within these frames, it is necessary to engage with its phenomenological dimensions–how it is experienced and felt in the body–while also attending to its structural and historical entanglements, which render certain bodies more vulnerable to it than others. In the next section, I turn to the phenomenology of humiliation, drawing from few excerpts from ethnographic encounters in India and Zurich to explore how this emotion is embodied, enacted, and resisted,how it shapes the sense of self, disrupts trust, and exposes the moral failures of care.

III Phenomenology of humiliation

To undergo humiliation is to have the world suddenly reorganized around one's perceived diminishment. It is an affective disclosure of hierarchy and injustice, in which the self is confronted not with its own moral failure (as in shame), but with the world's failure to accord due respect. Its intentional object is offense, not self. To be humiliated is to find oneself positioned within another's evaluative gaze,as if one's worth were appraised and devalued in public view. Humiliation reveals to us, through our bodies, that a moral order has been breached.

Drawing on Furtuk's [53] and feminist scholars [15,16,19,20], then, humiliation has a distinctive intentional structure: how it feels is inseparable from what it is about. One does not merely feel bad; one feels wronged. This felt wrongness is not a cognitive conclusion drawn from deliberation but an immediate, embodied apprehension of being treated unjustly or demeaned. The humiliated subject does not invent this significance; it is encountered as already there, embedded in a relational and institutional world. This capacity for affective recognition is both epistemic and ethical. Emotional attunement is crucial to moral understanding; one must be able to feel the wrongness of an act to grasp its meaning fully. In humiliation, the

body knows that something is amiss,it registers, prior to thought, that one's moral status has been unsettled. This does not make humiliation irrational; rather, as insists, emotions are modes of existential experience that structure our sense of what is done and possible. To feel humiliated is thus to perceive oneself as displaced in a moral landscape. The bodily intensities, the tightening chest, the inability to meet another's gaze, mark the site of this displacement. They are affective evidence that the world's order of worth has turned against the self. In this moment, consciousness and embodiment are inseparable: humiliation is not simply felt in the body but thinks through the body, enacting what Zahavi[54] calls the "co-constitution" of self and world in experience.

What humiliation reveals, then, is not only an injury to self-respect but the fragility of moral order itself. It discloses the boundaries of belonging and the terms under which recognition is granted or withdrawn. The person who knows that they are worthy of respect may still feel humiliation and it remains sedimented in the body. The emotional work of recovering from humiliation involves restoring the felt sense of moral standing that the world has denied. Humiliation, therefore, should not be dismissed as mere wounded pride or transient affect. It is an embodied form of moral knowledge, a way of perceiving the world's injustice through the tremors of one's own vulnerability. It discloses both the dependence of dignity on recognition and the violence inherent in its withdrawal. In this sense, humiliation is not only an emotion but a phenomenon of moral visibility: the point at which the self becomes aware, through affect, of the world's capacity to wound and define.

Engaging with critical scholarship and phenomenological studies of selfhood and intersubjectivity allows us to understand humiliation as an ontological disruption, a forced exposure of the self to a gaze that strips away oneself self-respect. To illustrate my understanding of the phenomenology of humiliation, I draw on two excerpts from my earlier studies. The first is an ethnographic study conducted in the South Indian city of Chennai [4–6], and the second examines the healthcare experiences of migrant women in Zurich [7]. Both studies explore how patients and family members experience disrespect within healthcare settings. The first highlights how caste, class, and gender intersect within a dominant power-laden healthcare context, while the second examines how race and gender shape experiences within a white-dominant healthcare system. Together, they reveal how experiences of humiliation across distinct yet comparable contexts. The comparability of these two contexts lies not in their sameness, but in their shared structures of dehumanization.

Quote 1, Vani
Vani, a garment factory worker from a lower-class-caste background, was taking care of her mother in a public hospital in South India. She said,

"I keep following them [the doctors] from the ward to their offices and back. They don't even bother to stop for a second and listen to me. I don't know what is wrong with my mother. We have been here for the past 15 days. Some days ago, the junior nurses told me that it was some infection. They performed surgery again but did not tell me anything about it–why or what. As everywhere else, we are made to keep waiting (with sigh)."

