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# **Social work for 'liquid old age': Some insights from an ethnographic study of a hospital social work team**

## **Abstract**

This article explores the values enacted by social workers involved in care planning for older people and their implications. The data are derived from an ethnographic study of a hospital social work team responsible for planning and arranging packages care, almost exclusively for older patients (aged 80+), prior to their discharge, in a large general hospital in the UK. The study set out to explore the nature of statutory hospital social work, how hospital social workers do their work, and how social work fits into the hospital context. The primary methods of data collection were participant observation and semi-structured interviews with social workers, clinicians, patients and carers. Where patients' mental capacity was not in doubt, social workers were found to be strong advocates of patients' choices as free individuals. It is argued that the individualistic focus of the social workers' practices facilitates the production of a precarious existence that can be characterised in Bauman's terms as 'liquid old age', which involves coping with the physical, emotional and social challenges of ageing alone or with little assistance. Depending on an individual's circumstances, the social workers' advocacy of personal choice can either be liberating or detrimental.

## **Key Words**

Social work; social work values; liquid modernity; ethnography; qualitative research; older people; critical gerontology

## **Introduction**

Although social work seeks to comprehend the difficulties that people encounter through a broad understanding of the nature of social structures and the effects of disadvantage, poverty and oppression (Payne, 2014) the reality of many settings in which social work takes place is that practice focuses on intervening at the individual level. Individualism is at the heart of a variety of long established and well-respected social work approaches, from counselling-derived interactions to care planning (Houston, 2016) and is particularly visible in social work with older people in all devolved nations of the UK. The tasks of older people's social workers since the enactment of the NHS and Community Care Act 1990 have been to assess individual need and arrange for the purchase of services on the individual's behalf by the local authority (McDonald, 2006). The emphasis on individualism and consumerism at the heart of this approach has become more entrenched with the introduction of direct payments and then personal budgets as the means through which individuals can take control of the services they require to meet their needs (Gardner, 2014). While the devolved nations of the UK<sup>1</sup> have begun to diverge from pursuit of the consumerist agenda – with Wales, for example, pursuing an approach based on citizenship rights (Williams, 2011) – it is nonetheless the case that care planning approaches continue to focus on the welfare of an individual and give little scope for social workers to intervene in the wider structures that impact on older people's lives (Lymbery and Postle, 2010). Across all four of the UK's nations, legislation such as the Care Act 2014 (in England), the Social Services and Well-being (Wales) Act 2014, the Social Care (Self-directed support) (Scotland) Act 2016 and the Health and Social Care Reform Act 2009 (Northern Ireland) continue to point towards the primacy of individual choice and self-determination.

## **Hospital Social Work**

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<sup>1</sup> Health and social care policy are devolved matters, meaning that the four nations of the UK (England, Wales, Scotland and Northern Ireland) each enact their own legislation independently of one another, although England and Wales share the Mental Capacity Act 2005, which governs decision making for people whose capacity to make decisions is impaired.

Across the UK, hospital social work has become particularly associated with discharge planning, since the growth in demand for health services, along with restrictions to the funding of health services demanded by the prevailing ideology of neoliberalism, has meant that there is constant pressure to free up hospital beds (Glasby, 2003; Moriarty et al., 2019). It is enormously challenging for social workers to meet the required turnover of patient discharges while continuing to maintain the core social work value of respect for individuals and families, especially since decisions over discharge destination can be difficult and take time, for example where residential care is being considered (Lee et al., 2013).

Discharge planning requires good interagency and interprofessional working (Lin et al., 2012; Barber et al., 2015; Albrithen and Yalli, 2016) yet relationships between social workers and health professionals are rarely straightforward. Tensions can arise both due to the conflicting priorities of each actor (i.e. health professionals need the patient's discharge to be speedy, while social workers may need to take time to make sure that the care plan is right for the patient) and due to social workers' position as outsiders within the hospital setting (Beddoe, 2011). Whereas the social order of the hospital coalesces around the authority of the most senior physician (Nugus et al., 2010) with a hierarchy beneath depending on a combination both profession and experience (Allen, 1997), social workers employed by local authorities regard themselves as belonging outside the medical jurisdiction, so that even the most junior social worker could be expected to challenge the opinion of the most senior doctor (Burrows, 2020).

