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Care management in practice: on the use of talk and text in gerontological social work

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This is a study of encounters between social workers and citizens in one type of welfare organisation, the municipal elder care system. The article sheds light on how older people's claims are dealt with in the processing of home care applications. Twenty encounters between social workers and older people were studied using discourse analysis. The findings reveal that discursive practices are part of the routine when the applications are processed. The application handling follows an agenda-bound pattern that is visible in the encounters. In these standardised procedures, oral discourse is embedded in routines that also include the use of texts. However, within this institutional order, there is also an important element of negotiation between the parties. It is therefore claimed that the encounters include a negotiated order that does not exist on its own, but is achieved in the ongoing interaction.

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Key words: assessment, elder care, institutional discourse, social work, gerontology

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Introduction

This article focuses on the assessment processes older people undergo to gain access to home care. This assessment often falls within the scope of public elder care, and in many Western countries is part of gerontological social work. The assessment processes include meetings in which municipal care managers, acting as social workers, interact with older people in their homes to discuss and reach decisions about their home care. The assessment meetings may be seen as a communicative practice in which talk and text are the tools used. This article identifies some of the communicative bases for decisions about home care for older people.

The assessment meeting may be regarded as an activity that regulates the distribution of society's resources for home care (cf. Lipsky, 1980). Studying assessments may reveal the conflicting interests that can occur between, for example, efforts to reduce the costs of elder care and older people's assistance needs. Other conflicts that can be explored in studies of care management practices concern the rules and regulations set up by society and which managers must follow versus managers' aims to develop their professional autonomy. Studies of care management can thus yield insight into how such tensions are handled in practice.

We will first briefly introduce the existing research into assessment processes in elder care. Then we will describe the methods and data used in the study, which was conducted in Sweden. The following section provides examples of communicative patterns in care assessment processes, illustrating some basic features of application handling. The article ends with a brief discussion of the findings.

Needs assessment in elder care

In many countries, the care of older people has undergone major changes in recent decades, and human services and care work have increasingly come to be viewed as primarily a public matter. This is also true when it comes to questions related to home care (Fine, 2007; Richardson & Barush, 2006). In keeping with this trend, organised public elder care has undergone extensive restructuring, and is constantly changing in terms of both its organisation and the conditions under which it is provided.

Needs assessments were introduced into elder care in the early 1990s. Needs assessment models are rooted

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in systems theory in which organisational and administrative interests dominate the assessment process (Milner & O'Byrne, 2002). Needs assessments arose from changes in social policy in combination with the introduction of the care management model, where the focus is on casework, i.e. the individualisation of care services. This renewal of welfare services is closely connected to an international trend called New Public Management (cf. Blomberg, 2008). The care management model includes procedures for processing cases via what has been called 'people-processing' (Prottas, 1979), in which the institution operates based on a set of pre-determined client categories. These procedures are used to convert information about individuals into the documentary basis for creating cases, i.e. objects that the institutions can identify and work with. Payne (2000) pointed out that one of the problems in implementing the care management model in a social work context is that it was derived from market economics-based thinking and was then developed and applied in different ways to different client groups. Lymbery (2004) further asserted that introducing care management into elder care has led to more entrepreneurial thinking, in which the availability of services is directly linked to financial costs and tighter resource allocation. He argued that this has led to the greater bureaucratisation of elder care. Research also shows that needs assessment is often a one-way process designed to meet organisational needs rather than those of individual older people (Richards, 2000).

Care management research from several countries has revealed differences in various parts of the assessment process in terms of, for example, documentation, assessment models and decisions regarding the provision of help in similar cases (e.g. Challis & Hughes, 2002). The relationships between needs and resources and between assessors and older people (Challis, Hughes, Jacobs, Stewart, & Weiner, 2007; Payne, 2000) differ in terms of how the assessors identify needs, which depends on their professions and knowledge base. However, many European countries, especially Great Britain, have assessment systems similar to Sweden's. Nevertheless, one difference between the Swedish and British assessment systems is that in Great Britain relatives who are also caregivers have the right to have their need for services assessed (Challis et al., 2007).

