

# Agency in multiprofessional work: A case study of rehabilitation of an older patient in hospital care

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**Abstract:** Working with an older person involves different professionals and domains of knowledge. This study examines narratives of the members of a multiprofessional team and an older patient in the context of hospital rehabilitation. Methodologically it draws on social constructionism and the membership categorisation device (MCD). The aim is to show how the situational context, the rehabilitation team, and the agency of its members and the patient get constructed in the accounts of the interviewees. The analysis shows that the social order in hospital rehabilitation includes patterns of action that favour physical, i.e. medical, expertise. The members of the team studied constructed their team as a geriatric one in their accounts. Neither the social worker nor the patients were constructed as active agents in the core of multiprofessional working. The context of health care and the 'quest for certainty' challenge social work to find alternative ways of seeing the truths in a patient's life and to negotiate the solutions in multiprofessional working.

**Keywords:** Agency; older patients; membership categorisation; multiprofessional team

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*That is, the same case may be told in many different ways (and often is when a new professional becomes involved and sees things differently). (White 2002)*

## **The problematic nature of the multiprofessional team**

Different professions and domains of knowledge meet in the care of older people. It is a shared working context especially for the health and social care professionals. The actors, including the older persons themselves and their families, may possess very different views of the situation and functioning ability of the particular person. Social and health experts can even be seen competing – and the social being put on the defensive (see, for example, McDonald, 2006).

On the policy level, the strategic aim of the care of older people in Finland is that they be able to live at home as long as possible. Staying at home, instead of being taken care of in an institution, requires sufficient functioning ability. Keeping up and promoting functioning by rehabilitation is a means to realise this strategic aim. In Finland, citizens who are categorised as severely disabled have a right to rehabilitation which is financed by the social insurance institution of Finland and carried out in special rehabilitation centres – but only up to the age of 65. After that age, rehabilitation usually takes place in the public health care setting with the individuals being either in- or outpatients.

Rehabilitation is carried out by multiprofessional teams. The efficiency of the multiprofessional rehabilitation of older patients has been shown in many Finnish studies: hip fracture patients, not too severely demented, and the stroke patients all seem to benefit from it (Aalto and Rissanen, 2002; Huusko, 2004; Kallanranta, 2002; Valvanne, 2001). Multiprofessional teamwork, according to Payne (2000), means regular working of several different professionals together. The concept and practice of multiprofessionalism may have different meanings though. Opinions vary on what expertise is needed which influences the composition of multiprofessional teams in practice. Members of a multiprofessional team also may have different potentials and power to influence decision-making and assessment of the functioning ability of the patient. A user-centred approach, a subjective dimension of functioning, user involvement in assessment, and patient participation in planning are usually thought to be good rehabilitation practices. However, opportunities for an older patient to participate, i.e. active agency, in the institutional practice are rare (Gubrium et al., 2003; Kinni, 2005; Richards, 2000; Ueda and Okawa, 2003).

This paper discusses these issues on the basis of the research material emerging from a case study (Kinni, 2005) carried out in a large Finnish city. The narratives of an older inpatient and those of the members of the multiprofessional rehabilitation team working with her in a public hospital were analysed. From the perspective of social constructionism, the reality of multiprofessional working was seen to be

composed of different voices. The focus of the article is agency in multiprofessional teamwork. Who is included in, who excluded from, the team? Who are the active agents in rehabilitation? Who has the right to produce expertise knowledge on the functioning ability of the patient, and what kind of device is used to make a piece of knowledge a fact? What is the position of social work in this team in a health care setting? The aim of the paper is to show how the situational context, the rehabilitation team, and the agency of its members and the patient get constructed in the accounts of the actors.

Before discussing the method and results of the research in question, the paper deals with some aspects of a multiprofessional team's work in health care rehabilitation, in the hospital setting. In considering the institutional hospital setting, the article draws from the work of Prottas (1979) on people-processing and from that of Billig (1985, 1996) on bureaucratic categorisation. Social constructionist ideas on constructing the social identity in action (talk or other) lead to a closer look at some studies by Latimer (1997, 1999) and White (2002) that explore how the patients' social identity is constituted by the health care staff.

### **Dominance of the physical expertise?**

Talking about old age often means talking about physical functioning and care. Ageing often is accompanied by physical illnesses and disabilities. The importance of physical knowledge also has historical roots in knowledge building: the medical, geriatric, knowledge led to the formation of gerontological knowledge (Katz, 1996; Phillipson, 1998). Rehabilitation is considered as geriatric rehabilitation, in the health care context. There is a tendency to emphasise the physical functioning of the patient. According to Finnish studies, the core of the geriatric rehabilitation team consists of a doctor, a nurse, and a physiotherapist. The position of a social worker is less distinct: a social worker may be seen as a member of the team, but not in the core (e.g. Hartikainen and Kivelä, 2001). In some accounts, social work is more closely attached to the whole of the multiprofessional team (e.g. Valvanne, 2001). Research concerning the position of social work in multiprofessional working, especially in the contexts where other professional groups are dominant, has explored the possible conflicts (e.g. Fast, 2003; Huotari, 2003; Irvine et al., 2002). Distinct assessments and definitions of the client's situation emerge.

The concept of people-processing offers some explanations for the suggested dominance of the physical expertise. Every institution defines its clientele according to certain criteria. The hospital institution also works on the basis of its power to categorise people: to process people into patients suitable for its service provision (Prottas, 1979). Street-level bureaucrats act on the boundaries of organisations in face-to-face interaction with the citizens, placing them into categories relevant to

the institution. The experts in the physical domain, i.e. the doctors, act as street-level bureaucrats in the hospital. They make the dispositional decisions about whether a person can be categorised as a patient needing hospital care in the first place, and they also have the last word concerning discharge, on the basis of their medical expertise. The street-level bureaucrats do not care about the 'whole-person', but are only interested in the aspects relevant to the categorising criteria of the particular institution (Prottas, 1979). In this sense, they are like Billig's (1996, p. 158) bureaucrats as they 'cannot treat each individual case as if it were unique, but each case must be placed into bureaucratically suitable pigeon-holes'. They are 'faced with the problem of processing the messiness of the outside world into orderly categories' (Billig, 1996, 158). Here, the term 'categorisation' indicates setting an object into a pre-existing category with other objects resembling it as in classification (Billig, 1996; Bowker and Star, 1999).

