This is to certify that the

dissertation entitled

Ethical Problem Encountered by Hospital Social Workers

presented by

Jerry L. Clark

has been accepted towards fulfillment
of the requirements for

Ph.D. degree in Social Science

John M. Herrick
Major professor

Date 3/31/1994

ETHICAL PROBLEMS ENCOUNTERED BY HOSPITAL SOCIAL WORKERS

by

Jerry L. Clark

A DISSERTATION

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of

DOCTOR OF PHILOSOPHY

College of Social Science

1994

ABSTRACT

ETHICAL PROBLEMS ENCOUNTERED BY HOSPITAL SOCIAL WORKERS

By

Jerry L. Clark

The focus of this study was the nature of ethical problems encountered by hospital social workers. A naturalistic research design (Lincoln & Guba, 1985) was used. Six key informants, four directors of hospital social work departments, two members of the academic community, as well as twenty informants, all staff hospital social workers, participated in the study. The sample included social workers from large, more than 250 beds, small, between 100 and 249 beds, and very small, fewer than 100 beds, hospitals.

This study identifies the types of ethical problems encountered by hospital social workers, the individuals and groups involved in these problems, and the guides used by hospital social workers in the resolution of these problems.

The hospital social workers encountered a wide range of ethical problems in their practice. There were several individuals and groups inside and outside the hospital involved in these problems. Social workers identified their own values, the mission of the hospital, and the National Association of Social Workers code of ethics as guides in the resolution of these problems.

ACKNOWLEDGEMENTS

I am pleased to thank many people who made the completion of this dissertation possible. I am grateful to Dr. John Herrick who chaired this dissertation committee. His assistance and scholarly guidance were invaluable. I thank Dr. Janet Bell for assisting in this project in spite of her own demanding schedule. I am grateful to Dr. Peter Manning for his scholarly insight, suggestions, and encouragement. I thank Dr. Linda Nelson. Her close guidance, criticism, and suggestions were essential for the completion of this project.

I thank Dr. Diane Levande, Dr. Margaret Bubolz, and Dr. Gil Green for their assistance, support, and guidance. I also thank the key informants and the informants who participated in this study.

I owe a special debt of gratitude to Dr. Jacqueline Scherer, a scholar, colleague, and very dear friend. Finally, this project absolutely could not have been completed without the companionship, encouragement, and assistance of Penny Clark.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1

STATEMENT OF THE PROBLEM

> Let us criticize and reform ourselves before some less gentle and appreciative body takes us by the shoulders and pushes us into the streets.
>
> -- R.C. Cabot
> (1931, p. 24)

Introduction

Though given over a half-century ago, Richard Cabot's frank advice to social workers would be relevant if offered today. It remains true that one of the many obligations incumbent upon a profession is to monitor and police its practice and practitioners. Such is the responsibility of social work.

There are many difficult issues facing contemporary social work, some of which pose especially serious threats to the profession. One such area is ethical problems that arise in the course of practice. Ethical problems are situations in which a disagreement exists concerning the right thing to do in a certain situation. Left unaddressed, or addressed improperly, such ethical problems can result in the loss of public confidence in the profession -- what Specht (1988, p. 9) refers to as social work's "community sanction." A loss of public confidence would seriously undermine the professional authority of social work, as well

as the profession's ability to respond effectively to social problems and provide services to its clients.

Nearly all social work practice takes place in a "host setting," i.e., in settings such as schools, courts and hospitals, where the primary activity is not the provision of social work services. They are therefore vulnerable to that "less gentle and appreciative body" which Cabot tells us may see social work as an irrelevant activity.

Statement of the Problem

Throughout the history of social work, research on the profession's knowledge, skills, and values has guided efforts to enhance its quality and effectiveness. Attention to its continually expanding knowledge base, its use of a variety of different practice methods, and its ongoing epistemology debates are examples of social work's efforts to become more effective.

Reamer (1993, p. 39) has noted that it is social work's "persistent embrace of values and a distinctive ethical framework" which distinguishes it from other helping professions. The values and distinctive ethical framework referred to by Reamer are reflected in the National Association of Social Workers Code of Ethics (Appendix A).

The topic of applied ethics, comprising ethics, ethical problems, and their role in informing social work practice, has been a major area of interest and research in social

work since the early 1980s. The present study developed out of this interest.

Focus of This Study

The focus of this study is an examination of ethical problems encountered in social work practice. Specifically, what is the nature of ethical problems encountered by hospital social workers?

The identification and resolution of ethical problems requires a rigorous approach to practice. Reflective practice is a part of such an approach and will be defined in this study.

Major contributors to the ethical problems faced by hospital social workers include rapid technological advances in the areas of reproductive and neonatal medicine, the aging patient population, and the increasing number of people without health insurance. These developments have created a difficult and complicated practice environment.

In particular, the current problems of providing as well as paying for health care have highlighted one important area of hospital social work: discharge planning. Discharge planning accounts for a substantial segment of social work practice in contemporary hospitals Volland, 1989). Discharge planning, refers to the process of planning for and facilitating the movement of hospital patients through the hospital system and into an appropriate post-hospital setting. The result is great pressure on hospital social

workers to "make professional decisions in the midst of complex, urgent and often conflicting demands" (Kugelman, 1992, p. 59).

In this study several questions will be explored. First, do hospital social workers in fact experience ethical problems? Second, who are the individuals involved in creating ethical problems? Finally, is there an ethical base or foundation that guides or informs hospital social workers' practice?

Need for This Study

Throughout the history of the social work profession, the growing complexity of the practice environment has brought with it increasingly complex ethical problems. Each succeeding decade has presented new and different possibilities for ethical conflict. This is particularly true in hospital social work for a number of reasons.

First, advances in medical technology have made it possible to maintain the life of a patient indefinitely. This has resulted in profound complications in deciding to withdraw or forego life sustaining treatment, in developing guidelines for actions to be taken by health care providers in the event of a patient's cardiac or respiratory arrest, and in deciding precisely what and how complex medical information will be provided to patients and families.

Second, financially strained institutions grapple daily with the issue of uninsured patients. What level and type

of care and services for this population are needed, appropriate, and ethical?

Further complications arise from advances in reproductive medicine, increasing numbers of hospital ethics committees, limited resources for organ transplants, and possible restrictions on access to treatments such as kidney dialysis.

Hospital social workers are involved in each of these areas. They work directly with physicians and other members of the health care team, and with patients and families in confronting these difficult and complex issues.

Today, the interaction between client and social worker remains a "fertile ground for unethical conduct by the social worker" (Levy, 1976, p. 50). Certainly social workers want to be ethical in the conduct of their practice, but, as Levy has noted, "they sometimes do not know how" (p. 18). The concern with ethics in social work has shifted from the morality of the client to the ethics of the social worker (Reamer, 1980; Trattner, 1974). Because of this shift, and the competing ethical responsibilities of the social worker, it is more critical than ever to examine practice and explore the role of professional ethics, ethical problems and dilemmas, and the ways in which such problems are addressed (National Association of Social Workers, 1990). Reamer notes, "There is significant concern

among social workers about the ethical aspects of their professional conduct" (Reamer, 1980, p. 531).

Because of the diverse nature of hospital social work practice and the multifaceted problems faced, it is important that care be taken to ensure appropriate responses to ethical problems. It is such vigilance, combined with research about practice, that can yield valuable information and insight regarding ways to improve the training and performance of practitioners.

Our contemporary health care delivery system is large, complex, and expensive. Ethical problems exist within the system at many levels. These problems have been discussed in detail by Bogdanich (1991), Rothman (1991), Stevens (1989), and Wohl (1984). The present study acknowledges this. The focus of the present study, however, deals with only one part of this much larger issue.

The implications of this research are substantial and far-reaching, relating to the fundamental way hospital social workers are educated, trained, supervised, and regulated. There are implications, as well, for how they continue to develop as practitioners.

Research that yields, identifies, or improves effective and appropriate practice methods is always needed. Professionals conduct practice research not out of fear of some less gentle and appreciative body, as Cabot (1931, p. 24) suggests, but because the professional relationship is

based upon a commitment to clients, practitioners, and the organization alike.

Such research cannot be conducted without sensitivity to epistemology and theory. Both epistemology, the study of the origin and nature of knowledge, and theory, the systematic statement of principles involved in an activity, interface with practice. Epistemology, theory, and practice interface and overlap. Each influences and is influenced by the other.

Attention must be given not only to the epistemology of practice, but to which epistemology serves social work practice best (Kondrat, 1992). This notion is reflected in recent calls for a "broader epistemology" in social work (Imre, 1984) and for attention to "local knowledge" (Hartman, 1992) and the "many ways of knowing" (Hartman, 1990) which exist in contemporary social work practice. The conceptual framework for practice research must also be sensitive to these ideas.

The conceptual and theoretical framework of this research is based upon a synthesis of reflective practice and symbolic interactionism -- or more correctly -- an application of the symbolic interaction perspective through reflective practice. Reflective practice is an approach which views each situation as unique, which assumes that more is unknown about a situation than is known, and which assumes that the meaning of a problem and its solution

involves both the client and the social worker (Schon, 1983). Symbolic interaction refers to the branch of social psychological thought that holds that man is a symbol creating animal, that through social interaction symbols are defined and redefined, i.e., given meaning, and that language serves to convey the meanings of symbols. Key conceptualizations which have shaped this study are those of Blumer (1969), Reamer (1979, 1980, 1990, 1993), and Schon (1983).

Purpose of This Study

The purpose of this study is to examine the self-reported practice of hospital social workers. There are three goals. The first is to determine if hospital social workers encounter ethical problems in their practice. Hospital social workers encounter a wide variety of problems in the course of their daily work. These problems may be characterized in a number of ways such as, administrative, legal, or logistical difficulties. The focus here is on those problems the social workers characterize as ethical. Information about the recognition, nature, and reconciliation of such problems will be sought.

A valuable sociological perspective with which to examine the meaning of ethical problems is that of symbolic interactionism. It is based on the assumption that human beings seek meaning and create, maintain, and change reality through social interaction. By examining the meaning of

practice decisions from a symbolic interactionism perspective, it is possible to understand how ethical problems are identified, interpreted, and reconciled.

The second goal is to determine who are the individuals that are involved in the ethical problems encountered by hospital social workers. There are many people involved in the care of a patient during a hospitalization. Some, such as physicians and nurses, are directly involved in patient care. Others, such as hospital administrators and "risk managers," are often involved in patient care but their involvement is much less obvious.

The third goal is to identify the ideals or principles that guide social workers or inform their practice as they deal with these ethical problems. While the National Association of Social Work code of ethics is intended as an aid in this regard, a number of other factors could also influence practice.

Definition of Terms

There are five concepts that require definition and some elaboration: (a) ethical problems, (b) hospital social worker, (c) the discharge planning process, (d) reflective practice, and (e) symbolic interactionism.

Ethical Problems and Dilemmas

Ethics in social work are social work values in operation. Ethics are concerned with what should be done in practice, and as such "transcend good work and good

practice" (Levy, 1976, p. 14). Often, in hospital social work, what should be done in a particular situation is not clear. An ethical problem exists when there are a number of things that should be done and some conflict with others. Ethical problems center around the right thing to do in a given practice situation (Loewenberg and Dolgoff, 1992, p. 7).

An ethical dilemma is said to exist when mutually exclusive moral actions or choices are equally binding. A frequent ethical dilemma is discussed at length by Bailey and Brake (1975). It concerns the difficulty practitioners sometimes have in discerning if an organization hires social workers to meet the needs of the clients it serves, or to meet the needs of the organization itself.

The issues of "creation, maintenance, or termination of life, or the quality of life to be experienced by an individual" (Reamer, 1985, p. 273) are examples of situations fraught with the possibility of ethical problems for the hospital social worker. A problem may be fairly minor, such as how a hospital social worker addresses an elderly patient, or as complex as the same patient's desire to forego life-sustaining treatment. Ethical problems are thought to be an inherent part of social work practice, since the social worker must often balance the interests of client and agency, client and social worker, and even social worker and social worker.

Such problems are rarely obvious and often go unrecognized. Recognizing the ethical problem is only the first difficulty. Addressing it is usually more difficult.

The practice arena of the present study, the hospital, presents substantial opportunities for ethical problems. It has been argued that an ethicist should be included on the staffs of teaching hospitals (Walker, 1993, p. 38). Ideally, the interests of the organization, (e.g. hospital, third party payers, practicing professionals (e.g. physicians, nurses, and social workers), and client (patient) are appropriately and ethically reconciled. This often is not the case, however, and the resultant problems pose substantial difficulty for the hospital social worker.

Hospital Social Worker

Social work in health care has a long history (Bracht, 1978; Hubschman, 1983; Kerson, 1982). Hospital social work traces its origin to Boston and the Massachusetts General Hospital at the turn of the century (Cannon, 1923).

In addition to hospitals, there are social work practitioners in a number of health care settings including nursing homes, health maintenance organizations, mental health clinics, dialysis and chemotherapy centers, and home health care organizations. Such practice diversity led to the broader concept of medical social worker (Goldstein, 1954). While the concept of medical social worker would include hospital social workers, it also includes

practitioners in the hospital-related arenas noted above. For the purpose of this study, the more narrow concept of hospital social worker provides greater precision in delineating a segment of practice for analysis.

A hospital social worker, as this study defines it, refers to a social worker who possesses a Master of Social Work degree and practices within a general hospital setting. Practitioners in such settings function with physicians, nurses, and specialists such as physical therapists and dieticians as members of the health care team. Most often they engage in generic social work activities such as patient and family counselling and the coordination of community resources. Most recently, a significant responsibility of hospital social workers has been in addressing special needs related to patient discharge planning.

The practice of hospital social work was chosen for examination for three reasons. First, such practice represents a significant number of practitioners. In 1988 there were 18,685 medical social workers in community hospitals. This number compares to 13,915 in 1981 (Rakich, Longest, & Darr, 1992, p. 46). Second, the activities these practitioners engage in are representative of the complexities faced by social work practitioners in general. Finally, hospital social workers constitute a clearly

discernible segment of the larger population of practitioners.

Discharge Planning Process

In the past patients came to the hospital when they were sick and, hopefully, left when they were well. Hospital length of stay was the concern of very few. Today, however, for a variety of reasons, the selection of patients to be admitted to the hospital and the determination of who will remain have become concerns to many.

Today the average length of stay for patients (approximately 6 days) is nearly half that of five years ago (approximately 10 days), and projections are for it to be nearly half of what it is today five years from now (Volland, 1989). The level of acuteness of today's hospital patients has never been higher. Because of stringent hospital admission criteria, contemporary patients are sicker upon admission, and sicker upon discharge, than at any time before. Planning for the orderly and appropriate movement of patients from entry to exit from the hospital system presents a difficult task for hospital social workers.

Discharge planning refers to the process that facilitates the movement of a patient through the hospital system and into appropriate post-hospital care. This is the central focus of many of today's hospital social workers

(Beckerman, 1991, p.2). In some hospitals it includes a broader range of activities than in others. For example, in some hospitals the discharge planning process is presumed to begin with planning a patient's testing and diagnostic workup prior to admission to the hospital. In other hospitals, discharge planning begins the day the patient is identified, usually by the physician, as ready for discharge. At this point, attention is focused on the needs the patient will have after leaving the hospital (Schlesinger, 1985). Examples of such needs are durable medical equipment such as a hospital bed, a bedside commode, or a walker, and home care, such as a visiting nurse or home physical therapy.

It should be noted that discharge planning is not the exclusive domain of social workers. In some hospitals these activities are performed by nurses, registered nurses, and licensed practical nurses, and managed most often by a Utilization Review Department. Another approach to discharge planning is multidisciplinary. In this approach a number of different disciplines work together, usually within a single department, in the discharge planning process to aid patients and their families in developing a feasible post hospital plan of care (Volland, 1989). Regardless of the particular configuration of the discharge planning process, there is sufficient complexity to afford the opportunity for reflective practice.

Reflective Practice

Reflective practice, as used in this study, is defined as follows: An approach to social work intervention guided not only by the values, skills, and knowledge acquired through professional education and training, but also by evaluation and reevaluation of one's practice decisions. A fundamental assumption of reflective practice is that social workers do not know more than he or she knows about a given problem. Social work practice requires precision, but also flexibility; information, but also inquisitiveness; clarity, but also reflection. Harrison notes, "Social work should deliberately examine further and emphasize reflective processes in its practitioners and students" (1987, p. 403).

Reflective practice represents an approach to practice articulated by Schon (1983). As with most theories or methodologies, it is an outgrowth of the work of many scholars. Argyris & Schon (1974), Boud, Keogh, and Walker (1985), Colaizzi (1973), and Polanyi (1966) are representative of these.

Schon (1983) suggests reflective practice is both a form of practice and an alternative epistemology. As opposed to the "technical rationality" of traditional professional education and training, reflective practice presumes every problem is unique, fraught with "complexity, uncertainty, instability, uniqueness, and value conflicts" (Schon, p. 39). The positivist approach, or a practice

template approach, works well in such fields as mathematics and physics where rationality and laws apply. The role of technical rationality is more in the "high, hard ground" of the professional practice topography. The practice arena of social work lies in the "swampy lowland where situations are confusing messes" (Schon, 1983, p. 43, emphasis in the original). Reflective practice is sensitive to such an environment.

In addition to social work, several fields have adopted some form of reflective practice. Among them are nursing (Powell, 1989; Wellington, 1991), education (Kottkamp, 1990, Osterman, 1990a; Osterman, 1990b), physical therapy (Shepard & Jensen, 1990), home economics (Vaines, Badir, & Kieren, 1988), medicine (Hewson, 1991), and philosophy (Walker, 1993).