The process of discharge planning can be bewildering and disempowering experience for patients, and hospital social workers therefore regard patient advocacy as an important part of their role (Heenan and Birrell, 2018), especially since they claim to have a more holistic understanding of people's needs than their medical colleagues (Beder, 2006; Nillson et al., 2013; Craig et al., 2015). There is some emerging evidence that more holistic and therapeutically orientated hospital social work interventions can reduce rates of

readmission (e.g. Basso Lipani et al., 2015; Alvarez et al., 2016), yet this has gained little traction so far with UK policy makers.

In summary, hospital social work represents a particularly high-pressured area of social work with older people, since the complex work of discharge planning takes place within an institutional context, and under systems of management, that demand swift task completion. Despite these pressures, hospital social workers assert their independence from medical dominance and, as will be explored below, act according to a coherent set of values.

### **Social Work, Old Age and Liquid Modernity**

Social work is naturally shaped by the socio-cultural context in which it occurs (Wallace and Pease, 2011). The individually focused nature of social work practice with older people should therefore be understood as deriving not only from government policies, with their underpinning neoliberal economic ideas around market discipline and consumer choice (Griffiths, 1988), but also from the wider prevailing culture and ideology of individualism in the society in which it is located. The primacy of individual freedom invoked by Enlightenment thinkers is commonly recognised as a core trait of the modern Western world (Siedentop, 2014) and is a bedrock of the ideology and legal realisation of human rights (Ife, 2012). The individualism of Western cultures in the contemporary era, however, goes beyond both the respect for individual liberty that was central to the Enlightenment and the economic model of neoliberalism, to permeate all aspects of social life, culminating in what Bauman (2000a) has described as 'liquid modernity' – an era in which the individual is both free and responsible for her/his own life and being, within a world that presents a never-ending stream of consumer choices and in which no way of being and living can ever 'solidify' into tradition or certainty. While Giddens (1992; 1999) and Beck (2000) note that this era presents opportunities to engage in 'life politics' through reflection, experimentation and the exercise of free choice, Bauman is pessimistic, arguing that individualisation has

become an inescapable fate in which the individual is abandoned to take responsibility for a fate over which she/he has no control.

Bauman's concept of liquid modernity has relevance to social work with older people because the uncertainty and unpredictability intrinsic to 'liquidity' are characteristic of the life stage in which older people tend to require social services for themselves for the first time – i.e. new entrance to, or progression through, the 'fourth age' (Laslett, 1989; Baltes, 1997; Baltes and Mayer, 1999), a period of life in which age-associated physical and/or mental decline begin to have an increasing impact on social participation and independent completion of the tasks of day-to-day life. In contrast to the empowering notion of a 'third age' defined by active ageing and continued social and civil participation, the fourth age represents a powerful 'social imaginary' in which individual agency is lost and dependency and decline replace former power, status and roles (Gilleard and Higgs, 2010). At the heart of both lived experience of, and professional understandings of, the 'fourth age' is frailty (Gilleard and Higgs, 2011), which denotes both a state of actual bodily or mental weakness and a high potential for new morbidity (Degnen, 2007). Medical services use the term 'frail' to denote (usually older) people with physical or mental health conditions affecting their everyday functioning, who are at high risk of further health complications due either to further disease or to accidents (e.g. falling) (Skillbeck et al., 2018). The concept of frailty can be functional in helping services to identify those who need higher levels of medical or social support, yet has been critiqued for focusing on changes in bodily or mental functioning as representing a failed state (Pickard, 2016) and for encouraging the assumption that those deemed to be frail lack agency (Grenier and Phillipson, 2013).