Care management in elder care is an area that has only recently drawn research attention, and a few studies have been published that compare various European assessment systems (e.g. Blackman, 2000; Blackman, Brodhurst & Converey, 2001). The elder care situations in Denmark, Great Britain, Greece, Norway, Ireland and Italy have been compared. The studies indicate that no formal right to access health and social care exists in three of the compared countries, i.e. Greece, Ireland and Italy, where the family is responsible for caring for its older members. In Denmark, Great Britain and Norway, the state assumes the overall responsibility for the care of older people, making these countries rather similar to Sweden.

Studies carried out in Sweden have focused on how needs assessments and decision making regarding elder care are managed in relation to legal requirements (Lindelöf & Rönnbäck, 2004) and the introduction of a specialised assessment system (Blomberg, 2004). Studies have also demonstrated that local policies and guidelines govern needs assessment processes, which in turn means that the processes have become more standardised and limited in terms of the assistance offered to older people (Andersson, 2004; Blomberg & Pettersson, 2003). Needs outside the standardised catalogue might thus be neglected (Petersen & Schmidt, 2003). The results of these studies paint a consistent picture of the inadequacies of the needs assessment system, indicating that the underlying spirit of the relevant laws is not consistent with how the needs assessment process works in practice. The studies also noted that the administrative process is institutionalised in that it follows certain overarching local guidelines, with the result that older people's options vary in terms of the services available from the formal elder care apparatus.

Similar results were presented in a Norwegian study (Vabø, 1998) of the allocation of home care together with how the limits of government responsibility are regulated by the various parties involved in elder care. Vabø claimed that various needs are uncovered in home care needs assessments, each assessment taking the form of a process of negotiation that can be interpreted differently between the care manager, the older people receiving care, and their relatives.

In an overview of research into needs assessment, Norman and Schön (2005) claimed that much is still unknown concerning both the administrative process and care managers as a professional group. The formal administrative process has been well described, while research into how care managers as professionals interact with older people is lacking.

The perspectives of the older people and their relatives involved in the assessment process have been studied to only a limited extent. However, a few studies have addressed this problem area, including how older people and their relatives experience the needs assessment process (Janlöv, 2006), and how home care functions in older people's daily lives, based on the behaviour of various people involved in the process (Andersson, 2007; Dunér, 2007). Janlöv's results indicate that older people and their relatives find deficiencies in how they are treated personally and professionally by the care managers. This can lead to their being neglected in the assessment process,

which can in turn lead to problems dealing, in a health-promoting way, with the new situation entailed by introducing home care. Janlöv's (2006) study indicates that receiving supportive treatment from professionals via the assessment process not only stimulates older people to participate in the process, but also can help them and their families to get through the lifestyle adjustment period in a way that promotes health and meaning.

The present article notes the critical issues raised in previous studies of assessment processes in elder care and focuses on the care managers and how they handle their tasks as professionals.

Aim

The present study has examined how care managers participate in the assessment meetings as professional actors, and how talk and text are used in the meetings. Can we thereby find out how standardised and predetermined models are used in the assessment meetings? Also, to what extent are elements of professional independence found in the various stages of care management? What kinds of conflicts can arise between the managers' professional aspirations and the various prescribed procedures, regulations and practices established in the care system?

To shed light on these issues, our research approach was to use the actual assessment meetings as empirical data, which thereby allowed us to explore how professional actions and standard procedures are found to varying degrees in different parts of the meetings. The study aimed to identify the discursive patterns prevalent in care assessment processes and to determine whether and how these patterns varied. The following section describes in greater detail the empirical data used in the study and how the assessment meetings were analysed.

Methods

The data were obtained from a larger research project examining the care management process (see Olaison, 2009; Olaison & Cedersund, 2006, 2008). One goal of this larger study was to examine how welfare organisations such as the elder care system use people processing to deal with people's needs, and how private problems are translated into organisational language (cf. Lipsky, 1980). The larger study was rooted in the social constructionist tradition that is linked to the assumption that reality is socially and discursively constructed in everyday practice (cf. Holstein & Gubrium, 2000). According to Payne (1999), a constructionist research approach has many advantages when used in studying assessment practices, since it focuses on negotiating and interpreting actions (often basic activities in this context).