Obviously, since humans are cognitive beings, there is a certain amount of reflection in all forms of human behavior. The present discussion assumes this. However, with regard to social work practice, reflective practice refers to activity substantially beyond the minimal reflection involved in usual human behavior.

Reflective practice refers to a questioning approach to problem solving, rather than approaching problems with predetermined solutions or answers. Conventional wisdom views social workers as having solutions to problems and answers to questions. They are often viewed as "social

mechanics" who have answers and solutions in the event of "social" breakdown (Rein & White, 1981, p. 7).

There are several elements of reflective practice. It acknowledges that each problem situation is unique. Persons whom social workers seek to help have unique life experiences which necessitate a unique interpretation of their life circumstances and their problems.

Reflective practice incorporates the client's own interpretation of the problem and formulation of a response or solution. Hartman (1992) has noted, "We must enter into a collaborative search for meaning with our clients and listen to their voices, narratives, and their constructions of reality" (p. 484). When the client is present and active in the intervention, "clientizing" and "imposing a well-meaning but externally generated set of ideas" (Harrison, 1987, p. 399) are much less likely to occur.

Reflective practice acknowledges that during the process of intervention, the practitioner may influence and be influenced by the phenomena with which she or he is working. Such interaction is unavoidable as problems and solutions are defined and redefined. It is also highly desirable, since it aids in the development of "a philosophy of knowing capable of encompassing all that is human" (Imre, 1984, p. 44).

Reflective practice ultimately results in the identification of options and choices for the client. The

extent to which practice has been reflective may be indicated in the number and creativity of options articulated.

Finally, reflective practice acknowledges that there are times when practitioners will not be able to develop good solutions to problems, or perhaps no solutions at all. Given variation in the human condition, sound and enduring solutions may never be developed. From a reflective practice perspective, however, there is rarely a situation in which "nothing can be done." Guidance and direction may be provided in the absence of solving a specific problem.

In the absence of reflective practice, the patient may be viewed as irrelevant for both the identification of the problem and for formulation of a solution. Criticizing mental health practitioners, sociologist Erving Goffman (1961) observed that ideally in many hospitals, patients would leave their social selves at home and send their physical container in to be repaired.

Reflective practice then, is an approach to practice that combines the values, skills, and knowledge of professional training with the experience of the practitioner. It holds that practice situations, while sharing certain elements, are fundamentally unique and call for unique intervention. And finally, it holds that the problem being addressed those addressing the problem are influenced, each by the other.

There are problems associated with disregarding the patient's interpretation of his or her situation. When hospital social workers disregard input from the patient, dehumanization or "objectification" occurs. Patients come to be referred to as hospital room numbers or as specific diagnoses. Worse yet, they are often labelled by such degrading nicknames as "F.L.K.'s," of Funny Looking Kids" (i.e. children born with birth defects or some other visible imperfection), "Gomers" (Get Out of My Emergency Room), "Frequent Flyers," (homeless or indigent patients who repeatedly come to emergency rooms for what is often routine medical care), or even "A head in a bed" (neurosurgery slang for a paralyzed patient) (Belkin, 1993, p. 32).

Symbolic interactionism

Symbolic interactionism rests on three premises, all of which have much to do with meaning: first, humans act based on the meaning things have for them; second, meaning is derived from social interaction; and, third, meaning is modified based on things that are encountered (Blumer, 1969, p. 2). Reflective practice is a perspective that fits well within this framework.

In writing about total institutions, in which all aspects of one's social functioning are rigidly controlled, Goffman notes that clients "...typically have statuses and relationships in the outside world that must be taken into consideration" (Goffman, 1961, p. 61). General hospitals do

not meet the criteria of a total institution, since patients are free to exercise many choices regarding aspects of their care. Most basically, they are free to choose whether they wish to remain hospitalized or not. However, the process of discharge planning is one during which dehumanization could easily occur.

Several chapters follow. Chapter two presents a review of literature relevant to the present study. Chapter three presents a discussion of the research design. Chapter four will present the findings of the study. Chapter five presents a summary of the findings and conclusions, a review of the problem statement, and suggestions for further research.

CHAPTER 2

REVIEW OF THE LITERATURE

Introduction

Before the substantive areas of the literature review are presented, it is necessary to understand the context within which contemporary social work practice occurs, including its vast range of activities and complex nature. It is precisely this complexity that gives rise to ethical dilemmas, the main focus of this study.

The practice of social work has never been more complicated and difficult than it is in contemporary American society. Social problems are vexing and the configurations of resource systems more tenuous than ever. Historically, the failure of informal resource systems gave rise to contemporary social work. Today, the capacity of formally trained professionals and of institutions to respond constructively to social needs is being strained.

The environment in which the contemporary social worker functions derives from a number of interrelated developments within both the profession and society at large. Following are brief discussions of some of the major developments.

The diversity of practice arenas. The early domain of social work was the settlement house and charity organization. Today, social work is practiced in every

segment of our society. In addition to traditional arenas such as child welfare, mental health, and social service organizations, it can be found in political, educational, correctional, and health care institutions. In only a few decades the focus of social work has broadened from concerns with charity, pacifism, and suffrage to such complicated projects as working with women prisoners, the homeless, hospital bioethics committees, and counselling patients with the AIDS virus. Another recent expansion of social work activities is in the area of critical incident response teams. These are teams of mental health professionals that respond to crises such as airplane crashes and school shootings by providing on-the-scene and follow-up services for those affected by the trauma of such events.

Hospital social work, the focus of this study, is a particular area of social work that has undergone dramatic transformation during a period of substantial growth and development in the past seventy-five years.

Hospital social work began in 1905 when, Dr. Richard C. Cabot, the Chief of Medicine at Massachusetts General Hospital in Boston, began to employ social workers in his outpatient clinic. A motivating factor for the use of social workers was his belief that a patient's "sickness, fear, worry, and poverty were found inextricably mingled" (Bartlett, 1975). The early focus of services was on patients' "domestic and social conditions," their compliance

with the physician's orders, and the coordination of patient needs with community resources (Shevlin, 1983).

Later, medical social workers began to practice in such health-related arenas as the general hospital, outpatient mental health facilities, and home health care. Most recently, medical social work practice has been established in health maintenance organizations, employee assistance programs, and independent private practice.

Expansion of social work knowledge and skills. It was recognized that the desire to help and the opportunity to do so are not the only ingredients for successful social work practice. As social work entered different arenas and witnessed unfamiliar phenomena, more had to be learned. Effective practice therefore required expansion of the breadth and depth of social work's knowledge and skill base.

In order to maintain its sanction and relevance, the mission and conceptualization of social work practice has been altered and refined throughout its history. Social workers "have produced multiple, shifting images of the nature of their practice" (Schon, 1983, p. 17), but the pace of change and breadth of knowledge needed at the end of the 20th century dwarf the knowledge required of social work pioneers.

The logical outgrowth of an expanded knowledge base is an expansion of practice skills. Schools of social work have undergone a metamorphosis in the last half century.

Curricula have been reorganized, obsolete courses and programs dropped, and new and innovative programs added. A prominent social work text notes thirteen "recognized fields of practice" (Bloom, 1990, p. 289). Today, however, it is possible to obtain a specialty or concentration in virtually any aspect of social work practice.

Increased number of practitioners. There are more social work practitioners today than at any point in the history of the profession. The United States Department of Labor reports that in 1990 there were 438,000 social workers in the United States (United States Department of Labor, 1992, p. 18). In 1983 the number was 407,000 (Bureau of the Census, 1990, p. 395). While the number of practitioners is not a major issue in and of itself, numbers can be important in ensuring a reasonable level of oversight, supervision, and competence, along with the maintenance of an appropriate practice environment.

Efforts to regulate practice have resulted in a hodgepodge of certification, registration, and licensure measures at the state level. In Michigan this has resulted in three levels of certification, "certified social worker," "social worker," and "social work technician." In addition, various forms of accreditation within the profession have evolved, such as, "Diplomate" and "Academy of Certified Social Workers."

Emphasis on quality and efficiency. The service sector of contemporary society is now confronting the demand for quality from consumers that the manufacturing sector has faced for many years. Programs such as Continuous Quality Improvement, Total Quality Management, and Quality Assurance are designed to meet heightened expectations for both quality and efficiency. These programs are in wide use in hospitals and other practice arenas today.

Continuous Quality Improvement and Total Quality Management are programs adopted from industry (Rakich, Longest, and Darr, 1992, pp. 407-442). Such programs represent a view of quality achievement which is markedly different from the traditional approach that sought a certain "standard" or "level" of quality. According to the traditional approach, once such a standard is achieved, an acceptable level of quality has been attained. Neither Continuous Quality Improvement nor Total Quality Management accepts such a view. In both, the basic assumption is that the quality of a good or service can always be improved. When poor quality exists, it is the fault of systems or processes, not people, since all of those involved in the production of a good or service want to do a good job (Oakland, 1989; Walton, 1986).

Quality Assurance programs differ somewhat. These are programs which comprise "activities designed to assess the services systematically, to determine whether they comply

with what is believed to be adequate services, and to correct any observed deficiencies" (Coulton, 1979, p. 10).

Demand for cost effectiveness. Social work services are often costly. Third-party payers, host settings, and policy makers alike have a strong interest in social work practice being as cost effective as possible. There is a constant demand for social work practice to be fully productive and not duplicate other services.

Training and titles. Social work practitioners vary greatly in their level of education and training. Some have less than a bachelor's degree in any field, while others have doctoral degrees of one kind or another. Social workers have a variety of titles, as well. While some are referred to as counselors or psychotherapists, others are referred to as social service workers, community social workers, caseworkers, or medical social workers (Levy, 1976).

In addition to these fairly specific issues, there are a number of broad social problems that contribute to the difficulty and complexity of social work practice. For example, the current health care crisis is a national concern. This is exacerbated by an absence of a public family policy and a high divorce rate. At the same time, traditional unemployment persists, with increases resulting from corporate retrenchment. Add to these conditions the continuing problems of poverty, racism, decaying inner

cities, and an aging society, and it is clear that the physical and mental well-being of thousands are at risk.

These issues contribute to what Levy (1976) refers to as the "diffusiveness of the social work profession and the diversity of its practitioners and their practices" (p. 16). This complex environment requires all the guidance, support, and assistance the profession can muster. Ethical guidelines are a central feature of such support.

Categories of Literature Reviewed

Five categories of literature are reviewed in this chapter. They are: (a) social work ethics and ethical dilemmas in social work, (b) the history and development of hospital social work, (c) the evolution of discharge planning in hospital social work, (d) the epistemology debate in social work, its history and current status, and (e) symbolic interactionism, which aids in the examination of construction of meaning.

Social Work Ethics and Ethical Problems

Commitment to a core of values has always been a central element in the social work profession. In the profession's formative years, discussions of ethics revolved around the morality of the earliest clients of social work -- namely, paupers. Nearly a century later, in contemporary social work, the focus has shifted to "the morality of practitioners and debate about the moral nature of the profession's aims" (Reamer, 1993, p. 39). The years in

between saw the development and evolution of the Code of Ethics of the National Association of Social Workers.

From the mid-1960s to the 1970s there was a significant effort within the profession to pull together the fairly wide ranging thinking about social work ethics. Among the many contributions to this effort, two are particularly noteworthy.

The first was the establishment of an Ethics Task Force by the National Association of Social Workers and its 1962 development of a brief code of ethics. This code has undergone minor revisions a number of times, with major revisions in 1967 and 1979. The current edition serves as "a guide to the everyday conduct of members of the social work profession" (National Association of Social Workers, 1990, p. iii).

The second was Charles Levy's (1976) comprehensive book, Social Work Ethics, a pioneering examination of how ethics influence practice. Levy distinguished between ethics in general and social work ethics, and argued that the social work profession needed a code of ethics to guide practice. His book served as a reference and guide for most scholars who discussed and wrote about social work ethics after his contribution and is still cited often.

Interest in applied ethics in health care and hospital social work grew in the 1980s and 1990s. At the same time,

interest grew in the subject of ethical problems in social work.

Interest in applied ethics, for example, is represented by Coulton (1990), who researched decision making regarding life-sustaining and long-term care. She described the elements of such decision making, such as recognition that a decision is needed, articulation of alternatives, and she showed how this process differs from a "rational" decision-making model. She also, noted the very short time frame in which critical decision making takes place (pp. 65-66). Today's hospital social workers are very much involved in such decision making.

Abramson (1990) examined the impact of technological advances on both social work ethics and practice. She notes three areas that are particularly affected: life support for terminally ill and elderly patients, reproductive technologies, and the severely impaired newborn (p. 5).

Roberts (1989) examined conflicts arising between the values of social work and those of medicine. Five areas where conflict arises were identified. They are: (a) saving life versus quality of life, (b) patient autonomy, (c) objective and subjective data, (d) patients with emotional problems, and (e) interdisciplinary team roles.

Mizrahi and Abramson (1985) also looked at ethical conflicts by comparing the values of medicine and social work in relation to: (a) training, (b) perspectives on

patient care, illness, and the role of the health care professional, (c) attitudes toward knowledge and data, (d) preparation for teamwork, (e) the role of the patient, and (f) social work's function.

Goldmeier (1984) assessed difficulties of ethical decisions in health care settings. He described three different "styles of decision making," or "ethical orientations": (a) legalistic, (b) antinomian, and (c) normative (p. 45). The legalistic style is one which provides the practitioner with "structure, boundary, and rules" (p. 52). The antinomian style represents the opposite of the legalistic, in that this approach is "basically lawless and unprincipled" (p. 54). The normative style represents an approach between "legalistic" and "antinomian" styles.

Ethics in social work are reflected in the work of Reamer (1979, 1980, 1985, 1990, 1993), Rhodes (1986), and Kugelman (1990). Reamer has written several books and articles related to different philosophical issues in social work. His 1993 book, The Philosophical Foundations of Social Work, describes how philosophy, logic, epistemology, and aesthetics relate to contemporary social work practice.

Reamer's 1990 study, Ethical Dilemmas in Social Service, examined ethical dilemmas in a wide variety of social work practice situations. It addressed such issues as truth-telling, informed consent, whistle-blowing, confidentiality,

and the limits of professional obligation. Rhodes (1986) also dealt with ethical dilemmas. He addressed specific issues such as confidentiality, coercion, bureaucracy, and empathy. Kugelman (1990) dealt with ethical decision making by social workers in agency settings. Wells and Masch (1991) addressed both applied ethics in social work and resultant ethical dilemmas.

Loewenberg and Dolgoff (1992) discussed ethical decisions and ethical dilemmas in social work practice, including problems of ethical choices, guidelines for ethical decision making, ethical dilemmas in private practice, and professional codes of ethics.

Despite considerable discussion of ethical dilemmas in social work, there has been relatively little discussion of ethical problems faced by hospital social workers. Dissertations by Beckerman (1991) and Levin (1986) and an article by Blumenfield and Lowe (1987) are notable. Beckerman's work focused on three issues: the nature of ethical dilemmas faced by hospital social workers, where social workers turned when they encountered an ethical dilemma, and how the dilemmas were resolved. Additionally, she examined the concept of truth-telling. Levin's work was more narrowly focused on specific ethical dilemmas regarding the care and treatment of newborns. Blumenfield and Lowe proposed a template for analyzing ethical dilemmas that arise in the process of discharge planning.

The present study will contribute to this emerging literature by focusing on some of the issues previously examined and expanding understanding of how hospital social workers deal with ethical problems. It will focus on those broader ethical problems which do not meet the narrow definition of a dilemma. Second, it will seek to identify the ethical base which guides hospital social work.

Hospital social work

Hospital social work was one of the earliest specialized fields to develop in the social work profession as it emerged at the turn of the century. There is a significant literature related to this development including Cannon (1923), Goldstine (1954), Bartlett (1975), Nacman (1977), Bracht (1978), Kerson (1982) and Shevlin (1983).

The precise origins of hospital social work are unclear. Several hospitals and departments claim to have been pioneers. Massachusetts General Hospital, Bellevue Hospital, and Johns Hopkins Hospital had hospital social service components prior to 1910. Massachusetts General Hospital is most widely credited with establishing and expanding the role and function of hospital social work.

Richard C. Cabot, a physician and Chief of Staff at the Massachusetts General Hospital, and Ida M. Cannon, both a nurse and social worker by training, began social services at the Massachusetts General Hospital in Boston. Cabot had

long recognized the need to address "the whole person" and not simply their medical condition. He established a project in his clinics where social services were provided from 1905 to 1907.

Early in the 20th century Cannon had seen the benefit of social services during her experience as a home care nurse. She attended a talk by Jane Addams and was moved to enter social work. She completed her social work training and was appointed by Cabot as the "head worker" in 1908 (Bartlett, 1975). They set up shop in a little used corridor of the clinic, and space was divided using bed sheets. Social work in the hospital had begun in earnest.

While there were some supporters of social work in the hospital, most took a wait-and-see attitude toward this hospital "interloper." It would take years, but strong allies emerged both within and outside the hospital. In 1919 the Massachusetts General Hospital Board of Trustees agreed to fund the new Social Services Department. The social work function would no longer be the financial responsibility of Cabot, but of the hospital. Social services became an integral part of the institution.

Over the next 10 to 15 years both Cannon and Cabot traveled extensively in the United States and abroad to advocate for programs such as the one they had developed (Cannon, 1923). During the same period, many visitors came to Massachusetts General Hospital to see the program.

Historically, this was a time of great expansion of hospitals in the United States. Social services in hospitals developed at the same pace. Programs and departments were founded in several cities and universities soon after the one in Boston. Social work departments were established at the University of Chicago clinics in 1918 and at Washington University in St. Louis in 1923 (Bracht, 1978).