Categorisation has advantages in office procedures: in organisation, order management, and efficiency (Billig, 1996). In social work, the issue is how to fit an individual into the criteria of certain social services or social security benefits. However, Billig (1985) goes further: categorisation without its counterpart particularisation does not exist in the human mind. Particularisation stresses the unique features of the object. Moving between these two processes makes our thinking rhetorical.

Billig's (1996, 168) statement moves us back to the multiprofessional team's problems: 'in selecting one form of discourse, or one schema, over another, we state implicitly that this form captures the essence of the matter best'. What kind of categories are used in the day-to-day practice in treating patients and making decisions concerning their discharge? The 'quest for certainty' (Gillett, 2004) in health care calls for using the objective, measurable qualities of the patients as the basis of decision-making. This is the case of the doctor as a street-level bureaucrat. To reach objectivity, better assessment devices, i.e. highly efficient measuring scales or other techniques, can be developed (see e.g. Ustun et al., 2003). There are certain consequences of looking at the issue only from this epistemological view. It leaves out the ontological issues of interprofessional encounters: how different expertises and domains of knowledge construct the reality of work and assessments of the patient? It also leaves out the patient (see Nikander, 2003).

## **Constructing the context and the agency of the members of the team**

Holstein and Gubrium (2000, p.ix) state that their interest has been

to deal with the question of the social construction of subjects and its mediating conditions in a variety of institutional settings', and go on to clarify that it is a question

of 'the ongoing practical activities of these settings, notably, the participants' shared understandings and the everyday work of interpreting actions and events of local interest'.

This paper shares these interests. The theoretical standpoint is in social constructionism: in the notion that the social reality is constructed in speech and other interaction, and the constructions bring with them different kind of action (e.g. Burr, 2003). In this study, the patient's social identity is seen to be constructed in the accounts of the professionals and the patient herself. It is constructed in a particular institutional setting: in the hospital. The professionals are health and social care professionals working in the multiprofessional team in the hospital ward.

In their everyday life, people make sense of what is going on in a particular situation; for example, by categorising other people involved in the situation (Antaki and Widdicombe, 1998; Holstein and Gubrium, 2000). They interact with others in the shared world of meanings, and create social order (Garfinkel and Sacks, 1986; Hester and Eglin, 1996; Holstein and Gubrium, 2000; Silverman, 1998). In this sense, the paper draws on the ethnomethodological tradition. The professionals in the hospital act knowing what they are up to, actively using the cultural resources available to them – also in the sense of people- processing. The patient also acts in this situational context. This study is interested particularly in finding out what the categorisations used by the interviewees tell about the agency of different parties in this multiprofessional context. Categories in this sense differ from the use of the concept by Billig (1985, 1996) in rhetorical social psychology. Here, no difference is made between general and particular categories per se. Categories are means for making sense of phenomena in situational human agency.

There is a rich literature dealing with the questions of constructing the identity of the client (e.g. Hall et al., 2003; Mäkitalo, 2002; Silverman, 1987; Spencer, 2001). In the current paper, special interest is in the works of Latimer (1997, 1999) and White (2002), who have examined the construction of the social identity of a patient in the health care setting. White (2002) has explored the case formulation in the British integrated child health service. She found three kinds of formulations: medical, psychosocial and not just medical. In her study, the material was produced in professional narratives about the cases. In a Finnish study (Kinni, 2005), White's idea of case formulation was applied in examining the social, psychological and physical aspects of functioning used in the construction of the social identity of the patient. This kind of examination gives information about the nature of the knowledge and expertise that affects the assessment and decision making in this case. Social aspects of functioning can be seen belonging to the expertise of social work. It could be presumed that emphasising social functioning of the patient would confirm the position and agency of social work in the multiprofessional setting.

Latimer (1997) studied the categorisation of patients in a British acute medical unit. According to her, nurses and doctors create social order in constructing patients'

social identities in order to organise disposal. Categorising entails making distinctions. Latimer draws on Silverman's (1987) study on diabetic patients in a clinic and 'the discourse of the social'. Following Silverman, she comes to the conclusion that 'the social' is not always beneficial to the patient. In her study, Latimer (1997, 177-178) noticed that when categorized psycho-social, older patients could be left without medical care. She writes: 'Those patients who cannot be moved up and out of the wards are also made disposable, but figuratively: they can be downgraded as social, as not belonging to the technical domain of acute medicine, they do not have to be cared about, responsibility can be minimalised, while more important tasks are pursued.' In Latimer's article, as well as in White's study, it was the professionals whose accounts were analysed. In the current paper, the patient's accounts also are analysed. Including her as an active agent entails interesting tensions between the expertise of a professional and a layman.

The agency gets constructed in two ways in this data: first, in the construction of the social identity of the patient through categorisation and, secondly, in the construction of the context of agency, the multiprofessional team (with its members and their social identities). People, i.e. the interviewees, place each other in categories relevant to the particular situation. Because people are acting according to their understanding what the situation is about, their accounts thus make visible the situational context itself.

## **Data and method**

### **Methodological foundations**

Social constructionism, as it is understood here, is interested in the agency: how people, as active agents, construct and reconstruct the social reality they live in (e.g. Parton and O'Byrne, 2000). The construction is made visible in the interviewees' categorisations. In their accounts, they make visible both the agency of each other and the membership in the rehabilitation team. Membership shows who are included in and who excluded from the rehabilitation team.

The importance of indexical, situational, properties of practical discourse is emphasized by the ethnomethodologists. Garfinkel and Sacks (1986, 161) state that practical reasoning is done by 'methodic observation and report of situated, socially organized particulars of everyday activities, which of course include particulars of natural language'. With indexicality they mean that 'the meaning of words is dependent on the context of their use', as Lepper (2000, p.4) puts it. The participants of the rehabilitation process use the words, including categories, depending on the way they see rehabilitation and the particular rehabilitation team.