As part of this project, data from 20 assessments including meetings and case-files were collected in three municipalities in Sweden. The data were collected over one year, during which time one author (AO) followed the work of 13 care managers. The 20 assessments were of 13 female and 7 male care applicants, with a mean age of approximately 83 years. The assessment meetings were documented by audio-recording and taking fieldnotes. The study was approved by the ethics committee at Linköping University, Sweden. All personal data were anonymised in the publications issuing from the project. The meetings were transcribed *in extenso* using a fairly simple verbatim system. The following notations are used in the quotations included in this article:

(.) denotes a pause;
( ) parentheses indicate feedback (back-channelling) from the current listener;
(( )) double parentheses indicate comments; and
[ ] square brackets indicate omitted words.

The excerpts quoted in this article were translated from Swedish to English. The audio-recorded and transcribed meetings were analytically organised using discourse analysis (Wetherell, Taylor & Yates, 2003). As used in the present study, this approach focuses on actions: relationships in institutional conversations are treated as discursive activities carried out in relation to the interpersonal contexts in which they are produced (cf. Hall, Sarangi & Slembrouck, 1999). The transcribed meetings were analysed in terms of their sequential structure and contents, as well as their function in the organisational context of elder care. The written documents – the case files, application forms and decisions – included in the study were analysed mainly with regard to their significance to the processing of individual applications.

The analyses reported here focus on how talk and texts are used in assessment meetings. The analyses were carried out in two steps. The first step included categorising the assessment meetings based on verbal interaction. This was done to find recurrent patterns of talk, and gave us an overview of the meetings and how phases and topics were evident in them (Linell, 1998). The second step focused on the interplay between talk and text, and on how texts were talked about in the meetings. This step helped us see how texts were produced in the meetings.

The next section presents the results of our analyses. While the presented results refer to all the analysed assessment meetings, quotations from two meetings are used to exemplify the various ways talk and text were used in the meetings.

Findings

At a general level, the assessment meetings have a fundamental pattern of division into several phases, as seen in Table 1.

Table 1. Phases of assessment meetings in elder care (adapted from Kullberg & Cedersund, 2001).

1. Greetings
2. Introduction (informal talk between the interlocutors)
3. Form-oriented talk
4. Talk about the older person (his/her circumstances and health status)
5. Talk about administrative procedures, rules, and regulations
6. Closing

The table gives a general outline of the meeting phases. This meeting structure resembles the fundamental structure of encounters between officials and citizens in other institutional contexts (Linell, 1990). Earlier studies (cf. Linell, 1990) have demonstrated that the phases comprise at least an introduction, a part in which the matter in question is discussed, and a closing section. Our findings support the existence of a similar overall phase structure for the assessment meetings in gerontological social work. Below, we present some quotations from the meetings to exemplify some of the variations found in the data. One assessment meeting starts as shown in the following example:

> Extract 1. Beginning of meeting no. 1. Participants: care manager (CM), a 40-year-old female social worker; and Agnes, an 85-year-old widow.
> 1. CM: *I'm going to start, Agnes, and ask you what personal number* ((personal identification number)) *you have*
> 2. Agnes: *18 09 01 – 12 26* ((fictionalised names, numbers, etc. are used in all quotations))
> 3. CM: *1226 and I've got a telephone number*
> 4. Agnes: *120022*
> 5. CM: *It also tends to be like this the first time eh get the names and telephone numbers of relatives you* (Agnes: *yeah*) *you had girls you said*

The above excerpt comes from a meeting of an institutional nature. Right from the start of the meeting, the manager focuses on formal information by asking for the older woman's personal data. This part of the meeting belongs to what is referred to as 'phase 3' (see Table 1) in that it covers details from the application form. The discussion displays a touch of 'standard procedure' when the manager opens by asking for the woman's personal identification, telephone number, names of family members and contact information.

