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Case Study

Beyond Medical Care: Exploring The Role of Medical Social Workers in Community-Based Palliative Care Through Case Narratives

Dona Maria Kuriakose[1]*, Jasmine Sarah Alexander[2]

Department of Social Work, Loyola College of Social Sciences, Thiruvananthapuram, Kerala, India

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***Corresponding author**
Dona Maria Kuriakose,
Department of Social Work, Loyola College of Social Sciences, Thiruvananthapuram, Kerala, India.
Email: dmaria541@gmail.com

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Abstract

Palliative care is a field that extends beyond biomedical care to include psychosocial and structural dimensions of suffering. Medical social workers (MSWs) are crucial to this holistic vision, yet their practice realities are insufficiently documented, especially in India. This article presents a qualitative case study analysis of four cases based on the narratives of an experienced medical social worker in a community based palliative care setting in Kerala, India. The cases shed light on various diverse domains of MSW practice, including material assistance, caregiver crisis intervention, educational support, resource mobilisation, and community-based rehabilitation. Each case is analysed through suitable theoretical frameworks, including strength-based practice, crisis intervention theory, and bridging social capital. Findings from the case descriptions affirm that social workers function as facilitators, mediators and as a link between health care and community. The study underscores the crucial role of medical social workers within Kerala's community based palliative care model and contributes to evidence based understanding of holistic care necessity in palliative care field.

Keywords: Palliative care; Medical Social Work; Community based rehabilitation; psychosocial care; case study

Introduction

Palliative care is a specialized branch of medicine that aims to improve the quality of life of individuals and their families facing life-limiting illnesses through pain management and symptom control (WHO, 2020). In healthcare, the biomedical dimensions are often attended to, while the psychological, economic and structural challenges faced by patients and their carers remain underexplored, especially in low- and middle-income countries. Medical social workers play a significant role in addressing these

[1] Research Scholar
[2] Assistant Professor

concerns, and they ensure holistic care. Kerala, a state in southern India, is recognized for its community-based palliative care model, which characterizes a strong integration of community volunteers, local self-government institutions, government health infrastructure, and multidisciplinary healthcare teams (Paleri & Numpeli, 2005; Kumar, 2013). Within this system, medical social workers play a distinctive role in bridging clinical care and community systems and addressing the layered vulnerabilities that patients and their families face.

The narratives used in this study were obtained from one medical social worker with ten years of experience in the community-based palliative care department of a private tertiary care hospital in Central Kerala.

This article documents and analyses four significant cases that illuminate the diversity and complexity of social work practice at the intersection of illness, deprivation and community. The study thus aims to: (a) document and describe various practice realities encountered by MSWs in community-based palliative care; (b) identify and analyses the intervention strategies employed by MSWs.

Case Descriptions

Case 1

A 35-year-old woman was the primary carer for her eight-year-old child diagnosed with cerebral palsy. Her husband was employed abroad, leaving her with the entire responsibility of the child. The child required daily therapy at a specialised centre, and for that she carried the child from the second floor of their rented apartment and travelled by auto every day. When the mother sustained a hip injury after a fall, she was unable to continue this routine. With no family support, limited assistance from her husband, and years of carer stress, her mental health deteriorated significantly. During a home visit by the palliative care team, the medical social workers observed signs of severe psychological distress. Through patient and empathetic communication, the medical social worker identified her thoughts of ending life along with her son. Recognizing the seriousness of the situation, the MSW contacted relatives of her husband, who attended the home and confirmed the urgency of the situation. Immediate referral to the psychiatric department of the hospital was arranged by the MSW, and severe psychological distress was confirmed there and proceeded to further treatment. Her husband was contacted by the MSW and explained the seriousness of the situation and requested his immediate return. Early identification, prompt crisis intervention, interdepartmental coordination and coordination of support systems for the person prevented a possible tragedy.

Case 2

A woman with Parkinson's disease lived with her two sons in a dilapidated rented house. Their father had been very abusive and abandoned the family a few years back to live with another woman. From young ages, the children had responsibilities beyond their age, including caregiving for their sick mother and doing household management. Responsibilities, poverty, and family disruption shaped their childhood. The elder son, after completing his secondary education with 85% marks, had no financial resources to continue his studies. Here, the medical social worker intervened by arranging sponsors who funded his college education, and he achieved academic distinction and also became the college union chairman. The younger son was in 11th class, and during a school visit, the MSW encountered teachers who penalized the boy for poor attendance, lack of books, untidy clothing, delayed payment and not bringing proper meals. The teachers viewed his situation as negligence, not knowing the challenges he faced. Following the social worker's explanation of the family background of the child, the teachers felt guilty for not being aware of such issues affecting students and expressed remorse for their judgements. Adding on to the situation, as the family was living in a deteriorated rented house, the social worker mobilised resources from donors and an NGO to construct a permanent shelter for this family. A doctor from the hospital donated 3 cents of land for the family, leading to the construction of a safe home for the children and their mother. The trust also provided the family with monthly medicines and food kits. To address the issue of poor clothing of the children, the MSW connected a nearby textiles company to this family, where they provided new clothes for free to the children.