As other programs began to emerge across the country, and in fact around the world, i.e. St. Thomas Hospital in England, the role and function of hospital social work evolved. These early developments paved the way for contemporary hospital social work practice.

One consequence of evolving hospital social work was that hospital social workers began seeing patients "on the wards." In the very early days, social workers were restricted to seeing patients in their own offices. Access to social work services was limited to the motivated and ambulatory patient. As restrictions on hospital social workers' activities were relaxed, social workers would venture onto the hospital wards in cases when patients were referred by their physician. Eventually, full access to the hospital wards signaled a broader acceptance of the role of social work and allowed for further refinement of duties.

As social workers became active on hospital wards, they were much more visible and accessible to patients, nurses,

and physicians. By the mid-1930s, social workers were accepted in "teams," along with physicians of different specialties and other hospital specialists such as dietitians. The physician served as mentor and leader of the team (Shevlin, 1983).

Soon social workers were allowed to enter "social summaries" in the patient's medical chart. By this documentation, the social worker could identify social problems contributing to the patient's circumstances and offer recommendations for their solution (Bartlett, 1975, p. 222).

Early in the 20th century, hospital social workers began to organize professional groups. The American Association of Medical Social Workers was established in 1908. At the same time, social work conferences in the United States, as well as in England, Germany and other countries, began to discuss this growing segment of the profession. Education and training requirements for hospital social work were formalized. Hospital social workers moved into such arenas as education and research.

The role of the early hospital social worker was modeled after the "friendly visitor," but was much less paternalistic and moralistic (Nacman, 1977). In the late-19th century, Charity Organization Society friendly visitors would "...investigate appeals for assistance, distinguish between the worthy and unworthy poor, and above all provide

the needy with the proper amount of moral exhortation" (Trattner, 1979, p. 83). Over the entire development of hospital social work, its central focus has remained the patient and his or her social circumstances.

During the 1940s, largely because of the influence of psychoanalysis, two distinct social work departments were developed in some hospitals. One focused on medical patients and the other on psychiatric patients. There was a perception that the skill and training of the medical social workers were less than that of psychiatric social workers. The perception is not based on reality since training is very similar for both groups, but the notion exists in some settings even today (Shevlin, 1983).

Hospital social work was strongly influenced by forces within the profession and in society at large during the 1950s and 1960s. In 1955 the American Association of Medical Social Workers combined with other professional social work to form the National Association of Social Workers. The consolidation of professional organizations and the continuing psychiatric and psychoanalytic influence resulted in hospital social work remaining somewhat adrift within the larger profession. Perhaps this was due to the perception that while the roles, goals, and purposes of the profession in general were becoming clear, those of hospital social work remained less defined.

Changes were taking place in society during this time, as well. Medicare and Medicaid came into existence with the passage of the Social Security act and a new population of patients entered the nation's hospitals. Social casework was also gaining in popularity and strength. Hospital social work was influenced by professional debates concerning such issues as which methods of practice were most appropriate and the professionalization of social work.

The 1970s and 1980s found hospital social workers practicing in many varied settings. They began to work with patients being treated by medical specialists in different hospitals. They also worked with traditional geriatric and psychiatric patients. In addition, cardiac, neurological, oncological, and nephrology patients became part of their caseloads.

Beyond work with specific patients, hospital social workers established support groups to assist patients and their families. These groups included cancer support groups, psychiatric education groups, and groups that worked with families who recently experienced the loss of a newborn or infant. Social workers also saw patients in clinics, such as pediatric and out-patient clinics.

Finally, besides working in new arenas and increasing in number, hospital social workers moved into supervision and hospital administration positions that ultimately led to

involvement on hospital committees and related "political" activities.

These expansions of the hospital social work role and function introduced a new issue. Social work could and, some argued, should do everything. This notion was critically reexamined when the financial crisis of the late 1980s and early 1990s became more apparent. Hospital social work services, after all, had to be paid for.

The need to preserve professional ethics and goals, while simultaneously honoring economic reality, is of vital importance to contemporary hospital social work. The task facing both hospital social work leaders and hospital administrators is to craft a role for hospital social work that is socially responsible, consistent with professional standards, and economically viable. One arena in which social work has an important role is in discharge planning.

Discharge planning

Millions of people are discharged from more than 5,000 hospitals in the United States each year (Rakich, Longest, and Darr, 1992, p. 262). Because hospital discharge is so common, it is widely believed to be a simple and straightforward event. It is neither. As Inlander and Weiner (1991) have noted, "Like everything else associated with hospitals, [a patient's] leaving is no simple matter" (p. 165).

The literature on discharge planning is substantial. There are a number of works that address its history (Cabot, 1919; Bracht, 1978; Volland, 1989), current status (Coulton, Dunkle and Good, 1982, Hubschman, 1983; Volland, 1989), models for implementation (Reichelt, 1982), and appropriate domain (Barker, Williams and Zimmer, 1985; Shine, 1983; Simmons, 1986). In addition a number of periodicals focus on discharge planning. An example is Discharge Planning Update.

Prior to the establishment of social services in the outpatient department at the Massachusetts General Hospital, there were activities at that hospital and in hospitals in England that would today be included under the rubric of discharge planning. Both Cabot (1919) and Cannon (1923) would later write about these activities.

Around the turn of the century English mental hospitals attended to the aftercare needs of their discharged mental patients. There were also "lady almoners" whose focus was to "investigate the finances of hospital patients in order to prevent the hospital from being imposed upon by persons who were able to pay" (Cabot, 1919, p. xxvi). Visiting nurses both in America and abroad paid much attention not only to their patients' physical problems, but additionally to their "economic, mental, and moral difficulties" (Cabot, 1919, p. xxvii).

During the first half of this century, activities that have become known as "discharge planning" were chiefly the responsibility of social workers and nurses. Little attention was paid to discharge planning needs during these years for a number of reasons. One was that such activities were not held in very high esteem. At the same time, the role of nursing was greatly expanding. Then, too, social work was becoming enamored with the psychoanalytic movement with the result that attention shifted to various therapies used in the mental health field and away from discharge planning.

Attention became strongly focused on discharge planning in 1965 with the passage of Medicare and Medicaid legislation. One consequence of these acts was that a significant number of frail elderly patients were admitted to the nation's hospitals. Such patients present a number of problems for the health care system with respect to the levels of care they should be given. Hospital length of stay for this population rose and initially, little concern was expressed.

During the 1970s, as health care costs began to mount, efforts were made which in effect drew attention to the need for discharge planning. With the Social Security Amendments of 1972 (PL 92-603), Professional Standards Review Organization (PSRO) programs were implemented. These were regional boards staffed with physicians and registered

nurses to monitor admissions and care of patients. They emphasized both prompt treatment and discharge of patients and post-hospital care. There were some sanctions of hospitals and physicians included in this in this legislation. For example, care which required longer hospitalization than the PSRO deemed necessary was viewed as poor-quality care, and "quality letters" could be sent to physicians and hospitals. A certain number of such letters could eventually bring the physician and hospital under closer scrutiny. Predictably, such programs had little effect either on prompt discharge or, by extension, health care costs.

As a part of the Tax Equity and Fiscal Responsibility Act of 1982, a Prospective Payment System was enacted covering Medicare patients. It did away with PSRO programs in favor of Peer Review Organizations (PRO), and instituted the Diagnostic Related Groupings (DRG) system. Prospective payment meant that hospitals would be paid a predetermined amount for a specific diagnosis made at the time of a patient's admission, regardless of the actual length of hospitalization or treatment required. The DRG system, through which a number of very similar diagnoses are grouped into a single classification for payment purposes, was at the heart of the prospective payment program. The establishment of PROs meant that physicians external to the hospital could authorize denial of payment for care that was

determined to be out of line with established standards of care (Volland, 1989).

Additionally, hospitals were required to have a discharge planning component to receive Medicare reimbursement. In 1984 the Joint Commission on Accreditation of Hospitals (JCAH), currently the Joint Commission on Accreditation of Health Care Organizations, issued guidelines identifying discharge planning as a part of high quality hospital services. The combination of these events resulted in discharge planning becoming a hospital priority.

There is considerable debate regarding the provision of discharge planning which revolves around two major issues. The first is which discipline, nursing or social work, should be responsible for discharge planning. The second is the extent to which discharge planning activities conflict or coincide with social work's professional ethics?

As these issues continue to be debated, one fact is clear: discharge planning, primarily conducted by social workers, is a prominent feature of contemporary health care.

<u>The epistemology debate in social work</u>

It was noted earlier that a discussion of professional practice is incomplete unless it includes epistemology. This is especially true for social work and it is linked to reflective practice. Social work's epistemological debate

has been long and intense and it continues to this day. What follows is a summary of that debate.

Reamer provided an excellent articulation of the philosophical foundations of contemporary social work (Reamer, 1993). He noted that the debate concerning "the nature, creation, and control" of knowledge within the profession (Reamer, 1993, p. 120) has often been bitter. This debate, present from the early years, has intensified substantially since the early 1980s.

While use of the scientific method was not unknown during the charity organization movement, the best known early evidence of it can be found in Richmond's Social Diagnosis (1917). Abandoning the term "investigation," Richmond used "social diagnosis" to signal a more formal, organized (i.e. scientific) approach to intervention. It also had "the advantage that from the first step it fixes the mind of the caseworker on the end in view" (p. 26). The use by caseworkers of scientific problem solving resulted in "social diagnosis."

Richmond's approach was scientific and it was heavily embedded in the medical model. She sought the "etiology" (p. 442) of social problems. She stressed the importance of "experiment" (p. 284) and social worker training in the use of "social evidence" (p. 39). The practice of social diagnosis, Richmond believed, would become an "adjunct" to the field of medicine (p. 26). This, one might argue, is

the situation in which hospital social work finds itself today. Richmond's ideas continue to serve as a foundation for contemporary social casework.

The use of scientific methods by Richmond and those in the social survey movement of the early 20th century contributed significantly to the ability of social work to do research and bring scientific methods to bear on social problems. The profession, however, relied on research training and education based on social science texts, most notably those of sociology and psychology, until the late 1970s and early 1980s.

Commentary within the profession about the nature of social work research began in earnest with the introduction of an article by Gordon: "Knowledge and Value: Their Distinction and Relationship in Clarifying Social Work Practice" (1965). Discussion of the nature of social work research and knowledge continued through the 1970s, 1980s and 1990s.

Heineman raised serious questions about the research model used by social work which she found to be based on logical positivism (Heineman, 1981). Social work, she argued, had embraced a scientific imperative which was being abandoned by philosophers of science and social scientists. This held that fundamental practice-related concepts could be empirically and quantitatively measured. According to Heineman, the empirical and quantitative focus resulted in

"an overly restrictive paradigm of research." As a result, "important questions and valuable data go unresearched" (p. 371). Heineman's call for "less restrictive approaches to research" touched off a protracted, often intense, debate. While the intensity has diminished, the debate continues.

In response to the assault on logical positivism, several attempts were made to counter Heineman. Perhaps the most ambitious response came from Hudson (1982), who elaborated on his earlier "axioms" that "If you cannot measure the client's problem, it does not exist" and "If you cannot measure the client's problem, you cannot treat it" (Hudson, 1978).

Fischer (1981) also advocated practice strategies which could be validated empirically. He envisioned a practice revolution in which practitioners would move toward empiricism rather than away. He wrote of a "<u>scientifically based practice</u>" (Fischer, p. 200; emphasis in the original) and a "new breed of social worker" that "systematically monitors and evaluates progress...grounds practice in empirically based knowledge...and keeps learning and seeking more effective approaches to intervention" (p. 205).

The debate during the 1980s consisted of different positions on which scientific imperative was most appropriate for social work (Brekke, 1986; Epstein, 1986; Haworth, 1984; Imre, 1984: Karger, 1983; Peile, 1988). Logical positivism and empiricism remained at the center of

the debate. There was, however, no serious call to abandon empiricism completely.

What emerged and currently exists is a call for a "synthesis" of these various approaches (Peile, 1988). The result would be an approach that retains the best features of empiricism and incorporates sensitivity to the utility and benefit of qualitative methods. This results in an approach to research that values quantifiable phenomena but recognizes the importance of elements of social work practice which are not amenable to quantification, such as its "languages" (Bloom, Wood, & Chambon, 1991). It is an approach that admits to the "many ways of knowing" (Hartman, 1990) which are in operation in contemporary social work. The epistemological debate in social work has given rise to a conceptualization of reflective practice that can serve as a model for practice as well as research (Harrison, 1987; Kondrat, 1992; Schon, 1983).

Symbolic interactionism and meaning construction

Interest in "individual-group relationships" (Hoult, 1969, p. 302) has been the central focus of symbolic interactionism. This paradigm evolved through the work of many scholars, and generated considerable interest between 1920 and 1950 because of the work of a number of sociologists at the University of Chicago. Between 1950 and 1970, interest in symbolic interactionism diminished as structural functionalism became the prevailing paradigm of

American sociology. During the last two decades, however, interest in symbolic interactionism has reemerged and grown.

While the major philosophical root of symbolic interactionism has been traced to the Scottish Moral Philosophers (Stryker, 1981, p. 5), the invention of the concept has been widely credited to Herbert Blumer. Blumer is said to have been heavily influenced by the writings of George Herbert Mead and, in particular, by the ideas Mead presented in Mind, Self and Society (1934). Mead's ideas, especially his conceptualizations embodied in terms such as "mind," "self," "generalized other," and "significant other," serve as part of the cornerstone of contemporary symbolic interactionism.

Mead's thoughts developed along with those of Charles Cooley and William I. Thomas. Other important contributions include Park's concept of role (Park & Burgess, 1921), Cooley's notion that society and person are two sides of the same coin of communication (Cooley, 1962); and Thomas' assertion that if humans define a situation as real, it is real in its consequence (Thomas & Thomas, 1928, pp. 565-567). Taken together, these ideas provide an overview of symbolic interactionism.

Blumer claimed that "There has been no clear formulation of symbolic interactionism, and above all, a reasoned statement of the methodological position of this approach is lacking" (Blumer, 1969, p. 1). Stryker (1981)

has also noted that, "there is no symbolic interactionist orthodoxy, no single vision of what the framework means" (p. 26).

This does not mean, however, that certain ideas of symbolic interactionism are not useful in the analysis of social interaction. Symbolic interactionism represents a theory, although sometimes a vague and unsystematic one, that is helpful in analyzing the ways in which people engage in activities together. A central feature of symbolic interactionism is the notion of meaning development. Symbolic interactionism holds that meaning arises in the process of social interaction and that meanings are, in fact, social products derived through the activities of people (Blumer, 1969).

According to Blumer (1969), "The premises of symbolic interactionism are simple. I think they can be readily tested and validated merely by observing what goes on in social life under one's nose" (p. 50). This is no doubt an overstatement of the ease with which symbolic interactionism and its features can be isolated and examined. However, there are elements of symbolic interactionism which may have utility in the present study. Meaning, self ("I" and "me"), interpretation, and role are examples of such elements. The concept of meaning, perhaps the fundamental element of symbolic interactionism, is of particular interest because of its relationship to behavior.

For example, as social workers go about their discharge planning activities, as they facilitate the movement of patients through a complex system, the cooperation of the patient is essential. In order for such cooperation to develop, the patient needs to have or develop an understanding of the meaning of the process.

Similarly, the meaning of an ethical problem is derived through social interaction. It is possible that when two hospital social workers confront the same situation, one may interpret it as an ethical problem, while the other does not. The same situation has different meanings for each of the social workers in this example. Symbolic interactionism can aid in the understanding of meaning formulation in such situations.

According to symbolic interactionism, "meaning is not rigidly predetermined" (Vernon, 1978). It occurs, in this instance, through interaction between the social worker and patient. This meaning construction often goes unrecognized and unacknowledged.

This specific inquiry represents a relatively small part of the overall study and, as such, is necessarily narrow in focus. In spite of this, the concept of meaning and how it is developed is one element of symbolic interactionism that can be a key to better understanding hospital social work practice and ethical problems encountered by hospital social workers.

CHAPTER 3

RESEARCH DESIGN

Introduction

Before this study could begin, it was necessary to obtain approval from the University Committee on Research Involving Human Subjects (UCRIHS). Approval was granted by UCRIHS on November 1, 1993 and the study began immediately.

The focus of this study, ethical problems encountered by hospital social workers, lies in what Schon refers to as the "swampy lowland" of social work practice topography (Schon, 1983, p. 42). Because the positivist paradigm works best with phenomena in the "high, hard ground," a naturalistic, rather than positivist, approach will be used in this study. The naturalistic paradigm, or "naturalistic inquiry," as articulated by Lincoln and Guba (1985) will serve as the model for this study. Naturalistic inquiry is carried out in a natural setting. It demands a human instrument that builds on his or her "tacit knowledge," knowledge that is intuitive or felt, in addition to "propositional knowledge," (Lincoln & Guba, p. 40) or knowledge that can be expressed in language form. It uses methods of data collection and analysis that are "appropriate to humanly implemented inquiry" (Lincoln & Guba, p. 187) such as interviews and observations.

Natural setting. The term natural setting refers to the

context within which a phenomenon occurs. The setting is important in the analysis of a phenomenon in that all phenomena "take their meaning as much from their context as they do from themselves" (Lincoln & Guba, 1985, p. 189).

A human as instrument. The phenomenon under study in a naturalistic inquiry is indeterminate. The human "instrument" provides responsiveness and adaptability that other instruments, such as questionnaires, scales or other quantitative measures, do not. The human is capable of functioning simultaneously in the domains of both propositional and tacit knowledge. With the human instrument there is also the capacity for clarification, summarization and the opportunity to explore responses (Lincoln & Guba, 1985, pp. 193-194).