The manager quoted in Extract 1 begins by saying 'I'm going to start' (turn 1) to set the procedure in motion. When she receives the first requested information – the older woman's personal identification number and telephone number – the phrase 'It also tends to be like this the first time' (turn 5) signals that the manager is following a pattern not unique to this meeting, but used on other such occasions when cases are handled 'for the first time' (for an older person).

This meeting was evidently not arranged according to an individually designed strategy. Instead, it was guided by a set of procedures aligned with the institutional order (cf. Drew & Heritage, 1992, on interaction in institutional settings), entailing the collection of necessary information about the person applying for home care services.

In the conversation quoted, it is the care manager who determines which topics are to be discussed in the meeting with the older person, and those topics provide a basic framework for the conversation. This is a pattern that recurs in the conversations analysed: the care manager is the one who brings up new topics in the conversation, and also the party who moves from one phase of the conversation to another. This communicative pattern of addressing certain subjects and progressing through specific conversational phases is supported by information that is being read from or entered into various types of texts. The form that is used in connection with applications for care from the elder care system contains questions that are raised in the conversation, and the answers then provide the basis for the information that is to be entered on the form during the course of the conversation.

The analysis shows how the forms and written regulations have an impact on the agenda. The care manager asks for formal information, i.e. personal information about the older person and her relatives. Such information is an essential element in the administrative processing of care applications. Some of the information that the care manager requests is, however, of greater complexity than the details that consist of numbers, addresses and other more register-related data. The health status of the older person is one such potentially more complex issue that is raised in the conversation. In the conversation between Agnes and the care manager, the topic of Agnes's health is discussed in connection with other information that is brought up. In example 2 below, we see how the subject of health is brought up by the care manager and how Agnes responds when the topic is discussed.

> Extract 2: Continued from meeting no. 1 (the same people as in Extract 1).
> 18. CM: *Then I also used to collect data about your health and you told me that you had problems with angina and when we talked on the phone you said you had pain in your knees*

19. Agnes: *Knees and back and hips – I'm so crippled (CM: mm) and I take so many pills*
20. CM: *It's a repetitive strain injury*
21. Agnes: *Yeah, that's it. I, I had some hope last year when I was referred to the orthopaedic clinic where they thought they would be able to operate, but my heart is too bad for that*
22. CM: *Yes*

Here, the manager says that she intends to 'collect data' about the older person's health, and briefly summarises what she discovered about Agnes's health when she talked to her on the phone: 'you told me that you had problems with angina and when we talked on the phone you said you had pain in your knees' (turn18). The manager uses medical terms in her utterance. Agnes responds in a much broader way when she describes her problems and how she deals with them: 'Knees and back and hips – I'm so crippled . . . and I take so many pills' (turn 19). Agnes's response may be seen as talk about various bodily problems, but she also mentions the effects of these problems on her everyday life. This is followed by CM's remark, expressed in medical terms, which refers to Agnes's problems as 'a repetitive strain injury' (turn 20). Agnes then talks about her hope of getting treatment, and tells how the plan to operate had to be cancelled: 'I was referred to the orthopaedic clinic where they thought they would be able to operate but my heart is too bad for that'. Extract 2 highlights how medical terms are preferred by the care manager in her encounter with the older person, and how the older person's everyday concerns may not be acknowledged in the assessment meetings. This conversation furthermore indicates how an intensely difficult situation for the older person may be described in just a few words (a repetitive strain injury) by the care manager.

The way in which the care manager conducts the conversation results in its remaining within an *administrative framework* (cf. Cedersund & Säljö, 1993, concerning 'the voice of bureaucracy'; Mishler, 1984). The care manager treats the subject of Agnes's health as one of a number of questions that are to be recorded and documented in the inquiry being conducted during the course of the meeting. Agnes responds to the health-related question by describing her everyday concerns about her back and hip pains, her need to take a lot of medication to cope with her situation, and her hopes regarding medical procedures, which are going unfulfilled because of her weak heart. The care manager chooses not to respond directly to Agnes's account of how the unperformed operation was an important experience for Agnes, but rather reverts to continuing the conversation within the administrative framework (cf. Cedersund & Säljö, 1993). The use of text during the course of the conversation provides support for the precedence afforded the administrative framework in the conversation. The items addressed in the form questionnaire guide the conversation and determine its course.