Case 3

A male patient who had been working as an auto driver sustained a fall from a height. The accident resulted in paralysis and complete confinement to bed. When the palliative team visited him at home, he was initially uncooperative and unwilling to communicate with the palliative care team. After one whole week of attempting to build a rapport, the social worker shared with him that her father was also an auto driver. This connection encouraged the patient to initiate open communication. Gradually, they built a rapport, and he began sharing his frustrations and fears. He expressed a strong desire to regain independence and his mobility. The MSW coordinated with local government authorities to secure a motorised three-wheeler scooter and a self-propelled wheelchair through a disability support scheme. His wife, the sole breadwinner of the family, earned only Rs.4000 per month, which was insufficient to meet daily expenses. The social worker assisted her in securing employment at the hospital at a salary of Rs 15,000. Later, the patient expressed a desire to have an income where he could support his wife. When this matter was discussed with authorities from local government, the community gathered together and arranged a football match for fundraising. This was a remarkable

example of community solidarity. The raised money was used to set up a small petty shop in front of the patient's home. He eventually managed the shop all alone, generating income and restoring his sense of self-worth.

Case 4

The fourth case involved a woman with the terminal phase of pancreatic cancer. With her condition worsening, she expressed her wish to stop further treatment and to have a peaceful, pain-managed death. However, her husband was not willing to accept this prognosis, and he continued to seek aggressive treatment for his wife. The couple's only daughter had eloped with a man from another caste four years ago, and the mother had not seen her daughter since then. During a home visit, the patient expressed two deeply held wishes: relief from pain and to see her daughter for one last time. Following these events, the medical social worker worked intensively with the husband for over two weeks to help him accept the prognosis and prepare him emotionally for his wife's death. Appropriate pain management measures were then taken. After this, the social worker tried to counsel the father to reconcile with his daughter. Eventually he agreed to contact his daughter. After four years of separation, the daughter visited her mother, and that night the woman died peacefully, with her final wish fulfilled.

Discussion

The case descriptions demonstrate that medical social work in palliative care is a specialised field that reveals a holistic practice model to address the social, psychological, emotional, economic, family and community dimensions of suffering.

Case 1 highlights the heightened vulnerability of carers within palliative care systems. A single adult without adequate social support assuming the carer role is often associated with elevated rates of psychological distress, burnout and depression (Payne, 2010; Milbury *et al*., 2013). In the case narrated, prolonged physical demands of caring for a child with cerebral palsy combined with social isolation and absence of spousal support created a crisis situation for the mother, which, if left unaddressed, would have ended up in a tragedy. Hudson *et al*. (2013) found that low social support and high functional burden for carers significantly elevated risk of clinically significant distress.

The medical social worker's ability to identify psychological distress and suicidal ideation during home visits highlights the critical aspects of observation, active listening and the importance of therapeutic relationships in crisis-prone contexts. Suicidal ideation among carers is often under-detected due to stigma and carers' tendency to suppress personal distress (Mitchell *et al*., 2011). In this case, the MSW's interventions of family notification, spousal engagement and immediate psychiatric referral align with established crisis intervention protocols which prioritise safety planning, immediate resource linkage and activation of support networks (James & Gilliland, 2017).

Case 2 presents a complex intersection of domestic violence, child burdens, poverty, parental illness, and educational deprivation. The children in this case represent what Aldridge and Becker (2003) term 'young carers', which are the children who assume caring responsibilities due to parental illness, often at the expense of their own development and well-being. Studies often illustrate the educational disadvantage associated with children assuming young carer status, including reduced academic performance, irregular school attendance and social marginalization (Becker, 2007; Thomas *et al*., 2003).