Ethnomethodologists' interest in the members' knowledge and social reasoning led Harvey Sacks to examine the methods that the members use in their reasoning (Garfinkel and Sacks, 1986; Hester and Eglin, 1996; Silverman, 1998). He created the method for analysing talk, the Membership Categorisation Device, MCD (called also Membership Categorisation Analysis, MCA), which was used in analysing the data in this study.

### **Data production**

The theoretical approach of the research is that of the social construction. Methodologically, thus, we can speak about producing the data – instead of collecting it. The data were produced in interviews: each of the interviewees was asked to tell his or her narrative of the patient's rehabilitation process in hospital. The narrative form was chosen to produce the data so that the work would be data driven and preset categories would be avoided. After the narrative was finished, some issues concerning rehabilitation (such as who were involved in the rehabilitation of the patient, or had a rehabilitation plan been drawn up) were discussed.

Narratives and thematic discussions are treated as actively and collectively produced and interviews as events with interaction (Holstein and Gubrium, 1995; Silverman, 2000). This creates a demand to analyse the process of producing the narrative. According to Atkinson and Silverman (1997, p.318), personal narratives are not 'any more authentic or pure a reflection of the self than any other socially organized set of practices'. The context was familiar to the researcher, since she was 'an ethno', in a way a member herself. In a situation like this, there is a danger of losing the strangeness that reveals the taken for granted, as Latimer (1997) points out. At some points in the data, it can be noticed clearly that the professional interviewees have been talking to a colleague.

The interviewed team consisted of a social worker, a physiotherapist, two nurses, and a doctor. The patient was a woman more than 80 years of age, who was recovering from a hip fracture. In the beginning of the interview, she was asked to choose a name for herself, to be used in the data, and she chose Catharine (originally Katriina in Finnish). The criterion in choosing the patient and the team was that the patient's immediate future was 'unclear', so that as much different information as possible would be produced, in the shape of different voices (Flyjberg, 2004). Also a social worker should be included in the working. Silverman (2000) speaks about purposive, i.e. theoretical, sampling in qualitative research. In the article, the case works as an example of how the construction of the social identity of the patient and the situational context, the multiprofessional team, can be constructed in the members' accounts (Silverman, 2000).

The narratives and other material were produced in the interview discussions between the researcher and each particular interviewee. In a strict sense, the data

is not naturally occurring as, for example, Sacks understood it (see e.g. Silverman, 1998). The discussions did not take place in the common interaction of all the interviewees, so nothing can be said of that. But it is possible to compare and set the separate accounts in relation to each other. The two nurses were an exception: they were interviewed together, as they declared that they work together as a pair.

### **Analysis of the data**

The data, 43 pages of transcribed text, were analysed by the Membership Categorisation Device, MCD. According to Lepper (2000, p.4), Sacks, the developer of the MCD, developed 'a systematic analysis of the ways in which classes of persons – membership categories – and their activities – category bound activities – are employed within a 'base environment' – a membership categorization device – to assemble the inference-rich, recognizable actions and descriptions'. Jayyusi (1984) explores the distinction between membership categories and membership categorisations: a categorisation needs the work of members to categorise other members or using characterisations (for example a studying mother, an object of care), a category is already culturally available (for example a doctor, a patient). Jayyusi has, according to Lepper (2000, pp.33-34), 'provided an enlarged framework for the practice of categorization analysis'. This includes the study of predicates of a category: category generated features and category bound activities (Jayyusi, 1984; see also White, 2002). Possession of power tied to a category and the following right for agency are predicates of the particular category.

Another basic concept of MCD is a collection of categories. The classic example of it is a family consisting of mother, father, and baby (Silverman, 1998). Constructions of the rehabilitation team are this kind of category collections constituted in the accounts. They include actors (categories) and (power) relations between them. These collections are accomplished through distinctions including some actors and excluding some others. Categories, including certain tasks, are made to belong together, in collections or groupings, in the accounts of the interviewed actors (e.g. Silverman, 1998).

Sixteen different categories or categorisations concerning the patient's social identity could be found in the data. 'A person needing institutional care' and 'a person coping at home' were two of them. The data extracts below show how the professional actors constructed the patient as a person needing institutional care, when the client wishfully constructed herself as a person coping at home with the aid of the home help service. These categorisations are examples of the categorisations that are easy to see to have practical implications: the lady was discharged from the hospital to institutional care.

The doctor considers the options after hospital care:



*Well, she is not able to make it at home any more. It is clear that she needs institutional care. She is mentally so spry, so perhaps the service centre in her neighbourhood [would be a good option].*

The physiotherapist follows the line when specifying the aims of the rehabilitation process of the patient:

*She could cope there [in the service centre] with the aid of one person.*

The doctor and the physiotherapist also do the people-processing work here: they process Catharine to fit in the criteria of the clientele of the service centres. The criteria include, for example, that a person does not cope at home but she needs only one person's help for her care.

The patient comes to a different kind of a solution in her accounts:

*C: It was [a bad experience in sheltered housing last year] and I wish I could go right home from here.*

*I: Yes. So you want to go to your own home?*

*C: My own home.*

(C=Catharine, I=Interviewer)

Category collections showing how the interviewees understood the rehabilitation context, precisely the rehabilitation team, also could be found in the accounts. The collections can be presented in a visual, graphic, form. Two of them, the one of the nurses' and the one of the patient's, are presented in the next chapter.

## **Who is involved?**

### **The core team**

The data show how some of the categories belong tightly together in the core team, while others were in the margin. All the category collections of the professionals included the core 'we'. This shows how the members include some of the agents (professional or other) in an 'inner circle' of action and exclude some others (professional or other). Some of the categories also seem to have influence on the others, they possess power in making assessments and decisions.