However, there is another way to handle the issue of the older person's health. We shall see how a meeting between the same care manager and another applicant develops. The extract below provides an example of how this issue is treated, not as an administrative one, but rather is accommodated in the conversation to a greater extent. Here we encounter David, who became a widower a number of years ago, and the care manager who is visiting him to assess his need for home care. David's adult children have urged him to contact the care manager to find out what in-home assistance he could receive after having had an accidental fall some time before. We begin the extract at the point in the conversation where David's health comes up for discussion:

Extract 3: From an early part of meeting no. 2.
Participants: care manager (CM), a 40-year-old female social worker; and David, an 85-year-old widower.
10. CM: *What about your health, then*
11. David: *Yes, if I can speak for myself rather than have someone speak for me (.) I think I have good health at present*
12. CM: *Yes*
13. David: *I sleep well as I take care of it all (.) I am fine and do all the cooking (.) I do take care of myself and I was going to try to bake bread as well, but it did not go so well*

CM asks David a question early in the meeting (turn 10) about the state of his health: 'What about your health then'. According to our division of the phases, this belongs to phase 4 (see Table 1). David says that he considers himself to have good health. CM listens to a description of some of the things of which David is capable – he sleeps well and can cook, although his bread-making has not been so successful. On this occasion, the care manager is meeting a man who apparently does not feel he needs the help he might be offered by the elder care service. To some, this might be seen an unexpected reversal of the normal situation in a meeting about a request for care assistance. To an experienced manager, however, it is perhaps not surprising; although the application process is designed so that it is the older person who is applying for home care service, other parties may become involved in the course of time. In David's case, it is mentioned later in the meeting that his adult children felt that he should have help with some household chores. David himself thinks that he has just a few temporary health problems: 'if I can speak for myself rather than have someone speak for me' (turn 11).

Our analyses of care management meetings indicate that care managers can organise meetings in different ways. However, the six basic phases comprise a form of agenda that determines what is talked about in the meetings. In the extracts above, it is the older people – Agnes and David – who attempt to evade the implicit agenda. One part of the care manager's job at the meeting with the older person is to collect information about the older person's condition and situation in relation to his/her need for care from the elder care system. With regard to the meeting between the care manager and Agnes (quoted in Extracts 1 and 2), the care manager uses a method to collect information in which she compiles the information that comes to light without achieving any deeper understanding of Agnes and her care needs. Agnes advocates an understanding of her situation that captures the pain she has in her knees, back and hips, and says that she cannot obtain the necessary orthopaedic operation. However, the care manager's response to Agnes's detailed story about her difficulties in coping with everyday life is not very elaborate. The CM's short reply, 'repetitive strain injury' (Example 2), indicates no clear recognition that Agnes finds her situation difficult to cope with or that she will be granted home care services.

The conversation with David takes an opposite course. CM offers David considerable space in the assessment meeting. David himself stresses that he is in good health. He says that the health assessment is based entirely on information he has provided, and the manager does not contradict this at this point. However, David's method of arguing indicates that there might be other ways to describe his condition. David's description of his health indicates that he is negotiating to present himself as a person who does not need help from the home care services. The care manager has a strategy of not contradicting David at this point. Later in the conversation, however, she raises opposing arguments, describing the pros and cons of being stubborn or persistent and wanting, like David, to manage one's own daily life without help. Later, the manager expresses the following viewpoint: '*persistence is very good, I usually say . . . but when persistence turns into stubbornness that's where to draw the line'* (quotation from the meeting between CM and David).