There are four elements of naturalistic inquiry: (a) purposive sampling, (b) inductive analysis of data, (c) development of grounded theory based on the analysis of data, and (d) projection of next steps in a constantly emergent design (Lincoln & Guba, 1985, pp. 187-188). Upon completion of a naturalistic inquiry study, results are disseminated in the form of a case report.

Purposive sampling. All sampling is done with some purpose in mind, such as representativeness and generalizability. In addition to random sampling, the preferred type of the positivist paradigm, there are several types which serve purposes other than facilitating

generalization. The sampling mode of choice for naturalistic inquiry is maximum variation design. The object of such a sample "is not to focus on similarities that develop into generalizations, but to detail the many specifics that give the context its unique flavor" (Lincoln & Guba, 1985, p. 200). Additionally, "It is based on informational, not statistical considerations. Its purpose is to maximize information, not facilitate generalizability" (Lincoln & Guba, pp. 201-202).

Inductive analysis of data. The inverse of deductive data analysis, which is used in conventional investigations, inductive analysis does not begin with a theory or definitions before analysis or investigation but rather with units of information that are to be analyzed. These units of information will subsequently be organized into categories by a process of coding. There are several sources of data for a naturalistic study. This study utilizes data from observational notes, notes made during the interviews, notes made during transcription, and the interview transcriptions.

Development of grounded theory. "Grounded theory, that is, theory that follows from data rather than preceding them (as in conventional inquiry) is a necessary consequence of the naturalistic paradigm" (Lincoln & Guba, 1985, pp. 204-205). "A grounded theory is one that is inductively derived from the study of the phenomenon it represents" (Strauss &

Corbin, 1990, p. 23). Collection and subsequent analysis of data pertaining to a particular phenomenon permit the building of a theory regarding that particular phenomenon. Grounded theory allows one to begin with a phenomenon to be studied and "...what is relevant to that area is allowed to emerge" (Strauss & Corbin, 1990, p. 23). Lincoln and Guba (1985) note that "...utilization of grounded theory is absolutely essential to the concept of emergent design" (p. 208).

Emergent design. Naturalistic inquiry assumes that the meaning of phenomena is, to a great extent, contextually determined. The existence of multiple realities prevents the development of a design based on only one (the investigator's) interpretation of reality. Therefore, the design changes and emerges during the course of data collection.

The investigator does not, however, "begin empty-handed and certainly not empty-headed" (Lincoln & Guba, 1985, p. 209). The investigator may well possess much tacit knowledge about the phenomenon under study which provides some necessary structure. "As the inquiry proceeds, it becomes more and more focused; salient elements begin to emerge, insights grow, and theory begins to be grounded in the data obtained" (Lincoln & Guba, p. 209).

Elements of the Research Design

There are several elements of a naturalistic research

design. These are defined as: (a) determining a focus for the inquiry, (b) determining fit of paradigm to focus, (c) determining the fit of the inquiry paradigm to the theory selected to guide the inquiry, (d) determining where and from whom data will be collected, (e) determining successive phases of the inquiry, (f) determining instrumentation, (g) planning data collection and recording modes, and (h) planning data analysis procedures (Lincoln & Guba, 1985, pp. 226-249).

Focus of inquiry. Determining the focus of an inquiry serves both to establish boundaries for study and to establish the criteria by which information, i.e. data, will be included or excluded. Both boundaries and criteria may be altered at some point during the inquiry (Lincoln & Guba, 1985, pp. 227-228). The focus of the present study is the nature of ethical problems encountered by hospital social workers.

Fit of paradigm to focus. There is no claim here that the positivist paradigm is not appropriate for inquiry into the focus of this study. The important question here is which approach is most appropriate for this study.

The naturalistic paradigm provides a better fit for the processes to be examined. There are several reasons for this. First, the phenomenon under study is represented by a number of complex and interrelated concepts. Second, this paradigm allows for investigator-phenomenon interaction.

This investigator-respondent-phenomenon interaction allows the investigator to shift and shift again the focus of questions as information is gathered, as data collection evolves. Third, there is a high degree of "context dependence" associated with the present study. The phenomena under study may be examined in a number of settings, such as a classroom or panel discussion. However, it is the context within which these particular phenomena occurs that provides the most insight and meaning. Fourth, the phenomena under study are ones about which respondents may not be forthcoming. The naturalistic paradigm, in large measure due to its demand for engagement and observation, allows the investigator to uncover and evaluate half-truths, utterances, and even falsehoods obtained during data collection (Lincoln & Guba, 1985, pp. 229-231).

Fit of paradigm to theory. The theoretical underpinning for this study, as was noted earlier, is a synthesis of the theory of reflective practice and symbolic interactionism. The theory behind both reflective practice and symbolic interactionism meshes well with the naturalistic paradigm for two major reasons.

First, reflective practice theory evolved because of a perceived inadequacy of the positivist paradigm. In fact, Schon (1983) presents reflective practice as not only an alternative theory of practice but as an alternative epistemology of practice as well (p. viii). At times the

concept of reflective practice is viewed as only an approach to practice when, in reality, it is a more complex and inclusive concept. It represents both a theory of practice, or "how professionals do what they do," as well as an epistemology, or "how they come to know what they know" (Schon, p. viii). Reflective practice, as used in this study, refers to the broader interpretation of the concept.

Second, a basic tenet of symbolic interactionism is that meaning is socially constructed and modified. Symbolic interactionism emphasizes the role of reflection in the analysis of phenomena and that phenomena are defined and redefined over time.

Data collection. It was noted earlier that for the naturalistic approach, a maximum variation sample is most useful. Maximum variation sampling results in a sample that will provide the broadest range of information. Maximum variation sample is selected and "...expanded until redundancy with respect to information is reached, at which point sampling is terminated" (Lincoln & Guba, 1985, pp. 33-234).

The sample for the present study was somewhat more purposive. It was selected to insure maximum variation and included large, small, and very small hospitals. There are several ways to distinguish between large, small, and very small hospitals (i.e. number of beds, patient days, number of employees). For the purpose of this study a large

hospital refers to a hospital with 250 or more beds, a small hospital refers to a hospital with between 100 and 249 beds, and a very small hospital refers to hospitals with fewer than 100 beds (Lemrow, Adams, Coffey & Farley, 1990, p. 106).

The American Hospital Association identifies four types of hospitals: (a) general, (b) special, (c) rehabilitation and chronic disease, and (e) psychiatric (American Hospital Association, 1992, p. A5). Respondents were selected from hospital social workers working in the fifteen general medical surgical hospitals within the Detroit, Michigan Primary Metropolitan Statistical Area (American Hospital Association, 1992).

The practice of hospital social work within general, medical and surgical hospitals is representative of hospital social work practice as it is defined in this study. For that reason special, rehabilitation and psychiatric hospitals were excluded.

While sample size for a naturalistic study is somewhat relative, Lincoln & Guba (1985) have noted "...it is usual to find that a dozen or so interviews, if properly selected, will exhaust most available information; to include as many as twenty will surely reach well beyond the point of redundancy" (p. 235). The sample for this study comprised twenty informants. There are eight informants from large hospitals, eight informants from small hospitals, and four

informants from very small hospitals.

In addition, five key informants, such as hospital social work directors and members of the academic community with an interest in this area, each with several years of experience, will aid in the development of an interview protocol. These key informants offer "familiarity with the social terrain of interactions, roles, and relationships" (Walker, 1993, p. 37) that provides fertile ground for the development of ethical problems.

This required several steps. First, a list of hospital social work directors in the area was obtained from the Michigan Chapter of the Society of Hospital Social Work Directors. From this list four directors from the Detroit metropolitan area, i.e. the counties of Wayne, Oakland, and Macomb, were selected and interviewed in the first phase of the inquiry. Effort was taken to insure the hospitals selected were representative of the metropolitan area hospitals. The group included an inner-city hospital and three geographically varied suburban hospitals. Names of members of the academic community emerged during interviews of these directors. As the review of the literature indicates there is much interest in this area of study. Members of the academic community added to the diversity of key informants.

Second, large and small hospitals in the Detroit, Michigan metropolitan area, i.e., the counties of Wayne,

Oakland, and Macomb, were identified and a letter of introduction (Appendix A) was sent to the director of social work in these hospitals seeking their participation in this study. This letter: (a) informed the directors of the focus of the study, (b) conveyed a sensitivity to how busy they and their staffs are, and (c) in exchange for their participation offered to conduct an educational inservice program for them and their staffs about the results of the study.

Third, follow-up telephone contact was made to directors. The purpose of this contact was to solicit participation, answer questions, and schedule interviews.

Successive phases of the inquiry. The present study consists of three phases of inquiry. They are characterized as: (a) the orientation phase, (b) the exploration phase, and (c) the validation phase (Lincoln and Guba, 1985, pp. 235-236).

The orientation phase consisted of interviews of five key informants. The major purpose of this phase was to identify what it is that we need to know about the phenomenon under study. Toward this end six key informants were consulted. Four of these key informants were directors of hospital social work departments, representing large and small hospitals, and two were members of the academic community with an interest in this area.

Each was given a general overview of the study to date.

The starting point for each interview was a single question, "If you wanted to study ethical problems encountered by hospital social workers, what information would be important for you to know?"

At the conclusion of each interview key informants were asked to recommend another person whom they thought would have ideas and relevant experience as well as a willingness to participate. Two key informants were identified in this manner.

Each key informant was very supportive, shared their thoughts freely and offered substantial insight. The key informants' genuine interest in this topic is reflected in the useful themes that emerged from their interviews. These interviews were not audio-taped.

Phase two, the exploration phase, consisted of twenty interviews, eight informants from large hospitals, eight informants from small hospitals, and four informants from very small hospitals. These interviews were structured, used open-ended questions, were audio-taped, and transcribed. It was during this phase that data concerning the nature of ethical problems encountered by hospital social workers and how these problems are reconciled was obtained. Following phase two, an analysis of the data obtained was conducted and a preliminary report developed.

Phase three, the validation phase, consisted of returning to the informants and sharing the preliminary

report with them. This phase had two purposes. The first was to insure that the report had accurately captured the data provided by the informants and to correct or amend it as necessary. The second purpose was to validate the report as being a true and accurate reflection of the informant's practice experience. At the conclusion of phase three, a final report was developed.

Consent and confidentiality. Consent (Appendix B) was obtained from each informant. Each respondents was also given a written introduction (Appendix C). The investigator transcribed the audio tapes and was the only person to have access to them. No names, of either informants or hospitals, were used in the preliminary or final report. Confidentiality was insured by these processes. The audio tapes were secured at all times in a locked container. The audio tapes will be erased and transcripts shredded three months after acceptance of the dissertation.

Instrumentation. Instrumentation in a naturalistic inquiry is very different than for the positivist paradigm. Naturalistic inquiry uses the human, i.e., investigator as the "initial and continuing mainstay" of instrumentation (Lincoln & Guba, 1985, p. 236). The investigator possesses "theoretical sensitivity" (Glaser, 1978; Glaser & Strauss, 1967, pp. 46-47; Strauss & Corbin, 1990, pp. 41-47). This refers to sensitivity to the issue under study as well as the multiplicity of issues, concepts, and behaviors that may

or may not be relevant to the inquiry.

The investigator for this study has fifteen years of social work practice experience, eleven of which were in the healthcare field. The benefit of such experience is noted by Strauss and Corbin (1990): "This knowledge, even if implicit, is taken into the research situation and helps you to understand events and actions seen and heard, and to do so more quickly than if you did not bring this background into the research." (p. 42). Most recently, he was director of the department of social work, with a twenty social worker staff, in large metropolitan hospital. This experience affords a base of experience and a perspective from which to explore the issues under study here.

An interview protocol was developed following the completion of phase one of the inquiry. This protocol consisted of broad, interactional questions. Specific, probing questions emerged as the study progressed. Due to the nature of "emerging design," neither the structure nor the content of the interview protocol is known prior to inquiry. The opening question for all informants was, "Do you encounter ethical problems in your practice?"

The present study consisted of one investigator, the author. While Lincoln and Guba recommend that a team be used for naturalistic inquiry, exceptions are made "where resources simply cannot be stretched" to include several investigators (Lincoln & Guba, 1985 p. 237). This is the

case with the present study.

Data collection and recording. The interviews were conducted on site, that is in the hospitals where the social workers practice during November and December, 1993. Care was taken to insure that the interviews are conducted in an area that was private and free from excess noise and distractions.

The main consideration of recording data is its fidelity. Fidelity refers to the ability of the investigator to reproduce exactly the data obtained in the field. Audio recordings do this best and were used in the present study. While field notes offer less fidelity, they are less threatening to respondents and help keep the investigator attuned to the data as they are being offered. For these two reasons, field notes were used during the recording and transcription of data in addition to audio tapes.

Data analysis procedures. Lincoln and Guba (1985) noted that "Not very much can be said about data analysis in advance of study" (p. 241). In a naturalistic inquiry analysis of data, or coding, is conducted using the "constant comparative method" (Glaser & Strauss, 1967).

The constant comparative method, which was used in this study, consists of three levels of coding: open coding, axial coding, and selective coding (Strauss & Corbin, 1990, pp. 61-142). These levels of coding guide the analysis of

data. They are sequential and increasingly rigorous as well as increasingly abstract.

Open coding refers to the initial phase of data analysis in which data are broken down, examined, compared and placed into broad categories. Axial coding refers to the process of putting data back together and making connections between and among categories. It is during this process that the categories are more clearly defined and subcategories are identified. Selective coding refers to a multi-step process by which data are arranged in "core categories" systematically related to other categories. Category relationships were validated against data. Finally, categories were refined and further developed.

CHAPTER 4

REPORT OF FINDINGS

> There are lots of things we don't know about these problems.
>
> (Key Informant #5)

There were three phases of inquiry in this study. Findings will be presented and discussed for each phase.

Phase One Findings

There were five major findings in this phase of inquiry. First, it is not clear if social workers recognize or identify ethical problems when they are encountered. Second, it is not known, at this stage, who the participants in these problems are. Third, the approaches to reconciliation or addressing these problems and the level of success obtained appears to vary substantially. Fourth, it was not clear what social workers use for a guide in dealing with these problems. These findings substantially guided subsequent phases of inquiry. Phase one culminated in the development of an interview protocol (Appendix F) to be used in phase two. The major findings, as well as some related ideas, are presented and discussed here.

Recognition of Ethical Problems. All of the directors had considerable staff hospital social work experience. The general consensus, based on their experience, was that

hospital social workers do encounter ethical problems in their practice on a fairly routine basis.

At the same time however, they acknowledged having little current first hand knowledge of their social workers' experiences with such problems. Further, they were not completely comfortable with the knowledge they did have. Except for those ethical problems brought to their attention by staff social workers, the directors had little knowledge of the day-to-day ethical problems their staffs encountered.

They expressed considerable uneasiness about this. One stated, "I just think I should be in better touch with them (staff social workers) on this than I am" (Key Informant #6). Another said, "Not only do I get paid to be on top of these things, I owe it to staff to be closer to it than I am" (Key Informant #1).

The director's lack of involvement, in the handling of ethical problems by their staff, was not seen as an ethical problem in itself. The directors were concerned about the implications of their lack of involvement for the staff, the patient, and the organization.

All had spent time "on the floors" with staff as part of their supervisory responsibilities. As they reflected on this, they shared some observations. A concern mentioned by one was that, "Staff social workers often act out of their own personal ethics rather than professional ethics" (Key Informant #1). Another said, "Supervisors and managers get

involved in ethical problems so line staff do not have to" (Key Informant #2). One said that as she observed her staff at work, she recognized, "Lots of ethical problems that the staff does not identify" (Key Informant #5). Finally, one stated that in working with her staff, she saw ethical problems "every day" that the staff did not identify. She also stated that, "Social workers don't have enough ethics training" (Key Informant #4).

A related concern, which further illustrates the complexity of the issue under study, was that hospital social workers might not recognize problems as being of an ethical nature. A director noted, "With ethical problems the direct issue is seldom raised" (Key Informant #1). Another noted that with ethical problems, "We almost never see anything happen straightforwardly" (Key Informant #4).

While the social workers might correctly identify ethical problems, two other interpretations could occur as well. The social workers might identify problems which were fundamentally administrative, financial, or logistical, for example, as being ethical. Or, they might identify fundamentally ethical problems as being of another nature.

Two steps were taken in response to this finding. First, the initial question of the interview protocol was designed in such a way as to elicit information about the types of problems the social workers encountered. The first question was, "Have you encountered ethical problems in your

practice within the past six months?" Whether answered in the affirmative or negative, a follow-up question was, "Can you give me examples of the problems you encounter?"

The responses to these questions provided important information about the nature and types of problems encountered. They permitted an assessment of the extent to which ethical problems are encountered or identified as such.

A second step was to provide respondents with an introduction to the study (Appendix E). The purposes of the introduction were to explain the general focus of the study to the informants and to explain what an ethical problem is and provide an example. It was read by the informant prior to the interview.

Recognition of the Participants. Another finding was that there was little agreement among the key informants as to who the individuals involved in ethical problems are. They did agree that at a minimum such problems would involve the social worker and either a physician, a nurse, another social worker, or a patient. Other individuals mentioned as possible participants were other members of the health care team (e.g. physical therapist), hospital administrators, hospital attorneys, and patients' family members.

In addition to individuals, some key informants stated that certain groups might also be a part of ethical problems. For example, hospital ethics committees and

hospital boards such as the board of trustees and the board of directors were mentioned.

One key informant (#5) stated that "Ethical problems arise at professional junctures." Professional junctures, she explained, were "those points at which professionals disagreed about what the right thing to do is." It is precisely at this juncture that the divergence of views and differences of opinion are addressed, confusion is cleared, and order is negotiated.

