



Brief Communication

Ableism, ageism, and other biases in healthcare: The impact on young adult patients

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ABSTRACT

Objectives: Young adult patients, particularly those with chronic and rare conditions, face unique challenges related to bias and discrimination when navigating the healthcare system. Making up a minority of individuals with chronic conditions, young adult patients can face micro- and macro aggressions from healthcare professionals related to their age or abilities. The consequences of these biases have a profound impact on the physical and mental health of young adults with chronic conditions. The purpose of this brief report is to present the findings of a multidisciplinary roundtable discussion on the impacts of bias in healthcare on young adult patients.

Methods: In a roundtable hosted by the patient-led advocacy organization Generation Patient, medical professionals, researchers, and young adult patients came together to discuss how ableism, ageism, and other biases affect young adult patients and identify solutions for how the healthcare system can begin to address this pervasive issue.

Results: This roundtable proceedings document outlines patient and healthcare professional perspectives on the consequences of ableism, ageism and other types of bias faced by young adult patients, including dismissal, misdiagnosis, and power imbalances in the clinician-patient relationship.

Conclusion: In this roundtable discussion, participants shared their vision for a more just healthcare system for vulnerable patients, including but not limited to young adults.

Practice implications: By bringing together the voices of key partners, this roundtable serves as a call to action for clinicians and the healthcare system to work together to reduce the root causes and subsequent implications of bias and discrimination in healthcare.

Introduction

Bias and discrimination remain pervasive forces in the healthcare system, deeply affecting how patients interact with their healthcare providers and access services.^{1,2} In the United States, it is estimated that approximately 60% of young adults are living with a chronic condition.³ For young adult patients, ageism (discrimination based on age)⁴ and ableism (discrimination based on ability/disability)⁵ are two particularly salient forms of bias and discrimination. Stereotypes that young people should be healthy, able-bodied, and resilient can lead to negative healthcare experiences for young adult patients.⁶ However, the unique experiences of young adult patients navigating bias and discrimination in the healthcare system have received little attention in the literature.

Experiences of bias and discrimination in the healthcare system do not occur in a vacuum, rather, they are influenced by many interrelated factors. Intersectionality refers to multiple different factors which can influence a patient's experience in the world and the healthcare system, including race, gender, sexual orientation, religion, age, disability, and mental health conditions.⁷ Those who are members of multiple minoritized groups based on their race, sexual orientation, or gender may be more vulnerable to discrimination and dismissal by medical providers,^{8,9} and these factors can compound the effects of ageism and ableism experienced by young adult patients. Understanding the impact of intersectional identities is key to addressing bias in healthcare and ultimately creating a more just healthcare system for all.¹⁰

These proceedings explore the harms of ageism and ableism in

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healthcare including dismissal, misdiagnosis and power imbalances in the clinician-patient relationship. The long-term impact of these experiences on the physical and mental health of patients was also discussed, as well as strategies to improve outcomes for this population.

Methods

The young-adult led community-based organization Generation Patient convened a round table discussion to explore the impact of ageism and ableism in the United States (US) healthcare system. This roundtable proceedings document explores how pervasive biases in the healthcare system and factors such as age and disability status can affect how young adult patients interact with the healthcare system. Key partners in the healthcare and health advocacy space were invited to participate in the virtual roundtable, including young adult patients, healthcare providers, community advocates, and researchers. Participants were intentionally selected to represent a wide range of experiences and opinions. Selection was based on topic area expertise (i.e., publications or patient advocacy work related to the topic area). The group's unique perspectives on the topic of ageism and ableism in healthcare resulted in a robust discussion which was recorded and used to inform this proceedings document. The following questions, co-developed by a group of young adult patients guided the discussion: How do ageist and ableist assumptions by healthcare providers specifically impact the diagnostic process and treatment outcomes for young adults with chronic or rare conditions? What are common assumptions that adult providers, in particular, make about young adult patients that are incorrect? How do these compound for women, LGBTQ+, and BIPOC communities? How do power dynamics in the provider-patient relationship uniquely affect young adults with chronic conditions? What role can patient narratives and lived experience play in shaping provider training and improving empathy and understanding in care delivery? What are good models of this? Following the roundtable, the transcript was reviewed by the roundtable leadership team and common themes were identified through group discussion and consensus.