Analysis of the phases of talk between the managers and the older people indicates that the meetings are institutional in character. The meetings with the manager are not informal, but have several qualities typical of conversations between citizens and officials, between lay people and experts (cf. Linell, 1990). However, is the use of standard procedures – in these data, the phase structure that follows a standardised pattern – a communicative practice that supports the development of the care managers' professional ability, or is it the reverse? The *negotiations* that occur in assessment meetings – as in the meeting with David (Extract 3) – may give more individual space to the interlocutors, allowing for the emergence of new ideas and approaches in the oral communication between the parties. Alternate ways of looking at events and living conditions can then be negotiated and even created – and co-created – in the meetings. These negotiation elements in talk allow some freedom to both parties. Accordingly, it is possible to identify the moments in the meeting when negotiations between the interlocutors could contribute to developing the care management practice. This part of the results highlights the care manager's professional aspirations and how she allows space for the older person to take part in the meeting – without demanding that he follow what is prescribed from the various procedures, regulations and practices established in the formal care system.

To sum up: *Oral communication* may be used to implement phases of the assessment meetings in elder care. However, the different phases do not necessarily occur in a fixed order. The manager's way of opening and gradually continuing the conversation, together with the applicant's way of responding, determine the actual order of the phases. The phase structure of the meeting contributes to the daily run of things, and the organisation's protocols may dominate the interaction.

Texts are important in elder care, since they are used for ongoing documentation of the work carried out in this field. Apart from this, as pointed out above, it is possible to discern the influence of texts on the oral discourse produced in the assessment meetings. The texts used during the assessment meetings tend to have a strong influence on what is discussed in the meetings and also limit the care manager's actions and his/her ways of organising the meeting. These written documents often tend to influence the meetings while making the care managers adhere to the administrative principles, and this tends to weaken the care manager's professional independence.

However, this interactive pattern – talking about filling in the form – is only one way in which texts influence the interaction in the assessment meetings. Table 2 gives an overview of the different phases of the assessment meetings. In this table, we have added where and how the texts are noticeable in the meetings.

Table 2 indicates that documents are involved in most stages of case processing in elder care, except at the opening and closing of meetings. In the stages when the care managers elicit information about the case (phases 3 and 4), this is done partly by using various texts. The final stages of the assessment process (phases 4 and 5, and the manager's work after the meeting) often involve making decisions about measures to be taken to assist the older person, and these decisions are

Table 2. Phases of assessment meetings and the use of texts: an overview.

Phase	Texts used and produced
1. Greetings	
2. Introduction	Texts containing information, e.g. leaflets about elder care and services provided by the care manager
3. Form-oriented talk	Forms that are filled in, read and reread
4. Talk about the older person (his/her circumstances and health status)	Information from documents concerning, for example, prescriptions, state of health and living conditions
5. Talk about administrative procedures, rules and regulations	Texts (forms, leaflets) providing information about applications for elder care and about the costs of care and services, fees, extra charges, etc.
6. Closing	Notes (for the case files) concerning specific details, including names and phone numbers of relevant officials in the elder care administration

supposed to be recorded in documents such as reports and case files (cf. Anward, 1997, on writing as part of professional practice).

Finally, the meetings thus entail very complex and demanding tasks for the care manager, who needs to work out a qualified 'interpretation' and 'translation' of relevant details to be documented. The older person and his/her abilities, health status and everyday life conditions will have to be described, and the descriptions then translated into a language acceptable to the organisation. The care manager's ability to produce texts is thus central to the application processing. It is not sufficient to consider only the oral part of the meeting. However, texts are not just seen as products; they can also function as agents in institutional contexts.

In what way do these texts take place – and perhaps also control – the interaction between the care manager, the older person and any relatives present? The use of written forms is linked to the regulations that underpin these forms and is not just a part of the care manager's technical skill of knowing which box to fill in (cf. Roberts & Street, 1997). The managing of such forms has been described as part of the 'gate-keeping' process (Erickson & Shultz, 1982; Roberts & Street, 1997). The processing of applications that we have analysed points at the importance of using texts and of mixing and switching between spoken and written language to meet the specific institutional demands as elements that reproduce 'how institutions think' (Douglas, 1986). The encounters between care managers and older persons can be compared with many other types of institutional encounters that are found to:

> . . . represent those highlighted moments of judgment and record-keeping when clients and applicants are evaluated as adequate, competent, and morally acceptable (. . .) [and that] control of the particular mix of oral and written language in interviews is often a source of power. (Roberts & Street, 1997: 181–182)

Discussion

This article has reported on a study of how talk and texts are used in meetings between care managers and older people. Care management can be regarded as an activity that regulates the distribution of society's resources for the care of older people. We have analysed care managers at work to shed light on how this distribution of care resources is done in practice. Using examples from meetings, we have shown how discursive practices are part of the routine when older people's applications for elder care are processed.