While the strengths-based approaches to social work challenge medicalised models of ageing that emphasise decline and deficit (Nelson-Becker et al., 2020), it is important to

recognise that coping with illness and disease is a prominent feature of many people's experiences of older age. Living with long-term illness can cause profound changes in relationships between spouses or between parents and children, with radical shifts in power, responsibility and dependency (Kitwood, 1997) and reversals of usual gender roles (Dahlberg et al., 2007). The age-derived uncertainties of physical and mental health, social and financial status, and close interpersonal relationships, combined with dependency on forms of care that are not dependable, can therefore result in older people existing in a state of ongoing precarity (Grenier et al., 2017), which might be summarised in Bauman's terms as 'liquid old age'.

Though Bauman's conception of liquid modernity has been critiqued for overlooking class and the impact of social disadvantage in the way mobility, impermanence and uncertainty are experienced (e.g. Atkinson, 2008; Garrett, 2012), the concept of liquidity in old age is helpful in the way it captures the multiple forms of uncertainty affecting older people. The body-driven precarity of older lives is located within a society whose liquidity limits the availability of support. The neoliberal economic model demands that state services are reduced to a minimum and targeted only at the highest need (Penna and O'Brien, 2013) while the prevailing popular discourse blames individuals for their dependency, deriding those who require care as a burden on others (Ray and Phillips, 2012) and as a threat to national economic success (Hastings and Rogowski, 2015). Even hospitals can become locations of exclusion and contempt for older people, with wards ill-equipped to deal with people presenting with the complex multiple morbidities so common in later old age, and staff reluctant to accept as legitimate patients older people who are identified as frail (Calnan et al., 2013). At the very time when state-provided services are shrinking, however, families are ill-placed to fill the breach, since it is demanded by the neoliberal economic system that working-age people be geographically flexible and able to work long and additional hours at short notice (Harvey, 2005). Family relationships therefore become more contingent and

fluid in their realisation, since opportunities to be physically present together are reduced. Thus, for those in need of care, individualism can indeed become an inescapable fate. 'Liquid old age' can be summarised as "a state of precarious living in advanced old age caused by the uncertainties of declining physical and/or mental health, within a society in which responsibility for one's welfare rests primarily with the individual, and in which the demands of the neoliberal economy limit access to state and family care," (Burrows, 2020, p.17).

## **The Study**

The findings of this paper are derived from an ethnographic study of a hospital social work team. The study set out to explore the nature of statutory hospital social work, how hospital social workers (HSWs) do their work and how social work fits into the hospital context. The fieldwork took place with a hospital social work team located in an urban area of the UK. The site was chosen as a typical example of a large general hospital in an urban area. Ethical approval for the project was granted by a National Health Service (NHS) Research Ethics Committee, after which the local authority in question gave swift consent.

The work of the hospital social work team in the study concentrates almost exclusively on patients in advanced old age (aged 80+), many of whom present with issues regarding their mental capacity to make important decisions about their discharge and ongoing care. Tasks performed with and on behalf of patients centre on discharge planning and assessment of care needs, with around eight hundred complex patient discharges being handled each year. At the time of data collection, the hospital social work team was composed of a team manager, two full-time administrators, eight social workers (six female and two male) and two (female) senior social work practitioners. The team was sub-divided into a small unit responsible for reviewing and restarting packages of care for patients who were already in receipt of local authority social care prior to their admission, and a larger



grouping who dealt with assessing patients for new packages of care, which tended to involve longer-term and more complex work. Besides the social work team, four doctors, four nurse managers, four occupational therapists, two physiotherapists and eight staff nurses were formally engaged as participants, as well as three patients (all of whom were aged in their 80s or 90s) and seven informal carers. This allowed for observation of social workers' involvements in multi-disciplinary meetings, access to multi-disciplinary meetings that were not attended by social workers, and some limited observation of social workers' interactions with patients and carers.

Data were gathered primarily through participant observation and semi-structured interviews. A total of six working weeks (Monday – Friday, 9am-2pm) were spent in the field. Fieldnotes both from participant observation and document analysis were taken contemporaneously or near contemporaneously in offices, meeting rooms and hospital wards and typed up more fully at the end of each day. I was not systematic in choosing which social workers to sit with in the offices on any one day, since it was not possible to know in advance who was going to be in their office at any given time of the day, but I tried to ensure that I did not overlook any individual. I would move around the offices to talk to the social workers freely, generally leaving my notebook in one place and coming back to write notes as needed. I did not use a formal schema for capturing observations. In addition to spending time 'hanging around' the offices, I also attended formal scheduled meetings in which patient discharges would be discussed, and, where it had been agreed in advance, accompanied social workers to direct meetings with patients and/or carers.