Quote 2 , Pema
Pema, a doctoral researcher from Bhutan, said,

"I am not dumb," she said, her voice rising with anger. "They speak to me as if I don't understand them… he [the dermatologist] just asked me to bring all my cosmetic products next

visit. When I did, he just walked up to me, didn't say anything, just grabbed my pouch and dumped everything in the dustbin… he could have explained or discussed with me… all I felt was shame and humiliation and that I didn't matter here."

Vani's account exemplifies the mundane yet deeply affective ways in which humiliation unfolds within public healthcare spaces. Her narrative reveals a dual process of exclusion–both epistemic and affective. Epistemically, she is denied access to knowledge about her mother's condition, relegated to a position of ignorance despite her role as a caretaker. This systematic withholding of information is not incidental but structural; it reinforces hierarchies that dictate who is entitled to knowledge and decision-making power in healthcare interactions. Affectively, her repeated attempts to seek recognition, through following doctors, asking questions, and expressing concern, are met with indifference and disregard. The act of waiting, of being ignored, of having to infer critical information from junior nurses rather than being directly informed, compounds the experience of being made to feel unworthy of acknowledgment and recognition.

Humiliation here operates not simply as an emotion Vani experiences, but as a relational and structural condition, one that shapes Vani's experience of caretaking and institutional navigation. Her testimony reflects the normalization of everyday indignities, wherein both patients and their caregivers come to accept disregard as an intrinsic feature of seeking care in public hospitals in countries like India or often racialized, minoritized and marginalised groups in any regions. This normalization does not mitigate its affective force; rather, it sustains and entrenches a system where some lives are rendered less visible, less valued, and less worthy of recognition.

By analysing such moments of everyday humiliation, we can examine how power operates through affect, bodily comportment, and institutional practices. Thus, humiliation is not merely a reaction to an isolated instance of powerlessness or targeting oneself; it is the sedimentation of repeated, historical patterns of disregard that define marginalized people's encounters with public institutions. It is, ultimately, a mode of social ordering, one that disciplines through disregard and enforces subjugation. Vani's repeated following of doctors, her tailing, is not an act of agency in the conventional sense, but an embodied condition of subjugation, of being made to occupy a space where recognition is systematically withheld. "Being followed" as an existential, affective, and bodily disposition, one that is imposed upon marginalised as a form of disregard and control. It is not only about physical movement but also about the affective weight of an imposed subject position. It structures perception, how one is seen, how one is not seen, and how one is made to feel through those interactions. Vani's experience of tailing the doctors from the ward to their offices and back is thus not simply about seeking answers; it is an embodied navigation of power, where she is simultaneously hyper-visible in her persistence and yet utterly disregarded. Her bodily presence as a young, lower-class-caste garment working woman seeking care for her mother is made intrusive, unwelcome, and inconvenient–she is present, yet absent; seen, yet unseen.

Moreover, the very act of following as a bodily disposition underscores the ways in which humiliation is not just felt internally but is externally imposed. The power-laden hierarchy in medicine, class-caste-gendered gaze disciplines bodies, which marks Vani's presence as disruptive and unnecessary. She is not just a caretaker; she is a body that must be ignored, taught its place. Her movement is thus a countermovement, an act of resistance that is simultaneously punished through institutional disregard. Thus, humiliation is not just an emotion but a structuring force–one that dictates how individuals must move, how they are

permitted to be present, and how they come to internalize their own social and political position within an unequal system. Vani's tailing of the doctors thus reveals how healthcare spaces function as sites of affective governance, where care-seekers must endure prolonged exposure to indifference, creating an everyday pedagogy of humiliation that disciplines through denial and disregard. Pema's experience encapsulates the phenomenology of humiliation as a lived, embodied condition that is imposed through hierarchical power relations and sustained by the structures of gendered medical authority. Drawing on George Yancy[55,56] and Sara Ahmed's works [57], particularly their analysis of how racialized and gendered bodies are positioned within spaces of authority, we can see how Pema's encounter with the dermatologist reflects a deeply embedded form of epistemic, affective and bodily disregard–one that hinges on her identity as a migrant woman.