The findings indicate that the application processes follow a rather standardised and pre-determined model used in the assessment meeting when actions are planned for older people. This standardisation of the assessment meetings shows how care management is carried out in practice. The findings of our study concur in two ways with earlier research summarised above. First, care management can be seen as part of the development of standardised procedures used in caring for older people when carried out as a public responsibility; and second, the discussion occurring in the meetings follows a pattern common to many other institutional encounters. The assessment meetings may thus be described as pre-structured.

Processing people in this kind of public organisation relies on standardised communicative practices. In these standardised procedures, oral discourse comprises clearly defined elements in which the written texts are also embedded in routines. These texts may be seen as tools for maintaining the institutional order. Pre-coded forms are often used to document information about clients. The use and production of texts in the 'intake' interview process can have many effects on social worker–client interactions (cf. Houptkoop-Steenstra & Antaki, 1997, on the use of written forms in interviews). The use of forms can influence the structure or sequential pattern of interaction between the interlocutors.

Talk – according to the present study – is thus a significant dimension of the handling of applications in elder care, and is supported in several significant ways by the use of texts. However, do these dimensions reduce the freedom of the actors involved in the meetings? The answer to this question seems to vary, since the communicative pattern varies in different parts of the meetings. When *talk* is the sole focus of the analysis, we see that the care manager can use talking to control the topic of discussion and how the discussion proceeds (e.g. by the manager's use of questions). Furthermore, the phases of the conversations are often initiated and closed by the care manager.

When the analysis of the meetings instead focuses on the use of *text*, and on the interplay between talk and text (Extracts 1 and 2), we can see that also the care manager might be controlled by the use of texts (cf. Cowley, Mitcheson & Houston, 2004, for similar findings from a study on the use of needs assessment schedules by health visitors). In such instances, the care manager and applicant may be required to follow what is described and asked for in the text. It is then possible to find influences from text in the talk produced in the encounter between the older person and the care manager. Moreover, the text seems to support the use of a certain vocabulary and thereby also to implicitly promote a specific way of thinking and acting.

However, within the overall framework of maintaining order through the use of talk and text, there are obvious elements of *negotiations* in the assessment meetings. It is not enough to rely on a research approach that sheds light only on the standardised patterns and descriptions of the phase structure (as done in many previous studies). Institutional order is often in some ways a negotiated order that does not exist on its own, but has to be more or less continuously achieved. This perspective on care management highlights the importance of preserving and strengthening the oral element of assessment meetings in elder care, since the negotiations tend to occur in the verbal interaction.

The use of written messages in care management can lead to some final reflections on the differences between text and talk. Written documentation of what has been discussed orally might be taken more seriously by the participating actors (and other stakeholders) than an oral message. With the creation of case files, the oral message is transformed into a more permanent form (viz. the written document). A text can often be perceived as more reliable and secure than an oral statement, which might soon be forgotten by the interlocutors (cf. Rommetveit, 1992).

This duality – oral versus written discourse in institutional interaction – opens up a perspective on human interaction that has been described by the Norwegian social scientist Ragnar Rommetveit (1992: 23). We will therefore end the article by quoting him:

> Context-bound understanding of our '*Lebenswelt*' from within as mediated by ordinary language is transcended by fixation of perspective within separate domains of practical–technological, professional and scientific expertise . . . Fixation of perspective is thus essential in the ramification of fragments of ordinary language into highly specialized technological, professional and scientific terminologies.

Achieving this understanding of an older person's *Lebenswelt* is one task dealt with in care management practice, and this task is largely supported by the interplay between talk and text. This interplay gives the care managers a way to handle their complex and demanding tasks, providing a tool that supports the translation of what is told by (and about) the older person into a language valid in the formal elder care system.

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