Results

Eleven individuals participated in this 90-minute roundtable which was facilitated by two young adult patient advocates. The participants included three clinicians, five patients/patient advocates, and three researchers. Three themes were identified from the discussion: *Stereotypes and dismissal*, *diagnostic delays and misdiagnosis*, and *the power imbalance*.

Stereotypes and dismissal

Dismissal is a key consequence of ageism and ableism in healthcare that was discussed by our roundtable. Roundtable participants shared how these biases led to dismissal of their symptoms and concerns by their medical team. While dismissal was mentioned by several patient roundtable participants, it was a particularly significant problem from those with invisible symptoms such as pain or fatigue, or those with disabling symptoms more commonly seen in the older adult population. One patient participant shared their experience of their symptoms being dismissed because of their age:

No one wants to diagnose it, because they're like, oh, you know, again, it's like you're too young for that... I think that's so frustrating, is, like, this idea that, like, oh, well, like, maybe right now you're too young, so let's just, like, wait and delay it, and delay it. Until, like, you hit a threshold where maybe it's possible for you to be actually sick. (Young adult patient)

This patient shared that they were denied a proactive treatment approach because of a provider's belief that they were "too young" to receive a particular diagnosis and instead needed to wait until their symptoms escalated well beyond what would have been considered

sufficient for diagnosis in an older patient.

The toll that dismissal takes on young adult patients was a common thread throughout the roundtable discussion. One clinician who specializes in palliative care shared their experience hearing from patients talk about the emotional toll of having invisible symptoms like pain be dismissed:

Patients were saying that often the pain and the anxiety of being unseen and unheard by their clinician rivaled the pain of the disease. Because it was just, you know, not being heard... not feeling like they're being even considered. (Clinician)

Participants shared how previous experiences with dismissal created a hesitancy to engage with their healthcare providers in future encounters and made it challenging to access needed accommodations and treatment. One participant described this: "That one bad experience can, unfortunately, reflect the way that we do or do not seek care for...the foreseeable future" (Young adult patient).

Participants described that these biases and the resulting dismissal have profound negative consequences on young adult patients as they try to navigate the healthcare system. One patient shared their experience of contending with bias in the healthcare system as a young adult patient:

There is this, like, overall shift of trying to take away paternalism in medicine, but I feel like that is the real root of dismissal, because I feel like there's this just agency, this, like, self-perceived agency that they have the ability to make decisions about our health and our bodies without really being able to take our opinions or symptoms seriously. (Young adult patient)

Diagnostic delays and misdiagnosis

Diagnostic delays were a central theme in the roundtable and highlighted the intersection of ageism, ableism, and the invisibility of many symptoms young adults face. Participants described being told they were "too young" and urged to "wait and see," sometimes even after hospitalization for worsening symptoms. Participants underscored that "I do not know" should lead to a plan such as additional tests, specialty referral, or a time-bound follow up rather than an open-ended "wait and see." Transition points mattered to participants as well. Several noted that moving from pediatric to adult care increased delays, with age-based gatekeeping applied where a needs-based approach would have been more appropriate. One participant with polycystic ovary syndrome (PCOS) described seven years of debilitating menstrual pain and later metabolic symptoms that were repeatedly framed as problems of motivation, diet, and "self discipline." She described how fatphobic and racialized stereotypes eclipsed clinical curiosity until a subsequent OB/GYN ordered an androgen panel and confirmed PCOS within days. Another participant with multiple autoimmune conditions shared:

I was experiencing side effects from a medication my doctors prescribed but when I told her she said that it was being caused by anxiety and not the medication. She sent me to see a psychiatrist, which did not help, rather than changing my medication. Having her put that in my chart has also led to new medical providers dismissing additional symptoms I have had since then as being psychological and not taking me seriously. (Young adult patient)

The power imbalance

Participants emphasized how clinical authority, including what is written in the medical record, can shape life trajectories in ways that outlast a single visit. As one participant stated, "One appointment can have lasting effects...your actions, decisions, opinions, even notes you write...last far beyond that 20-minute appointment" (Young adult

patient). In routine care, our participants shared that this power appears in several forms including gatekeeping tests, referrals, therapies, and paperwork that determine access to services, accommodations, and disability supports.