This observation brought into focus an issue of concern throughout the discussion regarding who was involved in ethical problems. During this discussion key informants listed the individuals they thought were involved, and all but one mentioned the patient at or near the end of their list or did not mention the patient at all. When asked specifically about the patient as a participant, key informants responded "of course," and "obviously" the patient was involved. Thus, it was not so obvious that the patient was either involved, or perceived by the key informants to be involved, in ethical problems.

When the patient is mentioned or thought of last, or not at all by the hospital social worker, does this reveal anything about the perceived importance or significance of the patient in a situation with possible ethical dimensions? To pursue this idea, the second question in the interview protocol was, "Who are the individuals involved in the

ethical problems you encounter?" More specific follow-up questions explored each individual informant's perception of the role of the patient, if any, in these situations.

Who Addresses the Ethical Problems? The notion evolved from key informants that there is a hierarchy of severity with respect to the ethical problems they encountered. That is, some are "routine" (Key Informants #2 & #3), "pretty common sense stuff" (Key Informant #4), or "a nuisance" (Key Informant #2). Others are "serious" (Key Informant #3) or "major" (Key Informant #6). Further, these problems are addressed at different levels within the hospital based on their severity. As one key informant (Key Informant #2) stated, "Routine ethical problems are solved at a low level." Another noted, "Responsible parties manage more serious ethical problems" (Key Informant #3).

In order to explore this notion further in phase two, the third question in the interview protocol was, "Are you successful in addressing the ethical problems you encounter?" Follow-up questions were asked to determine if social workers seek assistance in dealing with these problems and, if they do, what sources were used. Other follow-up questions were asked to explore the notion of a hierarchy of severity.

Guides to Practice. All but one of the directors had a copy of the National Association of Social Workers Code of Ethics hanging on the wall in their office. The code of

ethics, as stated in the preamble, "is intended to serve as a guide to the everyday conduct of members of the social work profession" (National Association of Social Workers, 1990, p.ii).

As the key informants shared their thoughts about how social workers addressed the ethical problems they encounter, another suggestion emerged. The key informants spoke about how ethical problem solving is often intuitive. One noted that at times social workers are "acting out of their gut feelings" (Key Informant #2). Another said that she often tells her more experienced social workers to "listen to those gut feelings" (Key Informant #6). Another observed, "sometimes things just don't feel right" (Key Informant #1).

All key informants were asked about his or her thoughts on the role of the National Association of Social Workers Code of Ethics in their practice and in the practice of their social workers. One said, "All the code of ethics does for me is focus the values I already had" (Key Informant #1). Another said, "The code of ethics is meaningless" (Key Informant #2). One responded, "There is nothing in the code of ethics that wasn't taught to me in my upbringing" (Key Informant #4). These sentiments reflect the views of some that there are many written, as well as unwritten, codes that influence or guide human and professional behavior (Rakich, et al., 1992, pp. 99-143).

The general idea emerged that the code of ethics may in fact play a small role as a guide in dealing with ethical problems.

Assuming that the code of ethics may not play a substantial role in guiding social workers as they manage ethical problems, the key informants were asked what they thought guided these efforts. Two sources were articulated.

First, "hospital culture" was identified as a strong influence. This notion of hospital culture is very complex. One key informant summed it up as follows:

> The accepted way of conducting business whether business is heart surgery or social work. The mission statement is only the written part,. there are lots of unwritten rules. Things get done certain ways, certain things are tolerated and other things are not tolerated. Community values are a part of it. Every hospital is different. It's hard to explain (Key Informant #1).

Responding to this idea another stated, "All the directors know the mission and values of the hospital." Further, "Organizational values supersede personal or professional values...the hospital code takes precedence" (Key Informant #2).

Second, hospital quality programs (i.e. Total Quality Management, Continuous Quality Improvement) were identified as substantial guides to practice. One reason for this, according to one key informant, was "CQI offers very clear, very easily understood standards, unlike the code of ethics that tries to be all things to all people" (Key Informant #6). She did, however, acknowledge some difficulty thinking

of and referring to the patient as a customer. Another reason that quality programs may guide practice was the perceived strong organizational support for these programs. Within the quality discussion, one key informant made the observation, "good ethics is good business" (Key Informant #1).

In order to explore this idea further in phase two, a fourth broad question in the interview protocol was, "What guides you as you address ethical problems?" Follow-up questions, as indicated, explored more specific factors which may guide practice, for example, the law, individual moral philosophy, or the National Association of Social Workers Code of Ethics.

There is virtually no limit to the questions that could have been asked in the study of ethical problems encountered by hospital social workers. Because of the scope, resources, and timetable of this study, limits were required. Based on the information provided by the key informants, the four broad questions in the interview protocol and specific follow-up questions provided substantial information about the focus of inquiry.

Very Small Hospitals. Two key informants noted that while the distinction between large and small hospitals was important for this study, another distinction might also be useful. They proposed including very small (100 or fewer beds) rural hospitals in the sample.

There were two main reasons for the inclusion of very small hospitals. The first, and most important, was that the experience of social workers in these hospitals could be very different from those in the large and small urban hospitals. Second, inclusion of such hospitals enhanced the variation in the sample.

Related ideas that emerged. In addition to the major findings listed above, other ideas emerged during this phase of inquiry. One such idea emerged during a discussion about how health care professionals in general and social workers in particular approach problems.

Social workers, approach to problems. When the discussion turned to differences in approaches, one key informant thought there was a major difference in the general approach to problems taken by social workers versus the approach taken by nurses. Her thought was, "Nurses correct problems, social workers explain them" (Key Informant #6).

She offered as an example a recent situation she had observed while on one of the floors working on an unrelated matter. The situation was one in which a physician had not met or talked with a patient and family about the results of an exploratory surgery that he had performed. The patient and family approached, at different times, a social worker and a nurse with this problem.

According to the key informant the social worker explained to the patient and family that this physician was one of only two physicians in the hospital that did these procedures and was very busy. Further, the physician had a lot of patients and families to meet with and should be meeting with them soon. A few minutes later the nurse was approached. She paged the physician on his beeper. When the physician returned his call, about five minutes later, the nurse informed him of the problem. The physician responded that he had been busy but he had forgotten about this patient. He informed the nurse that he would be up in a few minutes to meet with the patient and family.

This key informant noted several of the values that, in her view, were intended to guide social work practice. She identified: (a) primacy of clients' interest, (b) respect, and (c) self-determination. In the approach she described, some of these values are often not included.

She acknowledged that this problem was not of an ethical nature and was perhaps minor. It did, however, help illustrate her idea of how problems are approached.

Ethical behavior in an unethical environment. Another idea was presented by key informant #1. He talked about the idea of "ethical behavior in an unethical environment." He noted that today many hospitals are in reality large corporations. He was certain, based on his experience, that some high level corporate officials engaged in unethical

practices. He spoke of how, "business types are running the hospitals" and that, "the focus has shifted from taking care of patients to making money."

These ideas are very similar to those expressed by some in the field of applied ethics who indicate that a shift in the balance of power has occurred in today's hospitals. Power and authority are exercised more by administrators and less by physicians. Administrators are making decisions about moral problems that have been traditionally made by physicians and nurses (Fleck, 1989, p. 3).

To illustrate his idea, the key informant talked of how some hospitals "buy a certificate of need." When a hospital plans to provide a new service, such as heart surgery, obtain a major new piece of equipment, such as a computed tomography (CT) scanner or magnetic resonance imaging (MRI), or add to its physical plant, a certificate of need (CON) is generally required. A CON is issued by the state once it has been established that there is a need in a given locality for a given service or equipment. The process is highly bureaucratic and often takes many months to complete. The key informant thought that, on occasion, some hospital representatives influence the process, by financial or other means, to obtain a CON sooner than is customary or to obtain one when it would not otherwise be issued.

He also told about hospitals who own their own home health care organizations, durable medical equipment

company, pharmacy, ambulance company and so on. He believed that it is not necessarily unethical for the hospital to own these components but that hospital administrators "encourage" employees, including physicians, nurses, and social workers to utilize the services offered by the parent hospital exclusively.

This notion posed an interesting question. What are the ethical considerations when social workers assist patients to appropriately access services (i.e. nursing home, home healthcare, and so on) which may have been obtained or be operated in an unethical or illegal manner? This relates to an idea presented earlier. In chapter 1 it was noted that ethical problems exist within the health care delivery system at many different levels and that this study focuses on a very specific segment of this large arena.

Patient dehumanization. An idea emerged related to patient dehumanization that was different than the examples presented in the earlier discussion of the topic. The idea was articulated that, "the chart becomes the patient" (Key Informant #5). As this notion was explored this with other key informants it was noted that, "probably more attention, care, and certainly human touch is given the chart than the patient" (Key Informant #6). Another, emphasizing the practical importance of the patient chart, stated, "the chart is a documented record of the hospital experience, if it's not charted, it didn't happen" (Key Informant #2).

While not a focus of this study, sensitivity to this idea was maintained during phase two.

Another idea emerged that combined staffing levels and workloads. The directors thought that, in general, their staffing levels were appropriate. When asked specifically if all the patients referred for social work services received services, it was found that some did not. The reasons for this varied; low staffing levels from time to time and patients being in the hospital for very short periods of time were mentioned. A number of questions arise out of these situations. Perhaps most relevant is what are the ethical implications of social workers not seeing all patients referred for services? Again, this is not the focus of this study but it merits attention.

Informants' willingness to talk. The key informants were both forthcoming and candid in their interviews. However, there was some concern as to whether informants would be willing to talk about such a personal topic as ethical problems they had encountered. The general consensus, as reflected in a statement by key informant #1 was, "If they trust you." This is consistent with the naturalistic inquiry idea that informants will be both candid and forthcoming if they trust the inquirer (Lincoln and Guba, 1985, p. 256).

The major findings of phase one were incorporated in the interview protocol. The protocol served as the main

guide during subsequent phases of inquiry. The other ideas discussed above served as part of the broader theoretical sensitivity that was maintained as the study proceeds.

Phase Two Findings

Twenty informants participated in phase two of this study. There are two characteristics of the informants that are noteworthy and should be pointed out before a substantive discussions of the findings is presented. First, in total, the informants in this study identified virtually every unit of the hospital as their major area of responsibility. The social workers in the small and large hospitals reported they had responsibility for more than one unit (See Table 1).

Table 1

Social Worker Area of Responsibility

Unit	Number
General medical and surgical	5
Emergency room	3
Psychiatry	3
Geriatrics	2
Adult intensive care	2
Oncology	2
Neonatal intensive care	1
Child protection team	1
transplant team	1
HIV & AIDS	1
Discharge planning coordinator	1
Home care	1
Orthopedics	1
Dialysis	1

The social workers in the very small hospitals reported they were responsible for social work services for the entire hospital. The social workers worked, for the most part, in the hospital. However, three reported they also conducted home visits to patients. These were social workers working in hospital home care or hospice services.

Second, the minimum hospital social work experience required for participation in this study was one year. Only one informant had this minimum amount of experience; most had several years, some in several different hospitals. The years of experience ranged from one to twenty years. The mean was 5.5 years.

Figure 1

Categories and Sub-Categories of Data

1. PROBLEMS ENCOUNTERED
   a. presence/absence
   b. range
   c. misidentification
   d. magnitude

2. THOSE INVOLVED
   a. professionals
   b. family/patient
   c. groups
   d. hierarchy

3. ADDRESSING THE PROBLEM
   a. approach
   b. responsible parties
   c. dissatisfaction

4. GUIDES TO PRACTICE
   a. code of ethics
   b. intuition
   c. personal values
   d. training
   e. supervision
   f. experience
   g. hospital mission
   h. quality programs

5. REFLECTIVE PRACTICE
   a. situation uniqueness
   b. intuition

6. INTERACTIONISM
   a. framing of issues
   b. meaning construction

The first two levels of coding resulted in the development of categories and sub-categories of data. These are presented in figure 1.

The third level of coding aids in understanding the relationship between and among the categories and subcategories. These relationships will be discussed more toward the end of the data analysis.

The informants were asked if they had encountered ethical problems in their practice. Whether their answer was "yes" or "no" they were asked to give examples of the problems they encountered in their practice.

> We're very pressured in the hospital today in terms of code status, length of stay, and DRG's. It puts pressure on everyone in a lot of ways and I think it brings up ethical problems more than ever before. (Informant #12)

Do hospital social workers encounter ethical problems? When asked if they encountered ethical problems in their practice every informant in the study reported that they did.

Presence or absence of ethical problems. Follow-up questions about the frequency of encountering ethical problems yielded a wide range of responses (See Table 2). Informants said they encountered ethical problems "not often" (Informant #2), and "somewhat" (Informant #4). Others said, "they don't happen that frequently" (Informant #3), and "it doesn't happen that often" (Informant #6). Still others said they encountered ethical problems

"routinely" (Informant #11), "quite frequently" (Informant #15), "on a somewhat regular basis" (Informant #20), and "often" (Informants #5 and #12). And, others said, "frequently" (Informant #13) and "at least weekly" (Informant #8). Finally, an exchange with one informant went as follows:

> investigator: Do you encounter ethical problems in your practice?
> informant: All the time.
> investigator: All the time?
> informant: All the time.
> (Informant #9)

Table 2

Stated frequency of ethical problems

Statement	Number
often	2
all the time	1
not often	1
somewhat	1
they don't happen that frequently	1
it doesn't happen that often	1
routinely	1
quite frequently	1
on a somewhat regular basis	1
frequently	1
at least weekly	1

Regardless of the reported frequency of occurrence of ethical problems, informants were asked to give examples of ethical problems they had encountered.

Range of ethical problems encountered. The informants were asked for examples of the types of ethical problems they had encountered. The range of problems presented was

substantial. There were a number of ethical problems presented as examples. Two clusters of problems emerged. The first cluster related to the flow of information and a second related to issues of withholding or withdrawing of treatment. In addition there were ethical problems not related to these clusters.

There were several problems related to the flow of information. This type of problem was characterized by one informant as "who gets what information" (Informant #6). In one instance these problems concerned a family member insisting on withholding information from a patient. "A family member doesn't want the patient told about the gravity of his disease" (Informant #11). Or, "Do you tell a teenager that they are terminally ill if the parents don't want the child to know?" (Informant #3) A variation on this theme was told by one informant who worked with a physician, an oncologist, who often withholds information about the diagnosis "unless the patient asks" (Informant #11). Citing a similar situation one informant told of a patient who died without being told her diagnosis "She was never told of her diagnosis at the family's request" (Informant #18).

There were other ethical problems related to information. One informant stated, "I have seen patients be transferred to a nursing home and not be told until they arrive there" (Informant #19). Another said, "A lot of times the family doesn't want the patient to know they are

going to a nursing home until the very last day before they go. Then the family tells the patient, 'You're are going to another hospital'" (Informant #13).

A final group of ethical problems related to the flow of information was reported. Informants expressed concern about not telling "the whole truth" (Informant #11). One situation has to do with the pain management of a terminally ill patient. In some cases, a physician tells a family that because a patient has expressed to him that he did not want to be in pain, he will increase pain medication as needed. He informed the family that this will result in the possible loss of consciousness by the patient. According to one informant,

> What he doesn't tell the family is that the increase in medication will result in reduction in cardiac and pulmonary function and the patient will die. Now the family may not have a problem with the death, but I have a problem with it not being fully discussed. (Informant #11)

Related to this "whole truth" concept is the problem one informant had regarding the obtaining of informed consent. She said that oftentimes the test, procedure, or treatment being signed for had not been thoroughly explained. She reported, "Sometimes this notion of informed consent, a signature at the bottom of a form, is sort of a joke. I wonder how informed these people really are. I see that a lot" (Informant #11).

There were also many examples of ethical problems related to the withholding or withdrawing of treatment.

These problems center either around the treatment staff desiring to withhold or provide treatment against the wishes of the patient or family or on the patient or family desiring to receive or discontinue treatment against the wishes of the professional staff.

As one informant phrased it, "Sometimes the doctors don't want to give up, sometimes the families don't want to give up, and there's a lot of ethical questions about us continuing treatment" (#12). Another noted, "Sometimes there are problems between services. For instance, intensive care staff versus neurology or immunology. One set of doctors want to keep treating and another set of doctors want the treatment stopped" (Informant #3).

One informant gave an example that could be considered typical of this type of ethical problem. She recalled,

> A 38-year old patient with multiple sclerosis. She was married, had two kids, and was in a chronic vegetative state. The ethical problem centered around whether or not to surgically insert a feeding tube. There was a disagreement among the family as to how to proceed. There was some disagreement among the treating physicians as to what to do. (Informant #13)

Similar problems emerged in a situation that involved a multiple handicapped child and the issue of whether or not dialysis treatment should be started (Informant #2).

Another informant provided an example of a different situation:

> I've been involved with a dialysis and a cancer patient who decided to stop treatment. In both cases the doctors strongly encouraged them to

> continue. Neither one did. They were both young, I think that's why the docs wanted to keep trying. (Informant #19)

In a similar problem, the wishes of the family and not the patient prevailed. A patient wanted to discontinue treatment for cancer and go home to die. The family wanted treatment continued. "The family talked the doctor into continuing treatment and the patient died in the hospital a week later" (Informant #12).

One informant reflected on the ethical issues related to a patient who refused treatment. The patient did not want to come to the emergency room in the first place but a neighbor had coerced her. After several hours she left against medical advice. In trying to isolate the ethical issues involved in this situation the informant observed, "We were so focused on healing and helping that we didn't hear what she was saying" (Informant #19). Another told of a child being maintained on life support so it could continue to be in a research project (Informant #1).