Much of the data I gathered during observational time were in the format of informal interviews – either I would ask a participant about something about which I was curious, or they would initiate conversations with me, telling anecdotes about patients who had been particularly memorable to them. In my note taking, I distinguished carefully between conversations in which I was involved and 'work talk' between participants that I passively overheard. Inevitably, there were periods in which the social workers were using their

computers in silence, and I was unoccupied. Such periods were helpful for me to write up notes on the visual aspects of the field. I attempted to capture as much descriptive information about uses of space, the layout and décor of buildings and rooms and, of course, the non-verbal communication of all participants. This allowed me to build up a 'thick description' (Geertz, 1973) of my time in the field.

Formal semi-structured interviews were recorded on a dictaphone and transcribed. The lengths of the interviews ranged from 25 to 45 minutes. Nine social workers and their one team manager were interviewed, with the questions exploring the knowledge and skills required of hospital social workers, narratives of cases in which participants had been involved and the nature of inter-professional work within the hospital setting. Ten hospital professionals, including two doctors, two occupational therapists, two ward sisters, one physiotherapist, one staff nurse and two nursing managers also gave interviews. These focused on their views of the knowledge and skills of social workers, their opinions about the role of social work within the hospital, and their experiences of collaborative work with social workers. Additionally, five carers and two patients participated in formal interviews. These covered views on what the social worker had done for the patient and the effect on the patient or carer of having a social worker's involvement. Where patients or (in the case of patients with mental incapacity) carers had given consent, case files were also read and verbatim notes were taken, allowing analysis of the documents both as factual records of actions taken and as representations of social workers' rhetorical representations of events and actions (Taylor and White, 2000).

Analysis of the data adhered to the principles of symbolic interactionism, in which close attention is paid to meanings that are constantly created, interpreted and negotiated through human interaction (Blumer [1969] 1986). Open coding of the data utilising nVivo 11 software was employed to gain an initial familiarity with patterns of speech and interaction across both interview transcripts and fieldnotes, followed by a process of focused categorisation around symbolic interactionist themes such as identity construction, face

work, relationship work, relationship description, role identification and meaning assignment (c.f. Mik-Meyer, 2020). Each category was then explored to identify prominent themes through a process of comparison of data extracts borrowed from the grounded theory approach (Charmaz, 2014). Ultimately, the purpose of such analysis was not that ideas might emerge spontaneously from the data, but rather that thorough exploration and mapping of the data might promote abductive reasoning, allowing insights to be gained through asking the question, 'What might this be a case of?' (Atkinson, 2017, p.3). A total of forty themes were identified across the six categories, with several themes being relevant across more than one category. This paper focuses on a theme of advocacy, which was a recurrent subtheme across the categories of role identification and identity construction, and the themes of mental capacity and risk, which were prominent subthemes within the category of meaning assignment.

Keeping in touch with the social work team during analysis allowed me to share my interpretations of the data. The participants' generally positive responses to my interpretations, I believe, add credibility to the findings.

## **Findings and Discussion**

### **Social Workers as Advocates**

A particularly striking theme identified in the category of role identification was the social workers' self-definition as advocates for patients. In the face of the competing pressures upon patients to comply with the wishes and recommendations of clinicians and carers, social workers repeatedly referred to advocacy as a core activity.