In this case, the social workers' multi-pronged interventions for securing education sponsorship, material assistance, housing advocacy and school-level sensitization reflect a structurally informed practice that addresses the social determinants of health rather than giving sole focus to individual symptom management (Marmot, 2005). The encounter with teachers in school of younger boy in case 2 exemplifies the 'deficit attribution' in educational settings, where children's behavioural and academic difficulties are attributed to family or individual failings without accounting for structural disadvantage (Gillborn & Youdell, 2000). The case also showcases the significance of the concept of bridging social capital. Where the MSW here connects the needy family to resources like NGOs, local businesses, sponsors, etc. that the family alone would be unable to access. This competency in resource mobilization is identified as core in palliative social work practice (Reith & Payne, 2009; Fenton & Grubin, 2009).

Case 3 highlights the empowerment and rehabilitation following disability. The patient's initial hostility reflects a psychological response to sudden loss of normal functioning, which disrupted their personal identity, social functioning and future expectations. Loss of mobility is often associated with loss of self-esteem and purpose. The MSW's use of self-disclosure to establish rapport marked a significant milestone in the intervention process. She shared with him that her father too was a driver, and this is a technique with an evidence base in social work and counselling practice. Farber (2006) identifies self-disclosure as a means to reduce social distance, foster a sense of trust and equalize power asymmetry in professional relationships. The subsequent alliance formed helped in assessment and developing collaborative intervention plans. Multi-level interventions were provided for the family and the patient, like providing mobility aids like wheelchairs and three-wheeled scooters; providing spousal employment; community fundraising; and micro-enterprise establishment. All these showcase the model of the community-based rehabilitation (CBR) framework provided by WHO (WHO, 2010). This case demonstrates

the principles of strengths-based practice and client empowerment. The restoration of economic participation for the patient aligns with the concept that financial independence and purposeful activity are crucial in predicting well-being and self-efficacy among individuals with acquired disabilities.

Case 4 focuses on the most ethically and emotionally complex terrains of palliative care, like negotiating death, dealing with family conflicts, and family reconciliation. The tension between the patient's preference for painless, palliative-focused care and the husband's resistance to accept her end-of-life prognosis reflects a pattern commonly documented in literature on family decision-making in terminal illness. Broom and Kirby (2013) found that reluctance of family in accepting a poor prognosis is among one of the most common barriers to quality end-of-life care, often resulting in interventions that compromise the comfort and dignity of patients.

The social worker's intervention with the husband of the patient for over two weeks showcases a form of anticipatory grief counselling to prepare him for an imminent death. This intervention resembles the principles of advance care planning (ACP), which advocates for early discussions about patients' autonomy, right to self-determine treatment and preferences for end-of-life care (Rietjens *et al*., 2017). Similarly, the facilitation of family reconciliation reflects the concept of developmental landmarks of dying that includes the completion of relational business, including expressions of love and forgiveness, thereby enabling a meaningful farewell. The MSW's mediation between family members gave the patient a 'good death' marked with comfort, dignity, and meaningful connections.

Across all four cases, the role of the medical social worker as navigator within the health system is revealed. This aligns with Lyons *et al*.'s (2006) mention of MSW in healthcare as a 'system broker' and an 'institutional translator', who negotiates financial, relational and bureaucratic barriers to ensure patients receive care that addresses their holistic well-being. In each case, the social worker was competent enough to negotiate between local governance structures, welfare schemes and community networks. The Kerala model of palliative care, with its focus on inter-sectoral collaboration, community participation and government NGO partnership creates an enabling infrastructure for these functions of social work (Kumar, 2013). The interdisciplinary dimension of palliative care is also evident across all four cases. The medical social worker here liaises with people from several sectors, including physicians, psychiatrists, school teachers, panchayat officials, NGOs, sponsors and community volunteers. This kind of interdisciplinary collaboration is considered a prerequisite for comprehensive palliative care. Research by Egan and Kadushin (2004) demonstrates that when social workers are integrated into interdisciplinary palliative teams, it directly benefits family and patient outcomes, including emotional adjustment, satisfaction with care and quality of life and death.

Conclusion

This study identifies multifaceted role of medical social workers within community-based palliative care. The four cases examined situations of crisis intervention, educational advocacy, physical rehabilitation, end-of-life mediation, quality of life improvement and family reconciliation, which collectively showcased the effective palliative social work model. Triangulation with empirical research confirms that the interventions documented in these cases align with established evidence on the role of social workers in community-based palliative care. The cases also reveal the extent to which MSWs are to navigate structural barriers and gaps in systems that formal care systems have failed to address. The findings also highlight the strengths of Kerala's community-based palliative care model, which prioritises multi-sectoral collaboration, community mobilisation, and equal access to quality palliative care services for the needy at home.