The rehabilitation team constructed by the nurses is presented in the figure 1 and the one of Catharine in the figure 2. The nurses' one is exemplary of the professionals' constructions; nurses play a central role in caring of a patient in hospital, being the coordinators of the care. Catharine's construction differs from that of the professionals. It is clear that in this case the situational rehabilitation context in the speech of the

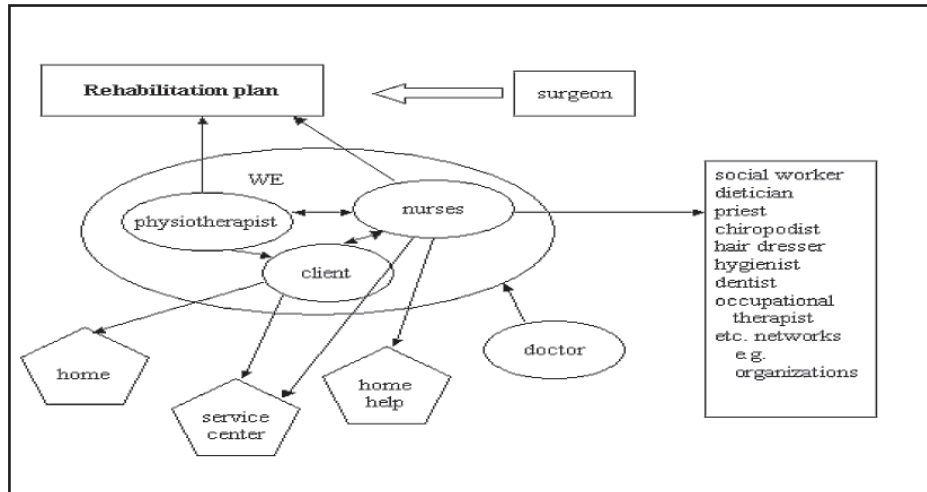


Figure 1. The nurses' construction of the rehabilitation team.

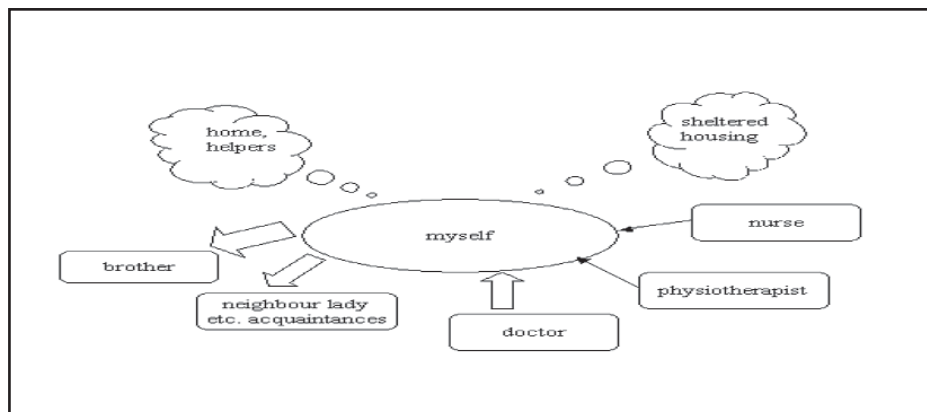


Figure 2. Catharine's construction of the rehabilitation team

professionals and the patient are totally different.

In the figures, the arrows represent relations. The direction of an arrow represents the direction of influence, sometimes also power. A broad arrow indicates high authority.

The nurses' construction represents the most general view of the team. The core team, the 'we', consists of the nurses, the physiotherapist, and the patient. It represents a geriatric rehabilitation team discussed in the earlier chapter. The nurse and the physiotherapist are a strong couple; they exclude the doctor from the core in their own constructions. They see each other in an active mutual interaction together.

*N1: ... we have planned with the physiotherapist what would be ...*

*I: Yes...*

*N1:...good things.*

*...*

*P: Well, written rehabilitation plans have not been drawn. I have only talked about them with the nurses. We have these little five-minute meetings every week. In them, we go through matters of our patients.*

(N1=Nurse 1, I=Interviewer, P=Physiotherapist)

The nurses believe that they have a special interplay with the patient. One's own professional involvement is seen to have a special meaning in the work with the patient. The nurses, according to their own accounts, coordinate the multiprofessional work with, for example, a social worker, a hair dresser, or a nutritionist. They also coordinate the cooperation with the networks outside the hospital.

*N1: We have these other professionals, a nutritionist is very important here. I do not know whether you have ever had to use one, do you even know that we have one? [the more experienced nurse asks the younger nurse]*

*N2: Seems quite unfamiliar to me.*

*N1: Yes. We do. If we have dietary problems, there is a nutritionist in the health centre, you can call her. A priest is one person we have to call quite often. The family wants Communion to be given.*

(N1=Nurse 1, N2=Nurse 2)

### **The social worker's position**

The social worker is included in every professional's construction of the rehabilitation team. However, the social worker is excluded from the core team. The social worker does not see herself belonging to the core, either. She was called to work with the patient by the nurse, the coordinator, and she performs the tasks the patient asks her to do. Her knowledge about the patient seems somewhat restricted.

*S: ...the nurse called and said that when one patient in the room had had a question, everybody else had had one, too... .. She [Catharine] had questions about the free card [concerning the hospital charges]... ..We agreed that I would look into the matter...*

*...*

*S: No, I did not have any more information except what she told me herself.*

*...*

*T: Yes. Well. Have you got an idea of the plans of the rest of the team?*

*S: No, there has not been any kind of a meeting or interaction in her case. She has this plan of further care in an institution and had these questions for the social worker.*

(S=Social worker, I=Interviewer)

The social worker is the only professional to include the doctor in the core team. She does not specify the other professionals in the core, but talks about 'rehabilitators'. This falls in line with her restricted knowledge about the patient and her treatment. In the social worker's construction the doctor defines who is involved in the patient's treatment.

*I: Yes. Who are the rehabilitators?*

*S: Er..*

*I: Professionally, I mean, what do you think?*

*S: I suppose, it is the staff in the ward, the members who have been assigned on the case by the doctor. I have not checked.*

(S=Social worker, I=Interviewer)

## Medical experts

Though the doctor generally is excluded from the core team, he does have influence. The client especially, sees the doctor as the most influential professional in her case. The doctor has expertise so he can be expected to make the right decisions.

*C: [laughing] I can make a wrong decision [about an operation], but it is not easy for a layman like me, to make those decisions.'*

...