A final example related to withholding or withdrawing treatment involved an infant who was born addicted to crack cocaine. The child had been raised by a foster parent since birth. The child became gravely ill as a result of the problems at birth and the issue of withdrawing treatment came up. The birth parents were called on to help make the decision. The informant asked, "What do you do when the

foster parent, who loves this baby dearly, has no say in the decision?" (Informant #3)

Informants also reported encountering ethical problems that were not related to the issues of information or treatment. One such situation involved what the informant called "a gift telephone." A child was to be discharged home on a lot of monitors and other equipment. One stipulation of the discharge was that there be a telephone in the home. When the social worker went out to the home for a predischarge visit she was informed that no one in the home could afford a telephone so the mother had a telephone installed in the name of one of the children. She could not pay the bill and the phone would be disconnected. She would have the telephone installed again in another child's name. The informant said,

> The doctors told the Mom that the baby had an apnea monitor and she had to have a phone in the home. The mother did what she had to do to have a phone in the home. I think she was afraid that if she couldn't provide for the child it would be taken away by Protective Services. Sometimes you just look the other way. (Informant #5)

Another informant discovered a parent had continued to carry one of her children on AFDC (Aid to Families with Dependent Children) after the child had died. She said, "This mother had been carrying her dead baby on her ADC card for over a year. She needed the extra money for survival" (Informant #6).

Ethical problems also involved prejudiced and bigoted treatment of family members. An informant said she had heard hospital staff deny a family medication at no cost because, "She's wearing gold. She's got gold on her neck and she's begging. Sometimes family members wear gold or carry beepers" (Informant #5). A similar problem was encountered by another informant who reported, "Sometimes the patients and their behavior don't fit the standards of the staff. You know, maybe white, clean, pleasant, and cooperative" (Informant #18). Finally, one informant noted,

> There is a lot of talk about the ethical problems connected to sending patients home too early, what about the ones that we keep too long. I have a patient right now that we were going to transfer out to a nursing home about a week and a half ago, she was doing fine. The family talked the doctor into keeping her here for a couple of days. The patient developed a staph infection in the blood and is doing a lot worse. (Informant #12)

There were several other examples given by informants. The ones presented here serve to convey the range of ethical problems reported.

Misidentification of problems. There were three findings regarding misidentification of problems. First, social workers tended to characterize most complex, emotionally charged problems as ethical. During discussion of these problems they frequently changed their characterizations. It is significant, however, that these problems were first identified as ethical. Half way through the interviews one informant was asked about social workers'

identification of ethical problems. When asked if she thought social workers identified ethical problems she replied, "Sometimes" (Informant #10). She was correct. Sometimes they did, but sometimes they did not.

One problem identified as ethical was related to a family meeting between the treatment team and a family about a patient's diagnosis and prognosis. As it turns out, five minutes into his explanation, the doctor discovered he had been talking about the wrong patient. The informant characterized this mistake as "totally unethical" (Informant #13).

Another spoke of how unethical it was to discharge a competent adult, homeless patient "back to the street. We wanted him to go to a shelter" (Informant #14). Other informants, when disagreeing with a doctor's medical decision to discharge a patient, would characterize such decisions as unethical.

Second, whether the problems were of an ethical nature or not, the social worker had substantial difficulty articulating the ethical tenets involved. When asked how she knew she was involved in an ethical problem, one informant said, "When I'm at a loss as to what to do. When I feel discomfort with a situation. When I'm uncomfortable" (Informant #7).

Third, informants often used the terms ethical problem and ethical dilemma interchangeably. The best example of

this was presented during a discussion about release of information. The informant said, "We've had ethical problems around releasing information which is always an ethical dilemma" (Informant #19).

The magnitude of ethical problems. The focus of this study is the nature of ethical problems encountered by hospital social workers and not merely the presence or absence of them. The idea emerged that the informants view some ethical problems as being more important than others. This notion was not articulated but it is reflected in a number of characterizations used in the discussion of ethical problems.

When asked to give an example of an ethical problem she had encountered one informant said, "Oh yes, I can tell you about a real problem" (Informant #9). Another, reflecting on a problem she had just remembered, observed, "That's a real ethical problem" (Informant #12). Referring to an ethical problem, another stated, " ...it's truly an ethical problem" (Informant #4). One social worker reported that the ethical problems she encountered, "..tend to be less severe, not serious" (Informant #6). Another said, "If it's a major ethical problem it will be brought to the ethics committee" (Informant #12). The last example of this was provided by a social worker who reported, "major ethical problems, like with our HIV patients" (Informant #2).

Few informants could articulate reasons for their determination of ethical problems as major or minor. One however, had an idea:

> investigator: What makes an ethical problem big or or little?
> informant: What makes it a big deal, from my experience, is if the hospital is likely to be sued.

Who are involved in these ethical problems? In any environment ethical problems rarely involve only two parties. This is certainly true for the hospital setting. The data in this study indicate that there are usually three groups involved: health care professionals, patients and their families, and any of a number of groups within or outside of the hospital.

Professionals. Professionals, variously referred to as "the care team," "staff," and "hospital types" are always involved in ethical problems. One informant said these problems involved,

> The patient or family member, depending on the problem, the physician, the nurse coordinator, and myself. Those would be the players. That is how, on my team, how it gets handled. (Informant #4)

Others reported, "Physicians, the nurse, whoever is defining the ethical problem, the patient, and me" (Informant #10), and, "Usually physicians and nurses because they're the most hands on, the people who interact most with the patient and family" (Informant #1). One informant, stressing the role of the patient and family reported, "A lot of patients and

family members talk to the doctor and come to some conclusion" (Informant #12).

Groups. The use of the term groups here refers to committees, departments, and boards within the hospital as well as agencies in the community. Informants reported that these ethical problems sometimes involve the ethics committee (Informants #1, #2, #3, #12, #16, and #20), the discharge planning committee (Informants #9, #11, and #12), the utilization review committee (Informants #7 and #16), the risk management department (Informant #18), and "administration" (Informants #6 and #19).

In addition to groups within the hospital, on occasion community groups are involved. Those identified by informants were Community Mental Health (Informants #5, #18 and #20) and the local Michigan Department Social Services office (Informants #5 and #19). In addition, one informant reported an ethical problem related to withdrawing treatment and "A local right to life group became quite involved" (Informant #17).

A hierarchy of involvement. In the analysis of the data related to those involved in ethical problems, an idea emerged related to the major versus minor ethical problem idea discussed earlier. That is, there are different levels at which ethical problems are addressed. According to the informants, most ethical problems are dealt with at the staff level. However, dealing with some problems involved

the risk management department (usually attorneys), the chiefs of different medical services, and the highest levels of administration. One informant reported, "When it becomes a real hot and heavy ethical issue, it involves the top doctors and hospital types" (Informant #2).

Addressing the ethical problems. The focus here is on how social workers deal with the ethical problems they encounter.

Approaches to resolution. The data indicate a number of approaches in dealing with these ethical problems. Some are relatively simple and straightforward and involve few people and a short process. Others are much more complex, involve many individuals and groups, and require a long process for resolution.

Whatever the approach, the central player in the reconciliation of these problems appears to be the physician. It does not appear that the physician always decides how a given ethical problem will be addressed. However, the physician is almost always involved and has considerable influence in the approach to resolution.

An example of this was reported by an informant who was in the process of arranging a family meeting to discuss termination of treatment of a patient. When the informant talked with the physician about this the physician said, "The docs will get together on this. I'll let you know what we'll do tomorrow" (Informant #8).

In other instances, the approach is the result of negotiations among a number of individuals, usually the social worker, nurse, and physician. Social workers appear to be rather comfortable in these negotiations. Commenting on this one informant reported, "It takes some courage, some confidence, and some credibility to have an impact" (Informant #12).

Responsible parties. After problems are initially identified as being ethical in nature and attempts to reconcile are begun, the issue may be redefined. For example, it may be determined that the problem is actually a legal problem. One informant reports,

> Sometimes you get involved in solving these problems and you find yourself out of your element. You have to remember that there are certain individuals in the hospital whose responsibility it is to deal with certain specific kinds of issues. If it turns out to be a legal problem, it's the lawyer's responsibility. If it's a medical issue, it's the doctor's responsibility." (Informant #16)

According to another, "If you come to find out you are dealing with a medical issue rather than an ethical issue, which happens, the bottom line is the physician is going to decide what happens to the patient. Always!" (Informant #19).

In most cases the informants report being satisfied with the resolution of these problems. This is true whether the problems are ethical or are defined at a later point as being of another nature. An informant reported that, "Most

of the time these problems are resolved appropriately" (Informant #5). Others reported, "I say in the large majority of the time they are resolved appropriately (Informant #8), and, "For the most part the ethical problems are resolved before the patient leaves the hospital. Ethical problems arise, there may even be some confrontation, but for the most part they are resolved" (Informant #14). Another noted that ethical problems were resolved, "Nearly all of the time" (Informant #6). Finally, one informant said this was the case, "Well, not 100%, but most of the time" (Informant #4). Satisfaction with resolution appears to be best when the ethical problem is specific to social work. This idea is reflected in informant reports such as, "When it deals with social work, these things tend to get ironed out" (Informant #20) and, "I would say (long pause) if it has to do with social work, I'm very successful and satisfied" (Informant #3). While these responses were typical, satisfactory resolution was not always the outcome.

Dissatisfaction with resolution of problems. Occasionally, informants report being unsatisfied with the resolution of the ethical problem or thinking the problem was not dealt with or managed appropriately. As one informant reported, "In several cases I was not comfortable with the way they were handled. That's a real frustrating

spot to be in" (#18). Another reported a somewhat philosophical view,

> You accept that you did what you thought was right. Sometimes these problems don't get solved the way you want. You suck it up and go on. There's nothing more you can do. The hospital may get sued, I won't. (Informant #9)

When social workers are dissatisfied with the reconciliation of these problems they are, for the most part, reluctant to register strong opposition. The reasons for this are not apparent. One informant reported that she does voice her dissatisfaction although it is not always well received: "Some people say I'm a little forward, but that's okay" (Informant #8).

Guide to handling ethical problems.

Kugelman (1992) states, "The critical document defining the standards for social work practice is the National Association of Social Workers Code of Ethics" (p. 62). This study indicates that the Code of Ethics is not a significant guide to practice.

> Investigator: Have you had training in ethics since graduate school?
> Informant: No.
> Investigator: Did you have ethics training during your social work training?
> Informant: No.
> Investigator: Do you think you are prepared to deal with the ethical problems you encounter?
> Informant: Oh yes. I do feel prepared.

As social workers encounter and deal with these often very complex ethical problems, what informs or guides their practice? The reaction to this question was different from

any other question asked. Informants reported that they found this question intriguing (Informant #14), very interesting (Informant #9), and thought provoking (Informant #11). One reported, "I've never been asked that question before" (Informant #18) and another said, "I know there are things that guide me, but I don't know if I can say what they are (Informant #7). There was often a long pause before responding to this question. The responses varied and indicate that there are a number of factors involved.

Personal values as a guide. The most frequently articulated guide to dealing with ethical problems was personal values. When asked what guided her in dealing with such complex ethical issues one informant reported, "I guess the first thing that comes to mind is my own values. That's probably number one" (Informant #16). Another was more certain as she reported, "My own belief system, my own faith" (Informant #1). One informant reported that her guide was, "My philosophy on things" (Informant #6). Another stated it a bit differently but reported, "The way I was brought up, being a Christian. My values are what I call gospel values" (Informant #11). Another reported, "I do what I believe in to be the right thing to do, my values" (Informant #13). Another was not quite sure but reported, "Maybe it's just based on my value system. Maybe my religious beliefs. It's just my own judgment, my own opinion, how I feel" (Informant #12).

Other informants articulated their own personal values as a guide to practice but suggested other influences. One reported, "I think my personal values guide me but my values are under the umbrella of social work values" (Informant #6). Another reported, "I went into social work because I had these beliefs and values to begin with. Social work supports a lot of them" (Informant #1).

One informant reported a situation in which her personal values were guiding her and a patient recognized this. The social worker was counseling a patient about a possible abortion. The social worker was opposed to abortion. The patient said, "You don't want me to have this abortion, do you?" The informant reported, "It must have been the expression on my face or something. I realized that somehow I had conveyed my personal values to her. She picked up on that" (Informant #3). In a similar vein an informant reported, "A lot of us have missions and carry torches" (Informant #4). However, one informant reported, "Your job is to be a social worker, not a person's judge or jury" (Informant #5).

Intuition. Several informants reported that they were guided by intuition. They reported this in a number of different ways. One informant stated she was guided by, "Things from the heart. You know, you have this intuition. I think we should get tuned in to those gut feelings. In most cases they're right" (Informant #12). Another

reported, "I always trust what I'm feeling inside. That inner voice, whatever it is" (Informant #13). Others reported, "I depend a lot on my instincts, intuition" (Informant #7), "You get a sense" (Informant #6), and, "Sometimes it's just a gut feeling. I think I am a very intuitive person. I don't have another explanation for it" (Informant #19). Finally, one informant reported, "There is something spiritual. I'm not a religious person but you go into the patient's room or hold their hand, you can feel things" (Informant #12).

The National Association of Social Work Code of Ethics. Though identified by several informants as a guide to practice, the NASW Code of Ethics was seldom the first guide articulated. Informants that identified the Code of Ethics first reported, "I think the Code of social work, the Ethics, my ethical beliefs as a social worker" (Informant #11), "I have a copy of the NASW Code of Ethics in my office that I refer to from time to time" (Informant #8), "My professional ethics" (Informant #14), and "I guess it sounds too obvious, but the ethics of the profession" (Informant #16). Finally, one informant reported, "Well, I know the ethical standards pretty well. The guidelines of what social workers are supposed to do" (Informant #19).

Two informants spoke of the NASW Code of Ethics in combination with other factors as being the guide to practice. For example, "A balance between the Code of

Ethics and my own values in working with people" (Informant #5) and "The ethics of my profession along with the goals of the hospital" (Informant #14).

Some informants reported that the Code of Ethics was not a guide at all. One reported, "I don't even know what the Code of Ethics is. I think I have it in my department manual" (Informant #17). Another, when asked if the code of ethics was a guide reported, "You would hope, but I don't think it's that way at all" (Informant #13).

Professional training as a guide. When informants noted professional training as a guide they usually included their formal education in this as well. Some informants stated this guide in very simple terms, "My training" (Informant #15), and, "The social work training I had" (Informant #10). Another informant reported, "I think my training and education are a major part" (Informant #17). Finally, another reported her professional training, "Especially the clinical assessment skills" (Informant #1).

There were other informants, however, that minimized their training and education as a guide. When asked specifically if training was a guide to dealing with ethical problems one informant reported, "For me, I can't say it is" (Informant #12). Another reported, "Not so much my professional training but the individuals I encountered during my training, priests and some colleagues" (Informant #13).

Supervision as a guide. Supervision either from supervisors or peer supervisors and consultation with colleagues was identified as "a strong guide" (Informant #14). Others reported that they frequently go to their supervisors for help and guidance in dealing with ethical issues. As one informant phrased it, "I process it with my supervisor" (Informant #6). Another informant reported, "The supervisor may suggest something or they may have to intervene" (Informant #8).

Experience as a guide. When informants identified experience as a guide in dealing with ethical problems most referred to a blending of personal and professional experience. One informant reported, "I think my main guide is my own professional and personal life experience. This teaches you what is worth getting upset about" (Informant #3). Another simply reported, "Probably my personal experience" (Informant #18). Finally, one informant reported, "I have been in hospital social work for ten years. My experience guides me with these problems. I've seen a lot" (Informant #7).

The hospital mission as a guide. Early in the data collection the idea of hospital mission and hospital philosophy emerged as a guide to management of ethical problems. Informants noted, "The philosophy of the team I work with is..." (Informant #1) and, "Our hospital mission is..." (Informant #2). When questioned further regarding

the significance of the hospital mission as a guide, one informant reported that compliance with the hospital mission was, "...a condition of continued employment" (Informant #2). This was noted later in data collection as well. Another informant reported, "We are being told a lot about the importance of the hospital mission. I know when I get stuck in one of these ethical issues, I'm sensitive to the mission and how this problem should play out" (Informant #14). Finally, after some reflection one informant noted, "I guess hospital mission does influence me in these problems because there have been times that I have felt compromised because I had to go along with the mission. I would have said no without first thinking about it" (Informant #17).

Hospital quality programs as a guide. During data collection there was substantial discussion about new and developing "Quality" programs. Quality programs are discussed in detail in Chapter Two. Some informants identified these programs as guides in dealing with ethical problems.

One informant reported, "TQM operationalizes things for you. The code of ethics is very abstract, very etherial. TQM brings it right down to home for you" (Informant #20). Another reported that their department mission was "a synthesis of TQM and the code of ethics" (Informant #12).

In addition to these subcategories there were other factors occasionally identified as guides in dealing with ethical problems. Informants reported that "the law" was a guide (Informants #3, #6, and #19). Others reported, "Length of stay is always a guide in these problems" (Informant #20), and, "I know what my job is. It's to create timely discharges. The bottom line is money" (Informant #14).

Two informants noted that the community surrounding their institutions influenced ethical problem solving. One reported, "You know what I think guides it? The community. If you're a community hospital, you are very influenced by the community. The community supports us financially" (Informant #17). This informant could not provide an example of this. Another reported, "One thing that guides me is being downriver. We have our own personality, our own way of doing things. I think each community has its own standards" (Informant #16).

Two other influences were identified. One informant reported, "I guess I'd have to say the institution itself. There are certain traditions within the hospital. Sometimes we don't question why we address these problems in a certain way, we just do it" (Informant #16). Finally, one informant reported, "At my social work cubicle I have this little card with 'Values to Live By.' That helps guide me" (Informant #9).