Many critical scholarships within racialized gendered health work on racial embodiment and the white gaze [58–61] reveals how power operates not only through explicit acts of violence or exclusion but also through the ways in which certain bodies are made to feel exposed–subject to an authoritative gaze that diminishes one's self-worth. In Pema's case, the dermatologist's actions–silently confiscating and discarding her belongings without explanation–exemplify this power dynamic. The doctor's disposal of her products can be read as a symbolic act of erasure–stripping away not just the material items but also her sense of agency. The act was not just a medical decision; it was an assertion of dominance, a display of power that rendered her irrelevant within the clinical encounter. This form of ontological exposure, through humiliation–where one's agency, knowledge, and dignity are dismissed–reinforces a social order where certain bodies are presumed incapable of rational decision-making and are thus undeserving of engagement, recognition, or respect.

The absence of explanation in the doctor's actions is crucial to understanding the phenomenology of humiliation. Had he engaged Pema in a respectful conversation, offering her medical reasoning, the experience would have been one of conversation. Instead, the physical act of discarding her belongings without dialogue framed her as 'Other' who was not acknowledged[7]. Similar to Vani's encounter, Pema's reflections and experiences aligns with how racialized and minoritized groups often experience a kind of invisible hypervisibility–they are seen, but not as knowing subjects; they are acknowledged, but only in ways that reduce them to passive persons rather than agents. The affective dimensions of humiliation–debilitating shame and anger shape how individuals navigate social and institutional spaces. Pema's statement, "I am not dumb" (expressed with anger), reflects her resistance to the imposed subject position of ignorance. Her anger is a direct response to the forced submission that humiliation entails; it is the affective refusal to be positioned as a passive recipient of disregard.

This turn, from pain to protest, draws attention to anger as more than a personal emotion: it is a deeply political affect shaped by histories of exclusion and struggle. Like anger, humiliation bears a history of racialized, gendered, and caste-marked regulation. As black scholars show[15,16,62], anger has been pathologized to silence resistance and maintain social control, yet when reclaimed, it becomes an empowering force against oppression. For Indigenous scholars, anger is a response to colonial dispossession, a form of felt knowledge and refusal of erasure[63,64]. Dalit writers and scholars B R Ambedkar, Siddalingaiah, Urmila Pawar, and Kancha Ilaiah [65–68] similarly express humiliation and rage as epistemic and political resistance disrupting Brahminical supremacy. Across these traditions, anger is generative rather than reactive,a collective insistence on dignity and justice. Black feminist thinkers further reframe it as creative and transformative labor, turning rage against dehumanization

into intellectual and political power. In this sense, experiencing humiliation becomes embodied knowledge, a refusal to be disciplined into submission and an assertion of justice in the face of systemic violence.

Then, “I am not dumb” with anger, is significant because it reveals the ways in which marginalized individuals contest and resist. In standing up to the doctor, Pema exercised agency, but in doing so, she became marked as disruptive, an “angry woman” who no longer fit the mold of the passive patient. Elsewhere, I have illustrated how everyday indignities, and othering creates a culture of disrespect[4], and through my own experiences of being ‘Bahujan/Adivasi/ (indigenous community)/person of color’ and minoritized and racialized patients’ experiences resist humiliating structure of health system. Pema’s decision to switch dermatologists reflects the navigation of this system: she recognized that her resistance came at a cost and that to regain control over her own care, she had to remove herself from that particular interaction. The dermatologist’s silent disposal of Pema’s belongings was not just an erasure of her choices and Vani not being recognized after multiple ‘tailing’, it was an embodied act of humiliation. This highlights how authority figures enact disciplinary control over marginalized bodies, often through seemingly mundane actions.

Pema’s subsequent reflection “if it was a white (male) person, would that person have done the same?”, points to the racialized and gendered nature of humiliation. The doctor’s actions cannot be detached from the social hierarchies that shape encounters in clinical spaces. The question she poses is not simply rhetorical; it is an articulation of the differential ways in which bodies are treated based on race, class, gender and migration status. It underscores that humiliation is not merely an internal experience but a social relation–it is the result of power acting upon a body that has already been positioned as subordinate. To summarize, unlike shame, which can operate as an internalized self-evaluation, humiliation is imposed from the outside. It is not self-inflicted, nor is it necessarily tied to guilt or wrongdoing; rather, it is the experience of being forced into a position of powerlessness, where one’s own worth is negated through another’s gaze or action.