*If you're challenging, it's our job to be advocating for patients.* (Team manager, from a fieldnote, recorded near verbatim)

*You need to be able to advocate for the patient. You need to be able to speak up in MDTs [multi-disciplinary team meetings]. You need to be quite confident. You need to be able to speak to people at all levels. (Social Worker 7, from an interview)*

*If it wasn't for us advocating, people would be caught up in the process and their choices would be forgotten about. (Social Worker 2, from a fieldnote, recorded near verbatim)*

It is not a coincidence that in each of these brief data extracts, advocacy is described in its verbal form – being a patient's advocate is not an abstract status, but an active and interactional process of countering forces that would otherwise act on the patient. For social workers, patients' being 'caught up in the process' represents being in the grip of Weberian bureaucratic power – that mechanism of 'solid modernity' in which individual identity is subordinated to the working of rules and the decisions of a faceless higher authority (Bauman, 2000a). In taking upon themselves the role of advocates, the social workers deliberately place themselves outside the Weberian bureaucracy as the defenders of individual freedom. It is telling that people's 'choices' are set up in opposition to the working of dehumanised process, suggesting that selfhood is defined through the exercise of choice, which must not be denied. The prominence of advocacy in hospital social work is also noted by Heenan and Birrell (2018), who also stress how difficult decision-making can be for older hospital patients.

The positioning of social workers as advocates for patients was affirmed by patients and carers who took part in this study.

*"So [the social worker], basically she became our advocate for the family because there was still pressure from people within the hospital to say why aren't you just taking him home? And she [the social worker] was able to say, no I had a conversation and he was very clear about what he wanted, and this is the way we're going to be working." – Carer 1, from an interview*

*“...where you feel like you’re up against a battle, I have somebody to shield me from it a bit because at least she [the social worker] can fight our corner.” – Carer 2, from an interview*

*“...[the social worker] answered my questions and was very clear – if you don’t want to do it [accept discharge to a rehabilitation centre], don’t do it... the decisions are made by the three of us: me, my son and my daughter-in-law. But nothing would be done against my will.” – Patient 1, from an interview*

The responses of patients and carers indicate that social workers place emphasis primarily on the self-determination of the patient, or on the wishes of their family where patients are not able to make their own decisions. Both carers in the extracts above indicate that there can indeed be times when pressure is exerted from within the hospital to make particular decisions or take particular actions with regard to patient discharges, and that social workers play a part in upholding the rights of individuals or carers to make decisions independently, through resisting this pressure where necessary. The social workers treat discharge planning as a process in which the needs and wishes of the patient, rather than the hospital, are central.

The social workers’ advocacy for patients not only involves helping patients and family members to negotiate with the hospital bureaucracy, but can also be employed to help patients to persuade family members to support care plans that appear risky. When asked in a formal interview to describe an occasion when she had been particularly satisfied with working with social workers, one doctor recalled,

*[there was] a patient who had early stage dementia, but still had capacity to decide the discharge destination, but she had daughters as well and they were very concerned about her going home again. But the patient really, really wanted to go home. So with the social worker managing with the daughters, we ... we just made a trial for the patient firstly to go home for four weeks, to see if the patient copes at*

*home... And in four weeks she will be assessed by the community social worker, and if she cannot cope, the possibility of going to a placement would be there. (Dr 2, from an interview)*

The doctor's description of the social worker 'managing with the daughters' is a reminder of how powerful family members can be in the discharge planning process – if their concerns and feelings were not 'managed' through the planning process, it is probable that the patient's return home either would not be accomplished, or would quickly end in re-hospitalisation. Discharge planning for social workers involves not only identifying and making the necessary practical arrangements for patients' future care, but also helping patients to overcome opposition to their decisions and mobilising the resources they have to support the choices they want to make. The idea of the patient having a trial of returning home is indicative of how discharge plans are not necessarily seen as permanent solutions to the needs patients have for care and support after discharge – an element of experimentality is permissible and, as will be discussed further below, considerable risks can be taken. The social worker's recognition of the patient's strengths, which might allow her to remain at home despite the difficulties she would face, represents a challenge to a more medicalised, deficit-based mode of thinking that might not have considered the risks to be worth taking. The doctor's investment in the plan ("**we** just made a trial") is a welcome reminder that, although hospital systems are not always as humane and person-centred as they could be (Calnan et al., 2013), there are many individual clinicians who do take holistic approach to the treatment of older patients.