Reflective practice. The concept of reflective practice was presented in Chapter One. It was noted that because of the complex nature of hospital social work, reflective practice, as a part of an overall practice strategy, would enable the social worker to better navigate the "swampy lowlands of professional practice topography" (Schon, 1983, p. 42).

As the data were collected, hospital social workers recounted their efforts to convert problematic situations into manageable problems and to reconcile ethical problems. These data were analyzed for evidence of reflective practice. Some informants reported that they were "rational" (Informant #6), relied on "clinical skills" (Informant #14), "policy and procedures" (Informant #12), and the law (Informants #3 and #19) for guidance. They stated they were very clear about their "defined roles" (Informant #9) and the bureaucratic avenues available to them for ethical problem solving.

There were times, however, when formal training and rational thinking did not help with ethical problems. One informant told of how colleagues had become frustrated with complex problems and situations and observed, "Sometimes doing social work 101 doesn't work" (Informant #5). Related to this another reported, "If it isn't in the book, we don't know what to do" (Informant #16).

One informant spoke of how, after a few years of experience, hospital social workers may tend to focus on the similarities among patients and their illnesses, diseases, and circumstances rather than their uniqueness. This view often results in a "template approach" to working with patients and their problems. This is sometimes the case in working with ethical problems.

Another informant spoke of an ethical problem related to "another 'failure to thrive' baby" (Informant #2). It is important to focus here not on the ethical problem, but on the social worker's characterization of the patient and his or her situation. "Failure to thrive" syndrome is a characterization used to describe a situation in which an infant, for a variety of reasons, does not bond with the mother, gain weight, and grow and develop properly. There are many variables, including physical, emotional, and social issues, that can contribute to this syndrome.

To refer to a situation as "another" anything connotes a preconceived approach to a situation on the part of the social worker. This may not be based on accurate information or knowledge about a situation. Nevertheless, this approach may be used to guide initial social work intervention. Unfortunately, this represents a way of dealing with complex problems which does not use reflective practice. Among some informants there was much evidence of reflective practice.

Situation uniqueness. One informant reported, "I believe it is important for me to treat the patient as a unique individual" (Informant #11). Another noted, "You can't write a policy or procedure for every situation you will encounter" (Informant #8). In addition, there were many responses of "that depends" and "depending on the particular situation" to questions asked.

An oncology social worker reported, "I know there are no two cancer patients alike. All these patients and families and life circumstances are very different, even unique" (Informant #9).

In understanding a situation as unique, much discussion of and interaction with the situation takes place. During "reflective conversations with the situation" (Schon, 1983, pp. 76-104), one informant reported, "You learn to read what the patient or family is saying underneath what they actually say" (Informant #16). Another informant called it, "Listening to what is unsaid as well as what is said" (Informant #20). Imbedded in these two observations is the use of intuition.

Intuition. Intuition results from a combination of experience and reflection. Reflective practice is based not on the mere presence of intuition but on its use in practice. The earlier discussion of intuition as a guide in dealing with ethical problems is adequate to indicate the presence of intuition in hospital social work practice as

well as social workers' recognition and utilization of it in their practice.

Symbolic interactionism. The findings indicate that interactionist ideas are used in two ways. First, they are used in the analysis and definition of problems. Second, they are also used in the construction of meaning.

Framing issues. Both Schon (1983), and Goffman (1974) discuss the practice of framing and reframing social behavior. Framing refers to a view of an event or social behavior, that includes both the objective elements of the behavior and the viewer's subjective involvement in it.

An informant reported, "As a social worker, I bring something different to the ethical problem. I think I have a way of looking at the situation" (Informant #14). What a social worker brings to the ethical problem is his or her framing of the problem. It represents a perspective on the problem and his or her role in both the definition and reconciliation of the problem.

Another informant reported, "If you were in the room with a physician, a psychologist, a social worker, a nurse and a chaplain, you would get five different perspectives on the problem. Each person has a different view and does something different" (Informant #4). Represented in this idea are the viewing of the objective aspects of a situation and the subjective involvement of the different participants.

The idea of reframing was also identified. An ethical problem developed related to the placement of a patient with Alzheimer's disease in a nursing home. There was a considerable amount of disagreement among family members about the appropriate thing to do. The social worker discussed the situation with a colleague. The colleague was not sensitive to the complexity of the situation. The social worker then said, "Look at the big picture. This isn't just about placing an old senile man in a home. There's more to it. This man is a husband and a father. What we decide to do impacts them too" (Informant #9).

The social worker was saying that one way of viewing the situation, i.e., framing, is to see just the patient and what needs to be done for him. When you "look at the big picture," i.e., reframe, the situation is different.

At times framing and reframing takes place as problems are identified. This is the case when the social worker initially identifies a situation as an ethical problem but after consultation with colleagues or other members of the care team the problem is seen differently.

Meaning construction. An idea that is closely related to framing is meaning construction. In the interactionist perspective all meaning is socially constructed. Fundamental to meaning construction is consensus. The right thing to do, which is at issue in all ethical problems, is socially constructed as well.

One informant served on what she referred to as the "mega-claims committee" (Informant #5). This was a committee in the hospital that reviewed the situation of patients whose hospital bill had exceeded $50,000.

In one instance a patient's case came before this committee for discussion and recommendations. The patient's attending physician made a presentation and there was much discussion. The hospital chaplain's assessment was, "What this means is we have a terrible ethical problem on our hands." Also in attendance was the hospital vice president for finance. His interpretation was, "What this means is we have a financial problem." Finally, a consensus was reached. It was decided that the situation was a financial problem. Until consensus could be reached, no meaning could be attached to the situation.

As informants identified and misidentified ethical problems, they also reported that negotiations over meaning were a part of this process. While they did not recognize it as such, these negotiations led to meaning construction.

Relationships among categories and subcategories. Level one and two coding resulted in the development of the categories and subcategories presented. Level three coding resulted in the identification of links between subcategories of data. There were three major findings in this regard.

First, the idea of a "magnitude of problems" is related to that of "hierarchy." These are related in that it appears that the "bigger" the ethical problem (magnitude), the higher up in the hospital bureaucracy (hierarchy) one must go to identify the appropriate person to resolve it.

Second, the idea of "intuition" is related to both the category of reflective practice and the category of guide to handling ethical problem. The meaning of the term is the same in both instances. However, at different times the idea was presented in reference to distinct categories.

Third, there is a link between "responsible parties" and "meaning construction." It appears that before reconciliation of ethical problems can occur, responsible parties must bring about consensus regarding the nature of the problem.

Very small hospitals. Hospital social work in very small hospitals (fewer than 100 beds) is different than in larger hospitals in a number of ways. Some were easy to identify, others were more difficult.

First, the patient populations of these very small hospitals are very homogenous. They tend to be white and elderly. Informants reported, "This is a rural, white community. There are very few minorities" (Informant #18), and "Because we are a very small rural hospital we deal with a lot of the elderly. Our average patient age is in the high 70s" (Informant #17).

Second, these hospitals have much smaller staffs and small organizational structures. This accounts for a number of differences. Problem solving and decision making regarding ethical problems tend to happen fairly quickly and without fanfare. One informant reported, "We have a biomedical ethics committee but, it met only once last year and hasn't met this year either" (Informant #19). One informant reported that the social worker had substantial influence in reconciling ethical problems. She reported, "In the larger hospitals the doctors seem to make the final decisions in these ethical matters. It's different in this hospital. I would say the majority of the times, it's my decision" (Informant #17).

The relationships among staff members were characterized as "good" and "strong." One informant reported, "It's easy to develop a good relationship with the staff. We have ten docs and I know them all well, personally. In this hospital, whenever I write a note in the chart, whoever reads it knows me personally" (Informant #17).

There may be a negative side to these outcomes. In the very small hospitals the doctors have generally known their patients for many years. One informant reported,

> The dying issue is real difficult for some of our physicians to deal with. This is because the doctors here know many of the patients and have a lot of ties to them. I think there are a lot of those ties. (Informant #18)

Third, there is a "fishbowl" existence for both staff and patients in very small hospitals. As one informant reported,

> Everybody sees what you do. Everybody knows who you are. You can bet an hour from now people on the other side of the building will say, "Who was that man in your office?" It's a fishbowl kind of existence in a small place. (Informant #17)

During the interview the this informant spoke of an incident of unethical behavior she had witnessed. She made the observation that at one time she believed that in a very small hospital there would be a lot of pressure to behave in an ethical manner. She was stuck by how much pressure there also was to leave unethical behavior unaddressed. "I guess you could call it peer pressure. You know, to go along and not rock the boat" (Informant #17).

One informant told of an interesting way of paying a hospital bill that is probably unique to very small hospitals. She reported,

> We have in this area a lot of rural farmers. We have people who don't put their money in the banks. For many of our patients their method of paying hospital bills is selling acreage or livestock, or digging it up out of the backyard. (Informant #18)

One informant reported that the community had some "right to life groups" that became involved in an ethical issue. The hospital was opposed to surgically inserting a feeding tube into a young, mentally retarded, terminally ill patient.

Finally, one informant made a general observation about very small hospitals and ethical problems. She noted, "We never saw these problems ten years ago, or even five years ago. Now this happens a lot" (Informant #17). She was referring specifically to the ethical issues related to the withdrawal of treatment.

Phase Three Findings

Phase Three: Validation. In this "member check" (Lincoln & Guba, 1985, p. 236) phase, a provisional report is presented to the informants. This phase is not primarily a data gathering phase. Its purpose is to obtain confirmation that the report has captured the data reported by the informants. Corrections, amendments, and extensions are made if indicated.

The investigator met with Informants from the small and large hospitals in the conference room of their hospitals. Other members of the department were not present. Informants from the very small hospitals were contacted by phone. The discussions with the social workers from very small hospitals were very brief. In anticipation of this phase, each informant was given feedback following the interview during phase two.

The informants were eager to hear the provisional report. The report, an oral presentation of tentative findings, took about an hour. The informants indicated that the report was very consistent with the information they had

provided. One informant quipped, "It should have been easy with the tape recorder."

There was a brief discussion about the concept of "reframing." This was a new concept for most of them. One informant said he thought reframing was "a fancy word for second guessing yourself." We discussed this in some detail.

Some informants were upset by the idea presented by a key informant that "Nurses solve problems, social workers explain them." One informant commented, "We don't give just pills or untangle IV tubing." Another said, "We call doctors and have them talk with families too." It was explained that there was no support for this notion in the data.

Two informants, recognizing their quotes, raised the issue of confidentiality. The steps taken to preserve confidentiality were explained once again and no objections were raised.

Some of the informants reported that they had thought about their interviews for days afterward. For some it was the first time they had given this aspect of their practice any thought. They were positive about the experience.

A summary of these findings is presented in the next chapter. Also presented are conclusions and areas for further research.

CHAPTER 5

Summary and Conclusions

The investigator for this study had fifteen years of social work experience. The last five years were in hospital social work, most recently as director of a department of social work in a large hospital. The seed for this study was planted three years ago. The following anecdote illustrates this.

One day the investigator received an urgent call to attend a special meeting that was currently underway. Also in attendance at this meeting were the Vice President for Nursing, the Chief Counsel from the hospital's legal department, the Director of Physical Therapy, assorted nursing and support staff, and a very upset and determined Chief of Surgery.

A patient had been admitted to the emergency room following an injury to his right hand. He had been drinking and playing cards with friends and became involved in a fight. During the fight the patient broke through a window with his fist, cutting himself severely. He was brought to the hospital emergency room.

The Chief of Surgery was called to the emergency room to perform micro-surgery on the patient's hand. The hand was saved but several days of noncompliance with

post-surgery instructions, refusing to keep the injured hand elevated, and demanding to be discharged, resulted, in the opinion of the Chief of Surgery, in the risk of loss of function in the hand.

The Chief or Surgery demanded that someone go to court, petition the court to involuntarily confine the patient to the hospital. His hand would be elevated, proper care provided, and adequate healing would take place. This would take about a month.

The Chief of surgery was a very influential physician in the hospital and well known for his gruff nature and propensity for verbal outbursts. The small meeting room was filled with hustle and bustle as those in attendance discussed how they could comply with the demands of the physician.

The Vice President for Nursing thought that adequate nursing care could be provided. The Director of Physical Therapy agreed that her therapists could manage the patient as well. The Head Nurse for the floor had no problems the plan. The attorney noted that this would involve going to Probate Court and reckoned that was a job for Social Work. All of this happened in a matter of minutes.

The investigator took the position that this could not be done, not just because it was insensitive and perhaps illegal, but because it was not right. This stance was not well received. As the investigator articulated the ethical

issues involved, emotions cooled and it was decided not to go to court and petition the patient as incompetent, but instead, to talk with the patient about the care he needed and either seek his cooperation or discharge him as he requested, but against medical advice.

Besides the investigator, none of these intelligent, competent, and influential individuals considered the ethical dimensions of the problem at hand. Do hospital social workers encounter ethical problems? How are they resolved? What guides this process?

This study was guided by a single broad question: What is the nature of ethical problems encountered by hospital social workers?

This was a qualitative study focusing on ethical problems encountered by hospital social workers. The theoretical guide for this study was a synthesis of the sociological perspective of symbolic interactionism and Schon's (1983) theory of reflective practice. The method used to conduct this study was based on Lincoln and Egon Guba's (1985) naturalistic inquiry method.

The focus of this study was the nature of ethical problems encountered by hospital social workers. Four related areas were examined. First, do hospital social workers, in fact, encounter ethical problems in their practice? Second, who is involved in the definition and resolution of these ethical problems? Third, how successful

are social workers in resolving these problems. Finally, what guides social workers as they deal with these ethical problems?

There were five key informants and twenty informants involved in this study. The key informants were Directors of Hospital Social Work Departments and members of the academic community with interest in this topic.

The informants were hospital social workers from very small hospitals, those with fewer than 100 beds, small hospitals, those with between 100 and 249 beds, and large hospitals, those with more than 250 beds. The informants in this study had an MSW degree and a minimum of one year hospital social work experience. Most informants had several years of hospital social work experience. They represented nearly every unit found in contemporary hospitals.

Initially there was concern about the informants willingness to talk about these sensitive issues. However, it was found that they were eager to discuss their issues and many stated that they benefitted from having participating in the study.

This study consisted of three phases of inquiry. In the first phase, the orientation phase, key informants were interviewed. The result of this phase was an interview protocol to be used in the next phase of inquiry. In the second phase, the exploration phase, twenty informants were

interviewed. The focus of this phase was the four questions presented above. Following this phase a preliminary report was developed. In the third phase, the validation phase, the preliminary report was presented to the informants. The purposes of this phase was to insure that the report had accurately captured the data provided by the informants and to correct and amend it as necessary, and to validate the report as being a true and accurate reflection of the informants practice experience.

Summary of Findings. This study found that hospital social workers encountered ethical problems in their practice. The frequency of these problems varied from social worker to social worker. Some social workers encountered ethical problems very frequently; other social workers seldom encountered ethical problems.

Ethical problems were generally recognized and dealt with. However, at times hospital social workers identified problems as being ethical when they were not. A related finding was that hospital social workers often used the terms ethical dilemma and ethical problem interchangably. An ethical dilemma exists in a situation whereby following one ethical tenet another is violated. An ethical problem exists when one ethical tenet conflicts with another. Ethical dilemmas constitute a sub-category of ethical problems.

Most of the ethical problems encountered by hospital social workers fell into two categories. The first were ethical problems related to the withholding, withdrawing, or refusing medical treatment. The second were ethical problems related to the flow of information.

In addition to these two main categories of ethical problems, hospital social workers also encountered a range of ethical problems that were not easily recognized. Examples were: 1) a physician noting in a patient's chart that he had performed a service he had actually not performed; 2) a patient's family obtaining electrical service in an unscrupulous manner; and 3) a patient's family obtaining telephone service in an unscrupulous manner.

Hospital social workers had difficulty articulating the ethical tenets involved in the ethical problems they recounted. This was true even when the ethical problems they recounted involved fairly clear ethical issues.

Hospital social workers viewed some ethical problems as more serious than others. The seriousness of a given ethical problem usually dictated who was involved in dealing with it. This study indicates that most routine ethical problems encountered by hospital social workers were dealt with at the staff level involving few individuals in a short time frame.

In addition to hospital social workers, physicians and nurses were usually involved in resolving these problems.

It is not clear, from this study, what the level of involvement of the patient or his or her family was in dealing with ethical problems.

Besides the individuals mentioned above, various groups became involved in resolving ethical problems. These included groups within the hospital such as ethics committees, discharge planning committees and groups outside the hospital such as community service agencies and political or social action groups.

Occasionally ethical problems were resolved and the social worker was not in agreement with the outcome. In those cases the social worker was either unwilling or unable to pursue the matter further. This was mainly because of the custom that the physician usually has the last word in cases where there is significant disagreement over what should be done.

Primarily, hospital social workers relied on their individual values as guides in dealing with ethical problems. They also relied on their own intuition. The National Association of Social Workers Code of Ethics was not identified often as a guide. Professional training and education, individual experience, supervision, hospital culture, hospital quality programs, and legal regulations also guided social workers.

Hospital social workers had little training in ethics during and after their professional education. However,

they believed they were prepared to deal with ethical problems they encountered.

Hospital social work practice in very small hospitals was different from that in large and small hospitals. In very small hospitals there was a great deal of familiarity among staff and between staff and patients. Informants in the very small hospitals referred to their "fishbowl environment." They reported that this level of familiarity and the fishbowl environment encouraged ethical practice.

Patient populations in very small hospitals was very homogeneous. The patient population was also older than in the large and small hospitals.

The practice of most of the hospital social workers in this study can be characterized as objective and rational. Some, however, exhibited significant reflection in their practice. They acknowledged that each patient's circumstances were unique, leading to very different kinds of ethical problems. This was demonstrated by creativity in ethical problem solving and by help-seeking behavior.