When understanding humiliation, one certainly then should focus on its structural and racialized dimensions. Learning from Dalit and Black scholars [17,18,57,65,69–72], we can see how colonialism, Brahminical and white supremacy, sexism, racism and castesim institutionalizes humiliation, embedding it into the very fabric of the social and moral world. In my earlier work in India and Zurich, due to embedded hierarchies of social political realities, and as described in many works on indigenous health research, this humiliation, through everyday indignities and othering, is not about a singular moment of insult but about the cumulative weight of being rendered inferior in a world that sees privileged ‘upper-caste-class-gender-religion’ and racially whiteness as the norm and “Other” as passive, incompetent, deviant, aggressive or dangerous. Learning from critical scholars one can describe this experience as a rupture in selfhood, where one’s own embodied reality is denied in favor of the dominant narrative that defines what one is allowed to be. It is through this structural imposition of humiliation that racial, casteist, class and gendered hierarchies are maintained along with biomedical culture: the humiliated are made to feel ashamed of their bodies, their histories, and their very existence. It forces us to see that humiliation is not an aberration but a fundamental feature of privileged power – a means of ensuring continued subordination.

Given that selfhood is inherently relational, shaped through encounters with others, the self is never simply self-contained; it emerges through being seen, recognized and situated within a social and moral world where meaning is co-constituted. When humiliation occurs, this

fundamental structure of recognition collapses–one is no longer seen as a person, but as an object of ridicule, subordination, or exclusion. Often shame is understood as self-focussed, and internalised. For instance, Zahavi[31] says "the feeling of shame does not occur because somebody else is doing something to you, but because you take what you have done to reveal an unpleasant truth about yourself… the focus of shame is on yourself… that their shame is deserved and justified. (p.350)". Let me unpack here little further on shame and humiliation. Pema's experience is not merely about shame because shame, phenomenologically, still allows for a sense of failure. It arises when one feels one has failed to live up to a norm one values. Shame is, in that sense, self-referential: I feel ashamed because I believe I have done something wrong, or because I imagine others see me as having done so. Humiliation, by contrast, is heteronomous , it is imposed. It originates in another's intentional act of degradation. Pema does not feel shame because she believes she has done something wrong; while she used both words, understanding within the larger context, she feels humiliated because the dermatologist's action , silently taking her belongings and dumping them in the bin. Her capacity to participate meaningfully in her own care is negated. The humiliation is therefore relational and structural: it is inflicted from above, through a gesture that enacts hierarchy and exclusion.

Taking forward Yancy's insights through 'white gaze', the humiliation lies in this ontological reduction: being made into something less than a coequal interlocutor in the moral community. Pema's humiliation operates in this register. The dermatologist's gesture communicates: your understanding does not matter, your words do not count, your body is to be managed, not engaged. This is why Pema's affective experience exceeds shame. Humiliation, however, exposes the fragility of one's moral personhood within a hierarchy of power; it reveals the structural denial of reciprocity. Her humiliation is not only emotional but ontological, a reminder that her presence in that clinical space is contingent, tolerated but not respected.

This preliminary characterization directs us to two related problems. First, we need to account for the trouble created by the asymmetrical gaze, the gaze of the dominant other that renders one hyper-visible yet unseen. In both Vani's and Pema's accounts, the disorientation that follows is not simply emotional; it is bodily, epistemic, and moral. Three interrelated elements capture this disturbance. First, humiliation disrupts one's habitual or taken-for-granted bodily relation with the world. Vani's repeated movements, following the doctors from ward to office and back, reflect not just desperation but a fractured relation to the hospital space. Like Fanon's "in the train, it was a question of being aware of my body," Vani becomes acutely aware of her bodily presence. What was once an unreflective movement of care for her mother becomes a self-conscious, effortful act, shadowed by institutional indifference. Her body as caregiver, as one marked by caste and class.

Second, humiliation generates a form of affective disorientation. In Fanon's[69] account, the collapse of the regular body schema gives way to an epidermal racial schema; in Vani and Pema's experiences, we see an analogous collapse of the relational body schema. Their capacity to move with confidence and moral assurance in institutional settings is replaced by an awareness of how they are being seen,as unworthy of explanation, of respect, or of voice.

The third and most critical element concerns how humiliation, while deeply disempowering, also contains within it a latent form of agency. From an anti-caste perspective, Guru[17], teach us that humiliation is not merely a psychological wound but a structural condition. Caste, like race, operates through everyday acts of disregard that discipline the oppressed into silence and self-doubt. Guru extends this analysis by arguing that humiliation is not only a form of injury

but also a claim, a moral and political assertion that one has been wronged, that one's dignity has been denied.