### **The Primacy of Self-determination**

Just as advocacy is central to the social workers' construction and understanding of their identity, the avowed goal of their activities is that patients about whom there is no question over mental capacity should be free to exercise choice as individuals. Individual self-determination is therefore a key value underpinning the social workers' approach to their work.

*I think, I've had situations where I've advocated for someone who really doesn't want services. And so for me, it's about making sure that person's voice is heard whatever ... whatever their decision is, and that is a challenge with health in itself, because I've worked with someone who the ward really didn't want to discharge, but ultimately I was of the opinion that this lady had capacity, she was making very unwise decisions, she wanted to go home, she was determined she was going to go home, and eventually the ward staff agreed to it and we signed that off and arranged the discharge. (Team manager, from an interview)*

*Well, if somebody's got capacity, they make their own decisions and as long as they understand the risks of going home, you know, that's fine, even if they say, well if I fall on the floor, I'll crawl to the phone or whatever. (HSW5, from an interview)*

Self-determination is understood here as a natural right implicit within the human condition (Ife, 2010), the exercise of which can be denied only on the grounds of mental capacity. Throughout the fieldwork, the social workers did not draw on legislation such as the Human Rights Act 1998 to strengthen the self-determination of patients – in fact, no explicit reference to 'human rights' was found in the fieldnotes or interview transcripts. Respect for the natural right of self-determination is instead treated by the social workers as a deontological imperative (Banks, 2012), irrespective of what the consequences of that exercise of self-determination might be. This is not to suggest that social workers are not attentive to the consequences of patients' decisions, but respect for the principle of self-determination does constrain the social workers' ability to act on purely consequentialist impulses. While the subjective experience of the individual is at the heart of the social workers' approach, the ultimate result is that responsibility for the consequences of a decision is seen to lie with the individual, and not with the social worker, nor with other professionals, nor even with the individual's family members.

The social workers' emphasis on individual freedom is accompanied by an implicit understanding of the precarious nature of advanced old age, in which it is accepted that the duration of care plans may be short, but that their abrupt endings do not necessarily signal failure. This is most aptly demonstrated by one social worker's response in a formal interview to describe a 'case' that was particularly memorable.

*When I first assessed her [an older person], she was on a ward and...she said she wanted to go home, so we were looking at a long-term package of care to discharge her home safely, she had dementia... We managed to persuade the family that home was an option and that we felt that we could actually support her at home, and although the family wasn't happy initially, they did, they did sway to the idea... And we got her home and she was home for about six, seven months, so to me that was an achievement, that was really good, so she'd done really well, and then she came back into hospital following a fall... (Social worker 9, from an interview)*

The social worker described two further discharges for the same person, each lasting a few months before the occurrence of another hospital admission, and was able to accept that a further accident had befallen the woman without considering that the care plan might have been at fault for failing to protect her from harm. There is an underlying sense that decline is inevitable, and that loss of independence is a likely eventual result for many people, but that those who wish to remain in their own homes should be given the chance to do so for as long as possible – even if there is a risk of serious injury. Again, this highlights a more strengths-based approach to care planning than would be the case if emphasis were placed on more medicalised notions of frailty and decline. Central to this approach is the notion that individuals should be able to define their own well-being and to judge the steps necessary to pursue it (Mullender and Ward, 1991). The intrinsic right of the individual to make her own decision took precedence over the social worker's and family's desire to pursue the most robust plan to protect her from harm. The primacy of individual freedom means that social workers feel able to support individuals in positive risk-taking (Morgan,



1996) since the moral (and, of course, legal) responsibility for any harm that might result in the exercise of free choice lie with the free individual, rather than the social worker. Thus, the state of uncertainty and impermanence caused by choosing to attempt to maintain independent living in the face of physical decline come to be accepted by the individual, the social worker and family members.

