Sarah – a Case Study in Unconscious Bias in Advocacy for Adults

1. Background

Sarah is a 52-year-old woman living independently in the community. She has a **mild learning disability** and a history of **anxiety** but overall manages her daily living with minimal support from a community support worker who visits weekly.

Sarah is known to services as someone who:

- Communicates verbally, though sometimes needs extra time
- Understands her needs when information is presented clearly
- Generally, engages well with professionals

Over a period of several months, Sarah begins experiencing:

- Persistent fatigue
- Unexplained weight loss
- Low energy and reduced appetite

Concerned, she agrees to attend a **GP appointment**, accompanied by her support worker for reassurance.

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2. The Professional Interaction

During the GP appointment:

- The GP **directs most questions to the support worker**, despite Sarah being present and able to respond
- Sarah attempts to describe her symptoms, but is **interrupted or not given enough time**
- The GP quickly concludes that her symptoms are likely linked to:
    - Lifestyle
    - Anxiety
    - Diet

No further investigations (such as blood tests) are arranged at this stage.

The appointment is brief, and Sarah leaves without a clear plan or reassurance.

The support worker feels uncomfortable but does not immediately challenge the GP's conclusions.

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3. Identification of Unconscious Bias

Several forms of unconscious bias are evident in this situation:

1. Ability Bias

The GP assumes that due to Sarah's learning disability:

- She may not understand her own symptoms
- She may not communicate reliably

➡️ This leads to reliance on the support worker rather than Sarah herself.

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2. Diagnostic Overshadowing

The GP attributes Sarah's physical symptoms to:

- Her existing anxiety
- Lifestyle factors

➡️ Her **physical health concerns are not explored independently**, leading to potential misdiagnosis.

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3. Communication Bias

The GP:

- Speaks *about* Sarah rather than *to* her
- Prioritises the support worker's input

➡️ This reduces Sarah's participation in her own care.

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4. Passive Bias (Support Worker)

The support worker:

- Recognises discomfort but does not initially challenge
- Accepts the professional's judgement

➡️ This reflects how bias can also exist through **lack of action**, not just decision-making.

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4. Impact on Sarah

The consequences of these biases are significant:

Emotional Impact

- Sarah feels **dismissed and unheard**
- Her anxiety increases
- She becomes less confident in attending future appointments

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Practical Impact

- Her symptoms are **not properly investigated**
- There is a **delay in diagnosis**
- She does not receive appropriate treatment

Rights-Based Impact

- Her right to be involved in decisions is not upheld
- Person-centred practice principles are not followed
- Equality in access to healthcare is compromised

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5. Advocacy Intervention

Following reflection after the appointment, the support worker recognises the presence of unconscious bias and takes action.

1. Re-centering Sarah's Voice

At the next GP appointment:

- The support worker ensures Sarah is spoken to first
- Encourages Sarah to describe her symptoms in her own words
- Supports communication by:
    - Allowing extra time
    - Using simple clarifying questions

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2. Professional Challenge

The support worker respectfully challenges the GP by saying:

- "Sarah has continued to experience these symptoms, and we're concerned they haven't improved."
- "Could we explore whether there may be a physical cause?"

➡️ This introduces **professional curiosity** without confrontation.

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3. Promoting Rights and Legal Frameworks

The support worker applies key principles:

- **Mental Capacity Act (2005)**
  - Assumes Sarah has capacity to describe her symptoms
- **Care Act (2014)**
  - Focuses on Sarah's wellbeing and involvement
- **Equality Act (2010)**
  - Ensures Sarah is not disadvantaged due to disability

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4. Escalation

When concerns are not fully addressed:

- The support worker requests further investigation
- A second opinion is sought if necessary

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6. Outcome

Following advocacy:

- Sarah is referred for **blood tests and further assessment**
- She is diagnosed with a **thyroid condition**
- Appropriate treatment begins

Positive Outcomes

✅ Sarah's health improves
✅ She feels **listened to and respected**
✅ Trust in services begins to rebuild
✅ The GP reflects on communication practices

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7. Key Learning Points

✅ Unconscious Bias is Common

Even experienced professionals can:

- Make assumptions based on diagnosis or presentation
- Overlook the person's voice

✅ Advocacy is Essential

Practitioners must:

- Ensure the adult is **central to all conversations**
- Speak up when something doesn't feel right
- Use respectful but clear challenge

✅ Communication Matters

Always:

- Speak directly to the adult
- Use accessible language
- Allow time for responses

✅ Impact Can Be Significant

Unchecked bias can lead to:

- Poor health outcomes
- Delayed interventions
- Emotional harm
- Inequality in service access

✅ Reflective Practice is Key

Professionals should regularly ask:

- "What assumptions am I making?"
- "Whose voice is leading the decision?"
- "Am I truly listening?"

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8. Application to Practice

This case study can be used to:

- Support **training on unconscious bias and advocacy**
- Evidence **reflective practice in supervision**
- Inform **safeguarding discussions**
- Strengthen **person-centred approaches**

💬 Optional Reflection Question for Learners

"If you were the support worker, what would you have done differently in the first appointment—and why?"