Thus, drawing from Guru's conceptualization, humiliation can be understood not merely as an affective state but as a claim. To appraise an act as humiliating, and to communicate this appraisal, to oneself, to one's community, or to the humiliator, is already to make a claim about one's worth, dignity, and rights. In this sense, resistance is not external to humiliation but internal to it. It is the very struggle for recognition of humiliation that signals a moral protest: a demand to be seen, respected, and acknowledged in the moral world. From this perspective, Vani and Pema's narratives are not only accounts of being disregarded but also of making claims. Vani's repeated efforts to seek information about her mother's condition, to follow the doctors "from the ward to their offices and back," reflect an implicit assertion of her right to be heard and informed. Her experience of humiliation becomes an epistemic and moral act, an assessment of injustice and an insistence that such treatment is not acceptable. Similarly, Pema's narration, "I am not dumb", is not only an expression of pain but a reclamation of agency. Her anger, humiliation, and shame coexist with a refusal to internalize the doctor's disregard; her speech performs what Guru identifies as the political act of communicating one's sense of disagreement.

Following Guru, I would argue humiliation thus presupposes a minimal possession of self-respect and dignity, without which humiliation cannot be felt or claimed. This means that those who can be humiliated are also those who have a sense of self that resists degradation. Humiliation, then, is both an injury and an affirmation. It exposes the structures that deny recognition while simultaneously attesting to the victim's capacity for moral judgment and protest. Seen in this light, the phenomenology of humiliation is not only about the affective disintegration of the self under the dominant gaze but also about the quiet, persistent work of reclaiming one's humanity through the very act of naming and claiming.

IV Significance of Humiliation

Before reflecting on the significance of humiliation for healthcare and medicine discourse, it's important we understand humiliation as it unfolds within healthcare, we must unsettle the assumption that the patient is a neutral or universal figure of vulnerability. In dominant biomedical ethics literature, the patient is imagined as an abstract and ahistorical subject, and vulnerable category. Yet, the patient is never a blank or equal category. It is always already marked by social hierarchies, of caste, race, class, gender, ability, and migration, that determine whose pain is legible, whose words are credible, and whose body is seen as deserving of care. Vulnerability, in this sense, is not an equalising condition but a stratified one: it is shaped by histories of marginalisation that render some more vulnerable to humiliation than others.

Humiliation does not often arise from being ill or dependent alone; it emerges when dependence is met with disregard, when institutional hierarchies of care reproduce the very social hierarchies that medicine claims to transcend. For those already marginalised, for instance, the poor, indigenous, Dalitbahujan, the migrant, the racialized woman, persons living with disability, clinical spaces become sites where social inequality is re-enacted through the body. Their vulnerability is not only physical but epistemic: their knowledge, voice, experience and moral standing are routinely dismissed. As a result, what might appear as a neutral exchange between doctor and patient becomes a reenactment of historical domination, a continuation of what Fanon called the "racial epidermal schema," where one's being-in-the-world is constantly mediated by the devaluing gaze of the powerful.

The humiliated subject in healthcare undergoes a similar disorientation: her bodily ease in the space of care gives way to an acute awareness of being seen, classified, and managed. The waiting, the tailing, the silent dismissal, these are not minor indignities; they are microcosms of a racialised and caste-marked order that defines who may speak and who must submit. In healthcare settings, such resistance often manifests through subtle but significant acts: Vani's persistent following of doctors, her refusal to disappear into the waiting space; Pema's angry declaration, "I am not dumb." These are not eruptions of irrational emotion; they are embodied assertions of epistemic agency. They challenge the norms of deference that structure the clinic and reassert the right to know, to question, to be treated as a subject rather than an object of care. Humiliation thus becomes the condition of possibility for moral knowledge, the moment when one's body reveals, through pain and protest, that injustice has occurred.