*I: Yes. Who will make the decision of your discharge, then?*

*C: I have not asked.*

*I: Well, is it you or somebody else who will make the decision?*

*C: I am going to decide myself, if the doctor does not order otherwise.*

(C=Catharine, I=Interviewer)

The leading position of a doctor belongs to the traditional medical teamwork model (e.g. Irvine et al., 2002; Payne, 2000). It is a feature that shows that we are dealing with a geriatric, i.e. medical, rehabilitation team here.

The nurses' construction of the rehabilitation team reveals a very powerful agent: the surgeon. This professional actor, outside the core team and the organisation in question, appears to have the most of the power in the decision-making. He has more power than the doctor in the team, a consultant, and he has the expertise to interpret the 'evidence', the X-ray.

*D: She has gone through so many operations, this person, that I am going to show this [the X-ray] to the surgeon.*  
(D=Doctor)

The judgement of the surgeon took place while the interviews were made in the ward. The nurses and the physiotherapist were interviewed afterwards.

*'N1: She has got a new fracture. She has very osteoporotic bones, and that is why there is... Yesterday the surgeon showed the X-rays, and there is a fracture in the thighbone with very bad cracks. I said to the surgeon that he may have thrown the nails in there, to stick to the bone. That is to say, it does not look good. Because she has already been in a wheelchair a long time, the discharge plan for her is the service centre in her own neighbourhood.'*  
(N1=Nurse1)

This confirms the idea that the social order of the medical rehabilitation is maintained by the professionals in this case. The social order in question allows power to the medical professionals, especially to the highly specialised one. On the other hand, it leaves the social worker without power of agency. The involvement of the client is recognised to be of crucial importance in texts concerning rehabilitation, but it is often ignored in clinical practice (e.g. Ueda and Okawa, 2003).

### **The patient's everyday life**

The patient's construction of the rehabilitation context, the category collections in her accounts, looks totally different from that of the professionals. Her wishes also are in a sharp contrast with the plans of the professionals. The patient did not mention much of the hospital and the agents within its institutional domain in her narrative. Issues concerning the agents in the hospital came up only in connection with the thematic questions. In her narrative, she spoke of her everyday life at home. This proves the benefit of the narrative in finding out the constructions, in this case the categories and categorisations, of the interviewed members themselves.

In her narrative, Catharine (C) explores her life before the accident (falling and breaking her hip), and the reasons for the accident:

*C: The helpers visited me every day: home help twice in the morning, and then in the afternoon, and meals on wheels at noon.*

*I: Yes.*

*C: Also now, I feel that... I could go straight home from here. I would not have to go to any sheltered housing... I was like a bird in a cage there [crying].*

...

*C: I think that it was divine providence that I got here.*

*I: Yes?*

*C: I can go and console my brother in there [in another ward].*

In figure 2, the two clouds above the patient's self represent her wishes and her fears: her home and her helpers (home help and relatives) are what she wishes for, and sheltered housing is the dark cloud not wanted. Her brother and all kinds of acquaintances were present in the narrative. The professionals came along 'guided' by interviewer's questions. Social work is missing in the picture, though the patient had met the social worker. Catharine's accounts also confirm the idea of a medical team, though she does not have a very clear view of it. She sees herself as an active agent in her own life, when it does not relate to the institutional order.

## **Actors and facts**

### **Power of expertises**

Social knowledge does not play an important role in this case. It is there, but does not have much effective power. It is not connected with social work, either. The nurses and the physiotherapist take Catharine's living community into consideration when categorising her as 'a local resident': they thought she might like living in her familiar surroundings rather than in the centre of the city. The physiotherapist is aware of the importance of a peer group in rehabilitation. The doctor discusses (with the social worker-interviewer) the social security benefits and inequalities in them. The social worker talks about the importance of working together with a patient's family. Catharine talks a lot about her social network:

*C: ...my helpers [the family of her nephew] live quite near.*

...

*C: A person from home help came and said that during her vacation something must have happened to me as I was so pale. She called the district nurse.*

...

*C: Friends come to visit me like they used to, because I live in the centre.*

The social is woven into Catharine's everyday life. She is looking at it from her particular point of view. It is particularisation in Billig's (1985, 1996) sense.

The social (as a feature of a category) is not the most important aspect of the functioning ability in any professional's categorisations. Quite the contrary: it seems to have a minor meaning for the professionals in constructing the patient's social identity. Accomplishing cases – as White (2002) did in her study – by using the three

aspects of functioning, the social, the psychological, and the physical, results in the following kinds of cases (all of them concerning Catharine):

- the social worker: psychological-physical-social
- the nurses and the doctor: physical-psychological-social
- the physiotherapist: physical-social-psychological

Physical functioning and physical knowledge have a strong position in the work of this team, which considers itself as a geriatric one, i.e. medical. The physical is constructed in the talk about the bones, operations, ability to move and aids for that, haemoglobin, physical training and geriatric problems in the care of older people. The discussion about the psychological is rich in the data. It is shown in the accounts of mental activity or mood, and especially in the categorisation of ‘a non-dementia-sufferer’.

*S: She is a no-nonsense person... Of course, she has a goal for her rehabilitation: to get into the condition to be able to return home.’*

...

*‘D: I would not like to see her as a long-stay patient here in the hospital, because 90% of the patients are demented in there [wards for long-stay], and it is not very inspiring an environment. People regress very quickly.’*

(S=Social worker, D=Doctor)

The categorisation of the non-dementia sufferer was used by all the interviewees, also Catharine herself. Dementia is such a common problem for old people nowadays that, even when absent, it arises in the accounts of the actors as a negation. The categorisation of the non-dementia sufferer gives the patient the right to act as an active subject. In the data extract above, the social worker thus gives her right to plans of her own, which was not the case with the other professionals.

### **Subject or object of one’s rehabilitation**

‘The subject’ and ‘the object of one’s rehabilitation’ were categorised in many other ways, too. The categorisations of an object and a subject are data driven, but their use as interpretative categorisations have been influenced by the discussions which emphasise the meaning of patient’s subjectivity for successful rehabilitation (e.g. Ueda and Okawa, 2003; Gubrium et al., 2003).

All the actors constructed Catharine as an object. All the actors except the doctor constructed her also as a subject. The two categorisations could vary even in the same account. There is a movement between the rhetorical categorisations (in the meaning of generalisations) and particularisations (Billig, 1996; see also McKinlay

and Dunnet, 1998). The actors place the patient in the categorisation of a subject, draw her back from that category, and vice versa.