Power also interacts with social location. Several participants reported being treated as more credible when they appeared older, professionally employed, or highly educated and less so when they were students, unable to work due to illness, or navigating financial insecurity. One participant noted that chart notes repeatedly referenced elite academic credentials, raising the concern that respectful care depended on proxies for education or class rather than clinical need. Racialized tone policing also shaped encounters. A Black woman described self-monitoring to avoid being read as “angry,” noting that fear of being perceived as unsafe can suppress legitimate advocacy and symptom reporting. Gendered expectations cut the other way for some men. One male patient participant shared that his pain was repeatedly discounted as a character issue rather than a clinical problem:

“...The amount of times [doctors] said, oh, just be a strong boy, you shouldn't be having pain, you shouldn't be... You'll get over it, you're a man, and all that. Just really putting you down, just making you feel even worse. (Young adult patient)

Another participant in their late twenties shared, “I could easily pass as 18 or 19...[and] the way I present myself in the clinic has a big impact on how I'm treated” (Young adult patient). These credibility markers were reported alongside racialized, gendered and size-based stereotypes, underscoring that age- and disability related bias rarely operates alone.

Discussion/conclusion

This roundtable discussion among young adult patients, clinicians, and researchers highlighted three key themes relating to healthcare bias and discrimination affecting young adult patients: *Stereotypes and dismissal*, *diagnostic delays and misdiagnosis*, and *the power imbalance*. Our roundtable participants emphasized the tangible consequences of bias and discrimination in healthcare, including diagnostic delays and misdiagnosis. Roundtable speakers discussed how young adult patients often don't fit the stereotypical picture of what a “disabled” or “sick” person looks like⁵, potentially resulting in dismissal and delayed or mis-diagnosis. Dismissal has also been reported in the literature: A 2019 study found that among their sample of over 500 hundred people living with the invisible condition myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS), 89% reported having experienced dismissal from a healthcare professional.¹¹ Similar findings were also reported in a study of individuals diagnosed with long COVID syndrome, who experienced dismissal of their symptoms resulting in delayed diagnosis and treatment.¹² The observations from our roundtable participants align with literature demonstrating how stigmatizing narratives, labeling, and documentation practices can entrench dismissal across settings.¹³

Whether implicit or explicit, bias affects all areas of healthcare from diagnosis to treatment. Due to their age and status as a comparative minority among those with chronic illness, young adult patients face unique challenges navigating bias and discrimination in the healthcare system. Young adult patients can face bias related to multiple intersectional identities, however, ageism and ableism are two particularly salient issues for this population that can have significant effects on diagnosis, treatment, and future health seeking behaviors for young adult patients.⁶ These roundtable proceedings report on a rich discussion between patients, healthcare providers, and researchers about ageism and ableism facing young adult patients. While this roundtable begins the conversation on addressing the causes and consequences of ageism and ableism, awareness is only the first step. Our roundtable participants reached the consensus that much work still must be done to address the root causes of bias and discrimination and help to create supportive healthcare environments where all patients feel safe and respected,

regardless of their age, ability, or identity.

Implications for practice

Roundtable contributors pointed to several practical ways to address biases in healthcare. First, clinicians can adopt explicit uncertainty scripts that state what is known, what is not, and the next steps, paired with automatic, time bound follow ups rather than open ended instructions to return if worse. Second, health systems can embed care navigators to coordinate referrals, prior authorizations, and disability paperwork, recognizing that gatekeeping shapes education and employment opportunities for young adults. Third, institutions can elevate patient voices through patient advisory councils, narrative medicine forums, and simulation-based communication training that centers validation of invisible symptoms. Finally, documentation practices can be aligned with these goals by avoiding speculative psychological labels, updating reported symptom lists as evidence evolves and including patient reported outcomes alongside test results. As participants noted, respectful care and accurate notes are not abstractions. They influence who is believed, what care is offered, and which futures remain possible.

CRediT authorship contribution statement

Katherine Melton: Writing – review & editing, Writing – original draft, Supervision, Methodology. **Meg Didier:** Writing – review & editing, Writing – original draft, Project administration. **Sneha Dave:** Writing – review & editing, Writing – original draft, Resources, Project administration, Funding acquisition, Conceptualization. **Rosewater Jemma Tiffany:** Writing – review & editing, Writing – original draft.

Ethical approval

Not applicable for this manuscript which reports the proceedings of a roundtable discussion.

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Generative AI was not used to write this manuscript.

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Declaration of Competing Interest

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Data availability

No data was used for the research described in the article.

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