To understand humiliation as a site of both affect and agency, we must begin by rejecting the view that emotions are merely private, irrational disturbances. As the phenomenological account reminds us, emotions are not projections onto an indifferent world; they are ways of seeing and knowing the world. Our affective experience and life disclose meaning, it is through feeling that we apprehend the moral and political significance of our situations. To feel humiliation, then, is not to passively absorb an external insult, but to recognize a dissonance between one's sense of self and the world's denial of it. It is the affective registration of moral disorientation, a moment in which one's dignity is denied and yet, paradoxically, asserted through the awareness of that denial.

Gopal Guru's conceptualisation gives this phenomenological insight a distinctly political form. The act of claiming humiliation, of saying, this is humiliating, is simultaneously an epistemic and political gesture. It requires a consciousness of self-worth and a language through which to articulate it. Thus, humiliation contains within it the seeds of resistance: it is a mode of affective recognition that both perceives and contests injustice. Thus, it becomes an affective mode of knowing through which dignity is reclaimed and a new moral horizon imagined. Taken together, humiliation is a dynamic process of affective recognition. It is a site where feeling and reflection converge to reveal injustice and where moral agency is enacted through the very experience of feeling wronged. It is an affect that speaks, a felt recognition that exposes domination while affirming one's irreducible worth. In this light, humiliation is not only the language of injury but also of moral awakening; it is how the oppressed come to know and their own capacity to resist it. Patients' resistance can come in many ways, for instance complaints are one way to understand.

When situated in medical contexts, this understanding of humiliation as affective recognition illuminates the ethical and political dimensions of patient experience that are often obscured by institutional rationalities. Within clinical hierarchies, humiliation frequently takes the form of epistemic disregard, the dismissal of a patient's pain, testimony, or judgment as irrational, exaggerated, or irrelevant. To feel humiliated in such moments is not merely to feel hurt; it is to know, affectively and immediately, that one's worth as a knower and sufferer has been denied. This is a form of affective recognition through which patients apprehend the moral texture of their encounters, and it becomes a felt recognition of structural disrespect. And yet, following Guru, this feeling only acquires moral force when it is claimed,when the patient, or those who stand with her, name the encounter as humiliating. Such naming is a political act, one that reasserts her standing as a subject entitled to respect and dignity.

This claim-making process is often difficult within medicine's asymmetrical structures of authority, where epistemic and moral hierarchies are normalized within certain social-political context. Yet even within these constraints, humiliation can become an incipient form of resistance. The quiet refusal to comply, the withdrawal of trust, or the articulation of discontent in the language of dignity, all are affective modes of reclaiming agency. Patients in moments of humiliation, can enact subtle forms of ethical reversal. By naming, by testifying, by demanding acknowledgment, they expose the moral failure of care that renders them invisible. Their affective awareness becomes the ground of moral critique. This reorientation challenges the dominant biomedical epistemology that treats emotion as a contaminant of rational judgment. As I have noted earlier [73], in clinical contexts, emotions are not merely reactive states but interpretive lenses through which both patients and physicians make sense of uncertainty, trust, and care. For instance, emotions influence not only how patients evaluate risks but also how they orient themselves toward treatment, compliance, and hope, shaping their moral and behavioural stance in the face of illness. If emotions are, as phenomenology suggests, a form of felt cognition, then the patient's humiliation offers insight into the moral landscape of medicine, into what kinds of bodies, voices, and experiences are granted or denied value. To take humiliation seriously is to recognize it as a diagnostic of injustice. It reveals the structural conditions under which care becomes degrading, and the affective labor through which patients struggle to retain dignity. Recognizing humiliation as both epistemic and political thus demands a shift in how medicine understands moral harm: from individual sensitivity to relational and institutional failure.

From the standpoint of those positioned within marginalized social worlds, experiences of humiliation in medical encounters are not isolated emotional responses but forms of knowledge grounded in lived histories of disregard. Vani, a garment factory worker from a lower-caste background, and Pema, a doctoral researcher from Bhutan, both inhabit positions that render them especially attuned to the subtle but repeated gestures of disrespect that structure medical institutions. Their interpretations of these encounters, as humiliating, dismissive, or demeaning,are not exaggerated sensitivities but socially informed recognitions. Vani's feeling that "they don't even bother to stop for a second and listen to me" is not simply frustration; it is an epistemic claim about the moral order of care, a recognition born from long histories in which people like her have been made to wait, to plead, and to remain unheard. Her knowledge that this is how things are for people of her background emerges from collective experience, from a shared social epistemology that renders intelligible the recurrent patterns of exclusion within public hospitals.