Of course, respecting an individual's right to make a bad decision can cause moral discomfort to social workers if there is clear evidence that the individual is acting rashly and making her/himself unsafe despite legally having the mental capacity to make such decisions. The same social worker expressed such a dilemma regarding a different patient:

*I had this man who just refused to have a care package. He hated social workers – he'd had his kids removed, his daughter had had her kids removed and all that. I'd talk to him and he just wouldn't take any notice of a word I'd say... He wasn't safe to go home but just refused a package of care, so I made him sign a disclaimer in the end to say he was going home without a package of care against my recommendation... I don't know where he is now. I've rung his GP to tell him I'm concerned but there's not a lot more I can do. I do wonder where he is now. (HSW4, from a fieldnote, recorded near verbatim)*

The social worker in this instance went to considerable trouble to mitigate the risks that the man would face on returning to his home without additional support, spending time with him to build rapport, working with his daughter to prevail on him to accept support, and liaising with his housing officer regarding tenancy issues. Similarly, the telephone call to the GP suggests that he was not happy to let the matter rest entirely – it had to be passed on somewhere, since the lack of a care plan meant that risks had not been managed at all. He did manage to persuade the man to agree to ongoing visits from a tenancy support worker. Despite doing all that he was able to do to influence the choices of a man who had the capacity to make his own decisions towards an outcome he believed would be more favourable, the fact that the social worker felt uncomfortable enough to insist on the patient

signing a 'disclaimer' indicates a deep uncertainty over leaving him without any of the services to which he might be entitled, and therefore at risk of further accidents. The difference between this example and other occasions when social workers were quite willing to advocate for individuals to take risks is that, in contrast to those latter occasions, the decision of this individual was not perceived by the social worker as resulting from a rational calculation of his own interests, but rather from his unwillingness to trust any social workers because of previous life experiences. In other words, the patient had not exercised positive liberty (Berlin, 1958). We might understand that this unwillingness would appear rational to the man in view of his life experiences, yet it is also apparent that his decision can be interpreted as irrational inasmuch as it constitutes a choice to reject a service that would likely protect him from harm and enhance his well-being. Social workers experience moral discomfort when the exercise of free choice is not accompanied by rational thought, yet their ability to intervene in the best interests of an individual is constrained by respect for the moral and legal principle of self-determination.

Where patients are deemed to lack mental capacity to make their own decisions, as defined and assessed under the Mental Capacity Act 2005, the social workers do not experience the constraint in their ability to pursue the best interests of the patient that can otherwise arise from the principle of respect for self-determination. In such cases, it is more possible for social workers to prioritise an active mitigation of precarity in older people's lives. While discussing a patient deemed to lack capacity who had been moved into residential care, one social worker commented:

*I mean, she's being cared for, she's made a really good recovery, she's eating and drinking in her nursing home, the manager says she's much happier... She's happier now she sees all of the children and now she's seeing her family, great-grandchildren she's never seen before... This woman has absolutely blossomed since she's gone in... And to see her actually improving to what she was*

*on the ward is well worth the effort. Because I know she's safe and being looked after.* (HSW1, from an interview)

There is a marked contrast between this extract and the earlier quoted example of a social worker being happy to facilitate a short-lived extension of independent living for a person with the capacity to choose for herself. In that latter example, the physical welfare of the individual appears to be a secondary consideration – the fact that she suffered injuries bad enough to merit admission to hospital is accepted as the hazard that comes with the exercise of rationally determined free choice. In the example above, by contrast, the social worker allows herself a 'happy ever after' story in which there is no room for ambiguity or impermanence, and in which the physical and emotional safety of the individual is of primary importance. The social worker has to use her own rationality (and, through the process of the best interest meeting, the rationality of other professionals and the patient's family) on behalf of the patient to determine what will most likely result in the patient's happiness. This results in a more 'solid' form of welfare provision, in which certainty about physical and emotional well-being are the primary consideration. It is worth noting that, even where residential care is chosen, the choice of the term 'blossomed' is a powerful indicator of the strengths-based emphasis of the social worker's approach, in which deficit-based conceptions of the fourth age are rejected.