The social worker talks about the important things in Catharine's rehabilitation, stressing her subjectivity in the beginning, then constructing her as an object of the rehabilitators work in the next sentence (if we think that the term 'rehabilitator' calls for a passive object):

*'Well [sighing], I got the impression that this person is taking care of her things herself and is taking part in the planning. I understood that she is working together with her rehabilitators.'*

Catharine answers the question about her rehabilitation in the hospital and what it has consisted of:

*Well, I have not really been rehabilitated... I have lifted my hands like this [shows how] myself. Like this ten times...*

*The beginning of the account comes in the passive object form, the rest constructs her as very self-motivated. To the question about who decides in her matters, she answers, as already discussed in the previous chapter:*

*I am going to decide myself, if the doctor does not order otherwise.*

All in all, categorisation as an object was somewhat more common than categorisation as a subject in this data. Categorisation as an object was especially common in talking about drawing up the rehabilitation plan.

*I: Have you had, you and the staff, any discussions about what would be the goal for this period in the hospital?*

*C: No-o*

*...*

*I: Yes. Well, what do you think, how has this person participated in the planning?*

*N1: ...Were you involved? [asks the other nurse] It is more like this: when we [the professionals] do our everyday work, we chat here and there.*

*(C=Catharine, N1=Nurse1, I=Interviewer)*

Catharine talks repeatedly about her bad experience during an interval in sheltered housing: the 'bird in a cage' experience. The accounts illustrate the experience of losing control of one's own life. There were other accounts in the talk of Catharine, too, that illustrated the loss of control when moving from one's home to an institution: leaving the diary and the purse behind at home, and being taken to the hospital in pyjamas. In an institution, a person seems in this case to become an object without control. Being an object seems to be a feature of a membership category 'patient' in the hospital institution.



## Moral issues

Catharine is in diapers in the hospital, which can also be seen as a way of losing control. Moral discussions about two issues concerning Catharine can be found in the data. The physiotherapist and the nurses take part in the moral discussion about diapers and goals. Making moral statements entails using power. The social worker stresses Catharine's right to determine her own business. She makes the patient's right for agency a fact by repeating it in almost all her accounts. The social worker doesn't make moral statements concerning Catharine (see, for example, Juhila, 2003; White, 2003).

The nurses and the physiotherapist see using diapers partly as Catharine's personal weakness; she should work harder to change the situation.

*N1: ...What more about the physical aspect? Now, really, she is moved to the wheel chair by one person with a hugging grip, but toileting is still problematic. We have a lot of training to do before we can get her to believe that she can go to the toilet and does not have to relieve herself on the diapers. It is a little sad a thing that she has stayed that way. She dines independently, tidily. Have you got something to say? [to the other nurse]*

...

(N1=Nurse1, P=Physiotherapist)

*'P: And then there is the toilet training. It is very important. We could get rid of the diapers and into a situation where [she could move] from the wheelchair to the toilet seat in the toilet.'*

Catharine herself considers the matter from a different angle:

*'I did not have to use diapers at all at home. I do not know why it is...that since the time I have come here I have needed [them]. There must be many psychological reasons.'*

The problem seems in Catharine's thoughts to be connected with the psychological loss of control when moving from home to the hospital.

The physiotherapist uses another interesting categorisation: 'a realist'. She is pleased to categorise Catharine a realist who has not got too high expectations about the goals of her rehabilitation.

*'P: Actually quite nicely, my goals have been quite the same, these goals of ours have met, the client's one and mine.*

*I: Yeah...*

*P: She is so much of a realist that she can assess this situation.*

(P=physiotherapist, I=interviewer)

### **X-ray is the fact**

In her narrative, the physiotherapist had stated that the goal of the rehabilitation cannot be set very high, because Catharine has spent two years in a wheelchair, and she will not be able to walk again. She also points out the surgeon's negative assessment of the new operation. The assessment of the surgeon, the highest expertise, is factualised by the X-ray.

The moral statements and the means for factualising are in line with the idea that professional expertise is of major importance in rehabilitation. They are also in line with the idea that the physical is the most important aspect of the functioning and expertise in this case. The physical expertise is given the strongest position in agency. The factualising process here is something like Gillett (2004) states: the patient's view and observations often are passed in medicine and *the* truth is believed to be obtained through objective measuring. That is what is expected to be reached by different measuring scales of functioning ability in the care of older people. Here, the X-ray is a very obvious technical tool to prove the rightness of one's assessment. The picture made the categorisation of 'the person needing institutional care' a fact. The appearance of the X-ray made a twist in the narrative, so that any other decisions could not be considered. The doctor gives his reasons to the need for Catharine's care in an institution:

*A place for her could be got in there, so she could have help and care around the clock. She has been a wheelchair patient, and will stay that way. I do not believe that the surgeon will suggest a new operation when he sees the X-ray, and reads those previous papers.*

All the other professionals agree. The social worker does not make any categorisation about Catharine's need for institutional care or staying at home herself. She gives up her agency, and accepts the categorisations done by the others – the professionals and the patient.

A person's point of view is contrasted with that of the institutional agents. Catharine explores her subjective functioning ability in a holistic way. In her accounts, all the aspects of functioning, the social, the psychological, and the physical, are found in a subjective, holistic, situated mixture. Catharine categorises herself as 'a person coping at home with home help'. Her actual, contextual, everyday life functioning does not come up very clearly in making decisions and constructing knowledge about the functioning ability (see Gubrium et al., 2003; also Richards, 2000).

The problem of discharge is discussed on the physical grounds, and the factualisation of the categorisation as 'a person needing institutional care' is done on the physical basis. However, it turns out that the final reason is more social. The discussion with the nurses brought out the following:

*I: Has she talked to you about going home? At any stage? As her goal?*

*N1: Yes, yes, she has. In a way, she is waiting to get home. But she has got second thoughts now when we talked about the service centre. She still thinks that she would be there only for a while, and then return to her own home.*

*I: I see.*

*N1: When I told her that, unfortunately, there [in the patient's place of residence in a countryside population centre] is no home help in the evenings, she became very thoughtful.*

(N1=nurse 1, I=interviewer)

The discussion shows that it is a question about the social and health services. A call from the home help in the evenings would have been needed, and that was not available in her living community. An extra call is what Catharine wishes herself, too:

*It [her home] is so nice, if only I could get somebody to come the third time [home help three times a day] from the service centre.*

However, these notions about crucial social issues are not given enough attention in the reasoning in the data.