Similarly, when Pema recounts her dermatologist's act, grabbing her pouch of cosmetics and dumping them into the bin without explanation, her anger and humiliation are not personal oversensitivity but a form of affective insight. To her, this gesture carried a moral meaning: that she did not matter, that her voice and understanding were inconsequential. Such recognition cannot be reduced to an individual's perception detached from history; it arises from the vantage point of someone whose accent, appearance, and social location have repeatedly marked her as less competent, less knowing. To claim that anyone could neutrally assess these encounters as humiliating would be to erase the interpretive authority of those who live within these hierarchies. Their judgments are not private emotions but socially grounded forms of knowing, made coherent by shared histories of caste, race, migration, and gendered subordination. Within these contexts, marginalized patients form what might be called an epistemic community, a community of knowers whose collective attunement to disrespect and disregard enables them to name what others overlook. Their recognition of humiliation,

then, is not only diagnostic of structural injustice but also a claim to moral agency and epistemic credibility within a system that persistently denies both.

Recently, one among many incidents revealed the intensity of these moral fault lines. In November 2024, Tamil Nadu, India witnessed a tragic escalation in tensions between healthcare professionals and the public after a brutal attack on an oncologist at a Super Specialty Hospital. The doctor was stabbed multiple times by the son of a cancer patient dissatisfied with the treatment his mother received. When the patient was later interviewed, she said, "The doctor spoke to me in a disrespectful manner. He didn't treat me properly which led to worsening of my condition… My son must have hurt the doctor out of love for me." This incident provoked statewide protests by medical professionals, with the Tamil Nadu Government Doctors Association (TNGDA) and the Indian Medical Association (IMA) demanding enhanced security and legal protection. While the attack was immediately framed as an act of violence against doctors, the mother's words bring into view another dimension, an unacknowledged landscape of humiliation, misrecognition, and moral injury. Her statement, seemingly simple, expresses a profound claim: that she was not treated with respect, that her suffering was not seen. When humiliation festers unaddressed, it can transform from a moral demand for recognition into acts of despair or vicarious retaliation. This tragic episode underscores how the affective economy of care in hierarchical systems can erupt when recognition collapses entirely.

Indeed, under conditions of systemic inequality, the humiliations experienced by marginalized patients often function as collective moral testimony. When Vani, Pema, or many marginalized voices their sense of being disregarded, they do not merely express distress; they reveal the moral fault lines of institutional care. Their humiliation becomes a communicative epistemic and political act, one that calls others into recognition, bear witness, making visible the boundaries of whose suffering is seen and whose is ignored. When received as credible testimony rather than emotional excess, humiliation opens spaces of empathy and moral repair. It transforms from a private wound into a political emotion, one that reconfigures the boundaries of who counts as a knower, whose experiences matter, and what justice demands. Thus, rather than treating humiliation as inherently corrosive, it is more illuminating to see its destructive potential as contingent upon the very injustices it seeks to expose. In contexts where the humiliated see no possibility of recognition, where their voices are repeatedly dismissed, the affect can harden into despair, bitterness, or moral withdrawal. But where there exists even a minimal horizon of acknowledgment, humiliation becomes a productive moral force. Its recognitional orientation compels institutions and actors to confront their complicity and opens the possibility of ethical transformation. In this way, humiliation reveals both the depth of moral injury and the persistence of moral agency. It is, at once, the symptom of injustice and the spark of resistance.

The significance of humiliation lies not merely in its affective depth but in how it unsettles the very grounds on which moral and epistemic theories of injustice have been built. Theories of epistemic injustice [74] and recognition [21] each begin from the moral intuition that subordination is experienced as disrespect, disbelief, and degradation, injuries that harm a person's relation to self. Fricker locates this injury within epistemic relations, arguing that those who are marginalized suffer testimonial and hermeneutical deficits that deprive them of credibility and interpretive authority. Honneth, situates the harm within moral relations, where disrespect and disregard violate the social conditions of self-realization, as well as suggest moral insights inherent in negative emotions. The experiences of Vani and Pema reveal, humiliation extends beyond epistemic discrediting or social misrecognition. Their encounters

with the hospital and bureaucratic apparatus do not simply reflect distorted relations of respect; they reveal a world in which the very capacity to appear as a credible sufferer is structured by hierarchies of caste, race, class, and gender. Then we can see humiliation is not a misunderstanding or deficit in recognition but an ontological condition. Against Fricker's moral optimism, Fanon[69] reading exposes the epistemic and affective violence that underwrites the very possibility of recognition. Here patient does not suffer from being unheard or disrespected; she is rendered unrecognizable within the terms of the existing world. Then, the next question for us is, how do we want to reimagine? When read through this lens, Vani's dismissal in the clinic and Pema's struggle to articulate pain are not instances of epistemic injustice to be corrected, but they disclose the persistence of one 'beingness' within modern institutions of care.