### **Strengths and Limitations of the Study**

The setting posed several constraints and difficulties for participant observation. It was a condition of ethical approval that recruitment of patients and carers to the study should be initiated by the social workers. It turned out that most were less willing to be observed in their direct contact with patients and carers than in meetings and office time, meaning that access to direct contact between social workers and patients/informal carers was limited. The limited number of patients and carers involved meant that access to case

files for document analysis was limited. The layout of the offices of the team also made unobtrusive observation difficult, since the social workers were in small rooms, meaning that my physical presence as an observer was never less than obvious. My identity as a white, male, cisgender and heterosexual academic meant that there may have been power imbalances between me and some of the participants. It is possible, therefore, that the 'Hawthorne effect' (Mayo, 1949) may have come into play in participants' observed words and actions. I attempted to minimise this through adopting a sociable demeanour and cultivating friendly relationships with participants as a potential confidante (Lonsmann, 2015), and am satisfied that the observations I made were a fair reflection of the way the team approach their work on a day-to-day basis. The practitioners appeared too busy to spend much effort in impression management for my benefit. The purpose of undertaking an in-depth case study has not been to produce findings that can be unthinkingly generalised, but to enable theorisation that can be applied critically to other, similar cases (Yin, 2018).

Rigour was enhanced by engaging in participant verification – a number of visits were made to the social work team to discuss emerging themes and the presentation of findings.

## **Conclusions**

Hospital social workers strive to uphold the rights of individual patients in the face of the power of both hospital professionals and family members, an approach directed and supported by legislation such as the Mental Capacity Act 2005, Care Act 2014 etc. and embedded in the British Association of Social Workers' (2021) statement of ethics, in which respect for individual self-determination is a key principle. In many cases, hospital professionals and family members simply want to take the safest option for the patient, even if this means a curtailment of their individual freedom. Where social workers advocate against this approach, and in favour of a riskier alternative, they are articulating and enacting

the values of liquid modernity, and facilitating the manifestation of 'liquid old age'. Social work practice directed by these values is liberating in that it enables individuals to make choices that they might otherwise have been denied, yet it may also be accused of abandoning people to their fate, if it leaves all the responsibility for dealing with the consequences of such decisions to individuals. As Bauman (2000b) notes, a social work practice orientated simply towards wish fulfilment without any further sense of moral responsibility would be, in its own way, as morbid as one that seeks to impose its own will without any regard for the opinions and desires of the users of its services. Social workers need to engage with people fully in thinking through the consequences of their decisions and in planning for contingencies – a matter that requires time and skill to build relationships and establish open and equal communication. In the wider international context of hospital social work, the emerging therapeutic and educational approaches designed to reduced rates of readmission (e.g. Basso-Lipani et al., 2015; Alvarez et al., 2016) are compatible with a deeper exploration with individuals about their longer-term desires and the implications of the decisions they make around their discharge plans.

The social workers' approach sits within the wider tradition of liberalism, which regards the sound-minded individual's exercise of free choice as being of primary significance, regardless of the consequences that the individual might bring upon her/himself (Siedentop, 2014). Within this construction, legally and morally, the exercise of free choice depends only upon the *capacity* of the individual to make a rational choice, rather than whether rational thinking in relation to the choice has actually been carried out. The findings of this study suggest that, where individuals whose mental capacity is not in question make choices that appear irrational or self-destructive, social workers experience moral discomfort but ultimately respect the rights of people to make free choices without interference. Irrational or self-destructive decisions taken by older people may come about as a result of a lifetime of disadvantage, marginalisation and oppression (Ray et al., 2015). Social workers therefore need to go beyond assessing eligibility and determining 'desired outcomes', to

engage in relational work with older people that takes account of their life histories and offer support through significant life transitions (Phillips and Waterson, 2005). Awareness of the wider field of critical gerontology and of the implications of 'liquid old age' should be considered a vital component of social work education, in order to ensure that social workers are morally engaged in the decisions in which they are involved. Social workers' willingness to advocate on older people's behalf must be accompanied by a critical gerontological approach that addresses the cumulative effects of disadvantage, the complex interplay of family relationships and the pervasive influence of ageism (Richards et al., 2014). Only when such powerful forces in the lived experience of an older individual are addressed can free choice be truly meaningful, and only then can social work with older people be truly said to be liberating.

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