## **Concluding remarks**

The members of the team studied constructed their team as a geriatric one in their accounts. The social order of the team includes such patterns of action that favour physical, i.e. medical, expertise (see Burr, 2003, 5; also Parton & O'Byrne, 2000). The members, and also the patient, act so as to reassert the agency and the entitlement to decision-making of a doctor, especially the surgeon. On the whole, it mainly is the experts in physical functioning who have active agency. The nurse, the physiotherapist, and the patient are included in the core team. The doctor is also included in some accounts. On the other hand, the social worker is excluded from the core in the shared understanding of the interviewees. The social worker is a member of the team, but she is acting in the margin. The social worker's position is somewhat subordinate to the other professions and expertises. The social worker does not use power in moral talk, either. The knowledge about the social functioning is somewhat important – very important in the patient's accounts – but it is not associated with social work. In this case, the social worker acts in a very client-centred way, stressing the patient's right to active agency, but she seems to give away her own agency as an expert professional.

The professionals did have different stories to tell by categorising the patient (see White, 2002). This is seen in how they construct the social identity of the patient in their narratives in describing her by making categorisations. However, their categorisations did not differ significantly. An important difference can be

seen between the categorisations of the professionals and those of the patient. The professionals categorised the patient as a person needing institutional care, while the patient categorised herself as a person coping at home with the aid of home help services. The patient also constructed the meanings in her agency and her social identity from her particular everyday life point of view. This view contrasts with the institutional view of the professional team. In institutional practice, the patient is not given full agency in her rehabilitation process, nor is her contextual everyday life taken into consideration.

This case study shows that the agency and knowledge of the social worker and the patient, i.e. the social and the everyday life knowledge, have a marginal position in the shared world of meanings of the multiprofessional team working in a health care institution. If, as Latimer (1997) claims, being categorised as social is not good for a patient, being categorised according to physical and psychological features is positive. However, for the profession of social work, and social workers working in a multiprofessional context of care, it is not very encouraging – and it also leaves part of the patient's life out of consideration. Social work does not have technical tools which would guarantee objective measurement to satisfy the criteria of the social order in hospital, and help the work of street-level bureaucrats in their work. Constructive social work could offer some solutions to the problematic nature of multiprofessional work (see e.g. Parton and O'Byrne, 2000). First, it could offer a way of looking at the patients' life situations with 'a critical stance toward our taken-for-granted ways of understanding the world', as Burr (1995, 2) puts it. Secondly, it could promote the kind of working habits and methods which – also in the health care context – would help interprofessional team to accept the ambiguity of situations and solutions. There are not always unambiguous criteria available according to which the patient can be placed 'in the right pigeon hole', and to make 'right' decisions. Emphasis would be shifted from 'a conception of truth as discovery to a conception of truth as process' (Parton and O'Byrne, 2000, 182). This kind of work would emphasise dialogic negotiation skills, and change the social order so as to include all the members of the multiprofessional work, including the old persons themselves, in the active agency.

## References:

- Aalto, A-M. and Rissanen, P. (2002) Yhteenveto kuntoutuksen vaikuttavuuden arvioinnista. in A-M.Aalto, H. Hurri, A. Järvikoski, J. Järvisalo, V. Karjalainen, H. Paatero, T. Pohjolainen, and P. Rissanen, Pekka *Kannattaako Kuntoutus? Asiantuntijakatsaus eräiden kuntoutusmuotojen vaikuttavuudesta. [Is rehabilitation beneficial? An expertise report on the impact of some models of rehabilitation]* Helsinki: Stakes, Reports 267
- Antaki, C. and Widdicombe, S. (1998) Identity as an achievement and as a tool. in C. Antaki and S. Widdicombe *Identities in Talk*. London: Sage

- Atkinson, P. and Silverman, D. (1997) Kundera's immortality: The interview society and the invention of the self. *Qualitative Inquiry*, 3, 3, 324-345
- Billig, M. (1985) Prejudice, categorization and particularization: From a perceptual to rhetorical approach. *European Journal of Social Psychology*, 5, 79-103
- Billig, M. (1996) *Arguing and Thinking: A rhetorical approach to social psychology*. (2nd ed.) Cambridge: Cambridge University Press
- Bowker, G.C. and Star, S.L. (1999) *Sorting Things Out: Classification and its consequences*. Cambridge, MA: MIT Press
- Burr, V. (2003) *Social Constructionism*. (2nd ed.) London: Routledge
- Fast, J.D. (2003) An in-law comes to stay: Examination of interdisciplinary conflict in a school-based health center. *Social Work*, 48, 1, 45-50
- Flyjberg, B. (2004) Five misunderstandings about case-study research. in C. Seale, G. Gobo, J.F. Gubrium, and D. Silverman, David *Qualitative Research Practice*. London: Sage
- Garfinkel, H. and Sacks, H. (1986) On formal structures of practical actions. in H. Garfinkel: *Ethnomethodological Studies of Work: Studies in ethnomethodology*. London: Routledge & Kegan Paul
- Gillett, G. (2004) Clinical medicine and the quest for certainty. *Social Science and Medicine*, 58, 727-738
- Gubrium, J.F., Rittman, M.R., Williams, C., Young M.E., and Boylstein, C.A. (2003) Benchmarking as everyday functional assessment in stroke recovery. *Journal of Gerontology: Social Sciences*, 58B, 4, 203-211
- Hall, C., Juhila, K., Parton, N., and Pösö, T. (2003): *Constructing Clienthood in Social Work and Human Services: Interaction, identities and practices*. London: Jessica Kingsley
- Hartikainen, S. and Kivelä S-L. (2001) Ikääntyvien ja iäkkäiden kuntoutus. [Rehabilitation of older people and people getting old] in T. Kallanranta, P. Rissanen, and I. Vilkkumaa *Kuntoutus. [Rehabilitation]* Helsinki: Duodecim
- Hester, S. and Eglin, P. (1996) Membership categorization analysis: An introduction. in S. Hester and P. Eglin *Culture in Action. Studies in membership categorization analysis*. Studies in ethnomethodology and conversation analysis no 4. Washington D.C.: International institute for ethnomethodology and conversation analysis / University Press of America
- Holstein, J.A. and Gubrium J.F. (1995) *The Active Interview*. London: Sage
- Holstein, J.A. and Gubrium, J.F. (2000) *The Self We Live By: Narrative identity in a postmodern world*. New York: Oxford University Press
- Huotari, R. (2003) Contradictions in interprofessional care: Possibilities for change and development? *Journal of Interprofessional Care*, 17, 2, 151-160
- Huusko, T. (2004) Geriatriksen kuntoutuksen vaikuttavuus. [Impacts of geriatric rehabilitation] *Vanhustyö*, 7, 11-13
- Irvine, R., Kerridge, I., McPhee, J., and Freeman, S. (2002) Interprofessionalism and ethics: Consensus or clash of cultures? *Journal of Interprofessional Care*, 16, 3, 119-210
- Jayyusi, L. (1984) *Categorization and the Moral Order*. London: Routledge & Kegan Paul
- Juhila, K. (2003) Creating a 'bad' client. Disalignment of institutional identities in social work interaction. in C. Hall, K. Juhila, N. Parton and T. Pösö *Constructing Clienthood in Social*