Here, Guru's concept of the "claim of humiliation" extends and reorients this discussion. Where Fricker seeks epistemic repair through virtue and Honneth imagines reconciliation through expanded recognition, Guru insists that humiliation itself can become a source of knowledge and agency. To recognize and name one's humiliation is already to perform an epistemic and political act, to know that one is humiliated and to refuse the moral order that legitimates that humiliation. This "claim of humiliation" transforms injury into moral appraisal, exposing the failure of the world to acknowledge one's worth. In Vani's insistence on being heard and Pema's declaration, "I am not dumb", we see this movement from imposed silence to the assertion of meaning. Their humiliation is not only something inflicted upon them but also something claimed by them, a form of resistance that refuses erasure. Then, humiliation emerges as a site where the limits of recognition and virtue ethics are both exposed and surpassed. It is not merely an affect or an injury but a form of critical consciousness, an embodied moral assessment of a world that has failed to recognize one's humanity. Through the phenomenology of humiliation, as illuminated by Vani and Pema, we see that the experience of degradation can also generate an ethical demand, a demand not simply for respect, but for the remaking of the world of care itself.

V Conclusion

I hope I have shown in this paper that humiliation, as an affective and embodied experience, is the felt experience of being devalued or degraded by another—an affect that arises when one's worth or standing is denied or diminished. Unlike shame, which turns inward and involves self-judgment, humiliation exposes the violence of disregard and the rupture of recognition between self and other. It reveals oppression not only as an external condition but as a felt disruption in one's self-respect and place in the world. Far from being a private emotion, humiliation is political: it registers the denial of recognition while simultaneously demanding it. It directs attention not to isolated acts of harm but to the structures, practices, and policies that sustain disregard. Then, humiliation is diagnostic, it exposes mechanisms of subordination while generating the affective conditions for ethical and political resistance.

In contexts such as medicine, where hierarchies of expertise often silence those who suffer, listening to humiliation as a moral claim requires acknowledging its affective and epistemic force. The humiliated are not voiceless; they are testifying. Their emotion is not a disturbance but a moral argument. When received as such, humiliation becomes a catalyst for ethical repair. Through this painful yet transformative labor of recognition, dignity is reclaimed, and justice begins to take shape. Unlike shame, which implodes inward, humiliation looks outward, it identifies the violation and calls it by name. Understanding humiliation as a distinct moral emotion shifts attention from the inner life of the self to the social and political structures that

deny respect. To take humiliation seriously, therefore, is to take agency seriously. It requires seeing those who endure humiliation not as fragile victims but as moral agents whose emotions convey knowledge about the injustices shaping their lives. Patients' articulations of humiliation, through persistence, complaint, silence, or quiet refusal, disrupt the image of the compliant patient and reveal the humiliated as perceptive, resistant, and desiring of dignity. Their gestures, refusals, and even silences can be read as affective and embodied critiques of the moral order that devalues them. To study humiliation, then, is not to catalogue disrespect but to attend to the subtle, often quiet ways in which the humiliated contest degradation.

Thus, taking humiliation seriously requires moving beyond the rescued-victim model that portrays those who suffer indignity as passive recipients of harm awaiting interpretation by the theorist. Patients who experience humiliation in healthcare are not inert; they anticipate, negotiate, and transform the terms of their subordination. Their emotional expressions are not mere outbursts but forms of moral knowing that unsettle the boundaries of medical authority. Reclaiming humiliation as a moral and phenomenological category opens new ethical and analytic ground: it compels us to reimagine medicine as a relational practice grounded in dignity, mutual recognition, and justice, one in which those once humiliated are recognized not as passive sufferers but as agents whose emotions disclose the truth of injustice.

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