Ultimately, the study demonstrates that social work is an indispensable component of holistic palliative care and, by addressing the psychosocial and practical needs of patients along with medical care, can contribute significantly to their dignity, quality of life and well-being.

Authors' Contribution

All authors contributed equally at all stages of research and preparation of the manuscript. Final form of the manuscripts was approved by all authors.

Conflict of Interest

The authors declared no conflict of interest with this article.

References

Aldridge J & Becker S (2003) Children who care: Inside the world of young carers. Loughborough University.

Becker S (2007) Global perspectives on children's unpaid caregiving in the family: Research and policy on 'young carers' in the UK, Australia, the USA and Sub-Saharan Africa. *Global Social Policy* **7**(1): 23–50. https://doi.org/10.1177/1468018107073892

Broom A & Kirby E (2013) The end of life and the family: Hospice patients' views on dying as relational. *Sociology of Health & Illness* **35**(4): 499–513. https://doi.org/10.1111/j.1467-9566.2012.01497.x

Egan M & Kadushin G (2004) The social worker in the emerging field of home care: Professional activities and ethical concerns. Health & Social Work **29**(1): 43–54.

Farber B A (2006) Self-disclosure in psychotherapy. Guilford Press.

Fenton K & Grubin D (2009) Social work in palliative care: Principles and practice. In B Monroe & D Oliviere (Eds.) Resilience in palliative care (pp. 89–105). Oxford University Press.

Gillborn D & Youdell D (2000) Rationing education: Policy, practice, reform and equity. Open University Press.

Hudson P, Trauer T, Kelly B, O'Connor M, Thomas K, Zordan R & Summers M (2013) Reducing the psychological distress of family caregivers of home-based palliative care patients: Longer term effects from a randomised controlled trial. Psycho-Oncology **22**(9): 1987–1993. https://doi.org/10.1002/pon.3243

James RK & Gilliland BE (2017) Crisis intervention strategies (8th ed.). Cengage Learning.

Kumar S (2013) Palliative care can be delivered through neighbourhood networks. Chronic Illness **9**(1): 83–92. https://doi.org/10.1177/1742395312464974

Lyons K, Manion K & Carlsen M (2006) International perspectives on social work: Global conditions and local practice. Palgrave Macmillan.

Marmot M (2005) Social determinants of health inequalities. The Lancet **365** (9464): 1099–1104. https://doi.org/10.1016/S0140-6736(05)71146-6

Milbury K, Badr H, Fossella F, Pisters KM & Carmack CL (2013) Longitudinal associations between caregiver burden and patient and spouse distress in couples coping with lung cancer. Supportive Care in Cancer, **21**(9): 2371–2379. https://doi.org/10.1007/s00520-013-1795-4

Mitchell AJ, Chan M, Bhatti H, Halton M, Grassi L, Johansen C & Meader N (2011) Prevalence of depression, anxiety, and adjustment disorder in oncological, haematological, and palliative-care settings: A meta-analysis of 94 interview-based studies. The Lancet Oncology **12**(2): 160–174. https://doi.org/10.1016/S1470-2045(11)70002-X

Paleri A & Numpeli M (2005) The evolution of palliative care programmes in north Kerala. Indian Journal of Palliative Care, **11**(1): 15–18. https://doi.org/10.4103/0973-1075.14607

Payne S (2010) White paper on improving support for family carers in palliative care. European Journal of Palliative Care, **17**(5): 238–245.

Reith M & Payne M (2009). Social work in end-of-life and palliative care. Lyceum Books.

Rietjens JAC, Sudore RL, Connolly M, van Delden JJ, Drickamer MA, Droger M, van der Heide A, Heyland DK, Houttekier D, Janssen DJA, Orsi L, Payne S, Seymour J, Jox RJ & Korfage IJ (2017). Definition and recommendations for advance care planning: An international consensus supported by the European Association for Palliative Care. The Lancet Oncology, **18**(9): e543–e551. https://doi.org/10.1016/S1470-2045(17)30582-X

Thomas N, Stainton T, Jackson S, Cheung W Y, Doubtfire S & Webb A (2003). 'Your friends don't understand': Invisibility and unmet need in the lives of 'young carers'. Child & Family Social Work, **8**(1): 35–46. https://doi.org/10.1046/j.1365-2206.2003.00266.x

WHO (2010) Community-based rehabilitation: CBR guidelines. WHO Press.

WHO. (2020) Palliative care: Key facts. https://www.who.int/news-room/fact-sheets/detail/palliative-care