- Work and Human Services: Interaction, identities and practices*. London: Jessica Kingsley
- Kallanranta, T. (2002) Neurologisen kuntoutuksen vaikuttavuus. [Impact of neurological rehabilitation] in A-M. Aalto, H. Hurri, A. Järvikoski, J. Järvisalo, V. Karjalainen, H. Paatero, T. Pohjolainen, and P. Rissanen *Kannattaako Kuntoutus? Asiantuntijakatsaus eräiden kuntoutusmuotojen vaikuttavuudesta. [Is rehabilitation beneficial? An expertise report on the impact of some models of rehabilitation]* Helsinki: Stakes, Reports 267
- Katz, S. (1996) *Disciplining Old Age: The formation of gerontological knowledge*. Charlottesville: University Press of Virginia
- Kinni, R-L. (2005) *Oma Arki Kotona – Riittävä Apu Laitoksessa: Vanhus kuntoutujana sairaalan moniammatillisessa työssä. [Everyday Life at Home – Sufficient Help in Institution: An older patient and multiprofessional rehabilitation in hospital]* Licentiate study, University of Kuopio, Department of social work and social pedagogy
- Latimer, J. (1997) Giving patient a future: The constituting of classes in an acute medical unit. *Sociology of Health and Illness*, 19, 2, 160-185
- Latimer, J. (1999) The dark at the bottom of the stairs: Performance and participation of hospitalized older people. *Medical Anthropology Quarterly*, 13, 2, 186-213. (Article retrieved 2.2.2007 from <http://www.jstor.org>)
- Lepper, G. (2000) *Categories in Text and Talk: A practical introduction to categorization analysis*. London: Sage
- McDonald, C. (2006): *Challenging Social Work: The institutional context of practice*. Basingstoke: Palgrave
- McKinlay, A. and Dunnett, A. (1998): How gun-owners accomplish being deadly average. in C. Antaki and S. Widdicombe *Identities in Talk*. London: Sage
- Mäkitalo, Å. (2002) *Categorizing Work: Knowing, arguing and social dilemmas in vocational guidance*. Göteborg: Acta Universitatis Gothoburgensis, Göteborg Studies in Educational Sciences 177
- Nikander, P. (2003): The absent client. Case description and decision making in interprofessional meetings. in C. Hall, K. Juhila, N. Parton, and T. Pösö *Constructing Clienthood in Social Work and Human Services. Interaction, Identities and Practices*. London: Jessica Kingsley
- Parton, N. and O'Byrne, P. (2000) *Constructive Social Work: Towards a new practice*. Basingstoke: Macmillan
- Payne, M. (2000) *Teamwork in Multiprofessional Care*. Basingstoke: Palgrave
- Phillipson, C. (1998) *Reconstructing Old Age: New agendas in social theory and practice*. London: Sage
- Prottas, J.M. (1979) *People-Processing: The street-level bureaucrat in public service bureaucracies*. Boston: Lexington Books
- Richards, S. (2000) Bridging the divide: Elders and the assessment process. *British Journal of Social Work*, 30, 37-49
- Silverman, D. (1987) *Communication and Medical Practice: Social relations in the clinic*. London: Sage
- Silverman, D (1998) *Harvey Sacks: Social science and conversation analysis*. Cambridge: Polity Press

- Silverman, D. (2000) *Doing Qualitative Research: A practical handbook*. London: Sage
- Spencer, J.W. (2001) Self-presentation and organizational processing in a human service agency. in J.F. Gubrium and J.A. Holstein *Institutional Selves: Troubled identities in a postmodern world*. New York: Oxford University Press
- Ueda, S. and Okawa Y. (2003) The subjective dimension of functioning and disability: What is it and what is it for? *Disability and Rehabilitation*, 25, 11-12, 596-601
- Ustun, T.B., Chatterji, S., Bickenbach, J., Kostanjsek, N., and Scheider, M. (2003) The international classification of functioning, disability and health: A new tool for understanding disability and health. *Disability and Rehabilitation*, 25, 11-12, 565-571
- Valvanne, J. (2001): Geriatriinen kuntoutus. [Geriatric rehabilitation] *Dementiauutiset*, 3, 4-6
- White, S. (2002) Accomplishing 'the case' in paediatrics and child health: medicine and morality in inter-professional talk. *Sociology of Health and Illness*, 24, 4, 409-435
- White, S. (2003): The social worker as moral judge: Blame, responsibility and case formulation. in C. Hall, K. Juhila, N. Parton, and T. Pösö (Eds.) *Constructing Clienthood in Social Work and Human Services. Interaction, identities and practices*. London: Jessica Kingsley