In the process of dealing with ethical problems hospital social workers defined and re-defined problems and sought alternative views as they framed and re-framed situations in seeking solutions.

There was very little evidence of patient dehumanization reported. The most frequent example cited was that patients were referred to by their room number or

diagnosis. Some patients that were referred for social work services did not receive it because of staffing shortages or short lengths of stay.

Conclusions. One function of social work research is to inform social work practice. This study has provided information about and understanding of the nature of ethical problems encountered by hospital social workers.

In hospital social work professional status enabled the social worker to practice alongside of physicians, nurses, and other health professionals in the provision of services to patients. Because most hospital social workers have earned a master of social work (MSW) degree, hospital departments of social work have been referred to as, "the second most educated department in the hospital."

The provision of social work services in the complex practice arena of the hospital requires the use of professional skills and knowledge and the ability to delineate ethical problems. Ethical problems in hospital social work often involve contentious situations and substantial disagreement among social workers, physicians, nurses, patients and their families. As these problems are dealt with, not only is the correct ethical solution at issue, so, too, are the competence and credibility of the professionals involved. When ethical problems are identified incorrectly or not recognized at all, the competence of the hospital social worker may be questioned

and the ability to provide services to patients may be impaired.

From a professional social work perspective, it is critical that during ethical problem solving hospital social workers be guided by the ethical tenets of the profession. This is a function of the National Association of Social Workers Code of Ethics. This study indicates that the NASW Code of Ethics is only a minor guide to hospital social workers as they deal with ethical problems. They rely more on their individual moral philosophy and intuition than on the Code for guidance.

This study suggests two questions. First, to what extent should the NASW Code of Ethics guide hospital social work practice in the resolution of ethical problems? Should the NASW Code of Ethics be "a" guide to practice or "the" guide to practice?

Second, how well are schools of social work preparing practitioners to deal with ethical problems? This study indicates that hospital social workers recall little training in ethics during their MSW program. This is reflected in mis-identification of problems as ethical and an inability to understand the ethical dimensions of the problems they encounter.

Further research. Studies such as this contribute to the understanding of ethical problems encountered by hospital social workers. However, research that is focused

less on the broad nature of such problems and more focused on particular elements of these problems is needed.

A number of suggestions for further research emerged from this study.

First, the findings of this study reflect "one reality" of hospital social work practice, the practitioners' perceptions. Further research involving observation of practitioners may identify still other "realities." Such research could provide valuable information about processes involved in the identification and mis-identification of ethical problems.

Second, research is needed to determine the extent to which ethics are taught in schools of social work. This would aid in determining if ethics training in schools of social work is adequate.

Finally, the extent to which the NASW code of ethics does or should serve as a guide to practice should be explored. This should include further examination of hospital social work and other practice arenas as well.

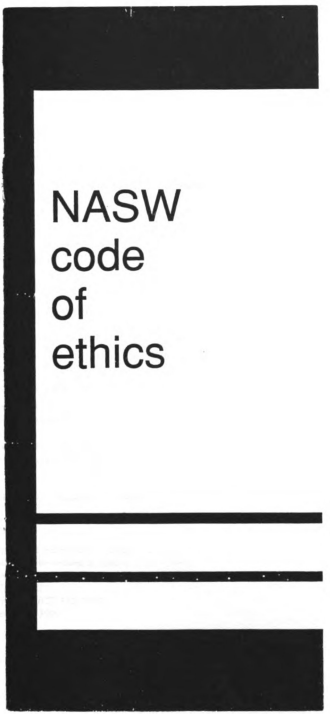
APPENDICES

APPENDIX A

NATIONAL ASSOCIATION OF SOCIAL WORKERS
CODE OF ETHICS

APPENDIX A

National Association of Social Workers
Code of Ethics



NASW PROFESSIONAL STANDARDS

Code of Ethics

Standards for the Classification of Social Work Practice

Standards for Continuing Professional Education

Standards for the Practice of Clinical Social Work

Standards of Practice for Social Work Mediators

Standards for School Social Work Services

Standards for Social Work Case Management

Standards for Social Work in Health Care Settings

Standards for Social Work Personnel Practices

Standards for Social Work Practice in Child Protection

Standards for Social Work Services in Long-Term Care Facilities

NASW CLINICAL INDICATORS

Clinical Indicators for Social Work and Psychosocial Services in the Acute Psychiatric Hospital

Clinical Indicators for Social Work and Psychosocial Services in the Acute Care Medical Hospital

Bylaws of the National Association of Social Workers

A single copy of these standards is available free of charge. Standards also may be ordered in bulk for a fee. Contact

NASW Distribution Center
P.O. Box 431
Annapolis JCT. MD 20701
1-800-227-3590

JPP-801F

Code of Ethics of the National Association of Social Workers

As adopted by the 1979 NASW Delegate Assembly and revised by the 1990 NASW Delegate Assembly.

National Association of Social Workers
750 First Street, NE. Suite 700
Washington, DC 20002-4241
(202) 408-8600

Contents

Preamble

This code is intended to serve as a guide to the everyday conduct of members of the social work profession and as a basis for the adjudication of issues in ethics when the conduct of social workers is alleged to deviate from the standards expressed or implied in this code. It represents standards of ethical behavior for social workers in professional relationships with those served, with colleagues, with employers, with other individuals and professions, and with the community and society as a whole. It also embodies standards of ethical behavior governing individual conduct to the extent that such conduct is associated with an individual's status and identity as a social worker.

This code is based on the fundamental values of the social work profession that include the worth, dignity, and uniqueness of all persons as well as their rights and opportunities. It is also based on the nature of social work, which fosters conditions that promote these values.

In subscribing to and abiding by this code, the social worker is expected to view ethical responsibility in as inclusive a context as each situation demands and within which ethical judgement is required. The social worker is expected to take into consideration all the principles in this code that have a bearing upon any situation in which ethical judgement is to be exercised and professional intervention or conduct is planned. The course of action that the social worker chooses is expected to be consistent with the spirit as well as the letter of this code.

In itself, this code does not represent a set of rules that will prescribe all the behaviors of social workers in all the complexities of professional life. Rather, it offers general principles to guide conduct, and the judicious appraisal of conduct, in situations that have ethical implications. It provides the basis for making judgements about ethical actions before and after they occur. Frequently, the particular situation determines the ethical principles that apply and the manner of their application. In such cases, not only the particular ethical principles are taken into immediate consideration, but also the entire code and its spirit. Specific applications of ethical principles must be judged within the context in which they are being considered. Ethical behavior in a given situation must satisfy not only the judgement of the individual social worker, but also the judgement of an unbiased jury of professional peers.

This code should not be used as an instrument to deprive any social worker of the opportunity or freedom to practice with complete professional integrity; nor should any disciplinary action be taken on the basis of this code without maximum provision for safeguarding the rights of the social worker affected.

The ethical behavior of social workers results not from edict, but from a personal commitment of the individual. This code is offered to affirm the will and zeal of all social workers to be ethical and to act ethically in all that they do as social workers.

The following codified ethical principles should guide social workers in the various roles and relationships and at the various levels of responsibility in which they function professionally. These principles also serve as a basis for the adjudication by the National Association of Social Workers of issues in ethics.

In subscribing to this code, social workers are required to cooperate in its implementation and abide by any disciplinary rulings based on it. They should also take adequate measures to discourage, prevent, expose, and correct the unethical conduct of colleagues. Finally, social workers should be equally ready to defend and assist colleagues unjustly charged with unethical conduct.

Summary of Major Principles

I. The Social Worker's Conduct and Comportment as a Social Worker

A. **Propriety.** The Social worker should maintain high standards of personal conduct in the capacity or identity as social worker.

B. **Competence and Professional Development.** The social worker should strive to become and remain proficient in professional practice and the performance of professional functions.

C. **Service.** The social worker should regard as primary the service obligation of the social work profession.

D. **Integrity.** The social worker should act in accordance with the highest standards of professional integrity.

E. **Scholarship and Research.** The social worker engaged in study and research should be guided by the conventions of scholarly inquiry.

II. The Social Worker's Ethical Responsibility to Clients

F. **Primacy of Clients' Interests.** The social worker's primary responsibility is to clients.

G. **Rights and Prerogatives of Clients.** The social worker should make every effort to foster maximum self-determination on the part of clients.

H. **Confidentiality and Privacy.** The social worker should respect the privacy of clients and hold in confidence all information obtained in the course of professional service.

I. **Fees.** When setting fees, the social worker should ensure that they are fair, reasonable, considerate, and commensurate with the service performed and with due regard for the clients' ability to pay.

III. The Social Worker's Ethical Responsibility to Colleagues

J. **Respect, Fairness, and Courtesy.** The social worker should treat colleagues with respect, courtesy, fairness, and good faith.

K. **Dealing with Colleagues' Clients.** The social worker has the responsibility to relate to the clients of colleagues with full professional consideration

IV. The Social Worker's Ethical Responsibility to Employers and Employing Organizations

L. **Commitments to Employing Organizations.** The social worker should adhere to commitments made to the employing organizations.

V. The Social Worker's Ethical Responsibility to the Social Work Profession

M. **Maintaining the Integrity of the Profession.** The social worker should uphold and advance the values, ethics, knowledge, and mission of the profession.

N. **Community Service.** The social worker should assist the profession in making social services available to the general public.

O. **Development of Knowledge.** The social worker should take responsibility for identifying, developing, and fully utilizing knowledge for professional practice.

VI. The Social Worker's Ethical Responsibility to Society

P. **Promoting the General Welfare.** The social worker should promote the general welfare of society.

The NASW Code of Ethics

I. The Social Worker's Conduct and Comportment as a Social Worker

A. **Propriety—The Social worker should maintain high standards of personal conduct in the capacity or identity as social worker.**

1. The private conduct of the social worker is a personal matter to the same degree as is any other person's, except when such conduct compromises the fulfillment of professional responsibilities.
2. The social worker should not participate in, condone, or be associated with dishonesty, fraud, deceit, or misrepresentation.
3. The social worker should distinguish clearly between statements and actions made as a private individual and as a representative of the social work profession or an organization or group.

B. **Competence and Professional Development—The social worker should strive to become and remain proficient in professional practice and the performance of professional functions.**

1. The social worker should accept responsibility or employment only on the basis of existing competence or the intention to acquire the necessary competence.
2. The social worker should not misrepresent professional qualifications, education, experience, or affiliations.

C. **Service —The social worker should regard as primary the service obligation of the social work profession.**

1. The social worker should retain ultimate responsibility for the quality and extent of the service that individual assumes, assigns, or performs.
2. The social worker should act to prevent practices that are inhumane or discriminatory against any person or group of persons.

D. **Integrity —The social worker should act in accordance with the highest standards of professional integrity and impartiality.**

1. The social worker should be alert to and resist the influences and pressures that interfere with the exercise of professional discretion and impartial judgement required for the performance of professional functions.
2. The social worker should not exploit professional relationships for personal gain.

consent, only for compelling professional reasons.
2. The social worker should inform clients fully about the limits of confidentiality in a given situation, the purposes for which information is obtained, and how it may be used.
3. The social worker should afford clients reasonable access to any official social work records concerning them.
4. When providing clients with access to records, the social worker should take due care to protect the confidences of others contained in those records.
5. The social worker should obtain informed consent of clients before taping, recording, or permitting third party observation of their activities.

I. Fees —When setting fees, the social worker should ensure that they are fair, reasonable, considerate, and commensurate with the service performed and with due regard for the clients' ability to pay.

1. The social worker should not accept anything of value for making a referral.

III. The Social Worker's Ethical Responsibility to Colleagues

J. Respect, Fairness, and Courtesy —The social worker should treat colleagues with respect courtesy, fairness, and good faith.

1. The social worker should cooperate with colleagues to promote professional interests and concerns.
2. The social worker should respect confidences shared by colleagues in the course of their professional relationships and transactions.
3. The social worker should create and maintain conditions of practice that facilitate ethical and competent professional performance by colleagues.
4. The social worker should treat with respect, and represent accurately and fairly, the qualifications, views, and findings of colleagues and use appropriate channels to express judgements on these matters.
5. The social worker who replaces or is replaced by a colleague in professional practice should act with consideration for the interest, character, and reputation of that colleague.
6. The social worker should not exploit a dispute between a colleague and employers to obtain a position or otherwise advance the social worker's interest.
7. The social worker should seek arbitration or mediation when conflicts with colleagues require resolution for compelling professional reasons.
8. The social worker should extend to colleagues of other professions the same respect and cooperation that is extended to social work colleagues.
9. The social worker who serves as an employer supervisor, or mentor to colleagues should make orderly and explicit arrangements regarding the conditions of their continuing professional relationship.
10. The social worker who has the responsibility for employing and evaluating the performance of other staff members, should fulfill such responsibility in a fair, considerate, and equitable manner, on the basis of clearly enunciated criteria.
11. The social worker who has the responsibility for evaluating the performance of employees, supervisees, or students should share evaluations with them.

K. Dealing with Colleagues' Clients —The social worker has the responsibility to relate to the clients of colleagues with full professional consideration.

1. The social worker should not assume professional responsibility for the clients of another agency or a colleague without appropriate communication with that agency or colleague.
2. The social worker who serves the clients of colleagues, during a temporary absence or emergency, should serve those clients with the same consideration as that afforded any client.

IV. The Social Worker's Ethical Responsibility to Employers and Employing Organizations

L. Commitments to Employing Organization —The social worker should adhere to commitments made to the employing organization.

1. The social worker should work to improve the employing agency's policies and procedures, and the efficiency and effectiveness of its services.

E. Scholarship and Research —The social worker engaged in study and research should be guided by the conventions of scholarly inquiry.

1. The social worker engaged in research should consider carefully its possible consequences for human beings.
2. The social worker engaged in research should ascertain that the consent of participants in the research is voluntary and informed, without any implied deprivation or penalty for refusal to participate, and with due regard for participants' privacy and dignity.
3. The social worker engaged in research should protect participants from unwarranted physical or mental discomfort, distress, harm, danger, or deprivation.
4. The social worker who engages in the evaluation of services or cases should discuss them only for the professional purposes and only with persons directly and professionally concerned with them.
5. Information obtained about participants in research should be treated as confidential.
6. The social worker should take credit only for work actually done in connection with scholarly and research endeavors and credit contributions made by others.

II. The Social Worker's Ethical Responsibility to Clients

F. Primacy of Clients' Interests—The social worker's primary responsibility is to clients.

1. The social worker should serve clients with devotion, loyalty, determination, and the maximum application of professional skill and competence.
2. The social worker should not exploit relationships with clients for personal advantage.
3. The social worker should not practice, condone, facilitate or collaborate with any form of discrimination on the basis of race, color, sex, sexual orientation, age, religion, national origin, marital status, political belief, mental or physical handicap, or any other preference or personal characteristic, condition or status.
4. The social worker should avoid relationships or commitments that conflict with the interests of clients.
5. The social worker should under no circumstances engage in sexual activities with clients.
6. The social worker should provide clients with accurate and complete information regarding the extent and nature of the services available to them.
7. The social worker should apprise clients of their risks, rights, opportunities, and obligations associated with social service to them.
8. The social worker should seek advice and counsel of colleagues and supervisors whenever such consultation is in the best interest of clients.
9. The social worker should terminate service to clients, and professional relationships with them, when such service and relationships are no longer required or no longer serve the clients' needs or interests.
10. The social worker should withdraw services precipitously only under unusual circumstances, giving careful consideration to all factors in the situation and taking care to minimize possible adverse effects.
11. The social worker who anticipates the termination or interruption of service to clients should notify clients promptly and seek the transfer, referral, or continuation of service in relation to the clients' needs and preferences.

G. Rights and Prerogatives of Clients-The social worker should make every effort to foster maximum self-determination on the part of clients.

1. When the social worker must act on behalf of a client who has been adjudged legally incompetent, the social worker should safeguard the interests and rights of that client.
2. When another individual has been legally authorized to act in behalf of a client, the social worker should deal with that person always with the client's best interest in mind.
3. The social worker should not engage in any action that violates or diminishes the civil or legal rights of clients.

H. Confidentiality and Privacy —The social worker should respect the privacy of clients and hold in confidence all information obtained in the course of professional service.

1. The social worker should share with others confidences revealed by clients, without their

2. The social worker should not accept employment or arrange student field placements in an organization which is currently under public sanction by NASW for violating personnel standards, or imposing limitations on or penalties for professional actions on behalf of clients.
3. The social worker should act to prevent and eliminate discrimination in the employing organization's work assignments and in its employment policies and practices.
4. The social worker should use with scrupulous regard, and only for the purpose for which they are intended, the resources of the employing organization.

V. The Social Worker's Ethical Responsibility to the Social Work Profession

M. Maintaining the Integrity of the Profession—The social worker should uphold and advance the values, ethics, knowledge, and mission of the profession.

1. The social worker should protect and enhance the dignity and integrity of the profession and should be responsible and vigorous in discussion and criticism of the profession.
2. The social worker should take action through appropriate channels against unethical conduct by any other member of the profession.
3. The social worker should act to prevent the unauthorized and unqualified practice of social work.
4. The social worker should make no misrepresentation in advertising as to qualifications, competence, service, or results to be achieved.

N. Community Service—The social worker should assist the profession in making social services available to the general public.

1. The social worker should contribute time and professional expertise to activities that promote respect for the utility, the integrity, and the competence of the social work profession.
2. The social worker should support the formulation, development, enactment and implementation of social policies of concern to the profession.

O. Development of Knowledge—The social worker should take responsibility for identifying, developing, and fully utilizing knowledge for professional practice.

1. The social worker should base practice upon recognized knowledge relevant to social work.
2. The social worker should critically examine, and keep current with emerging knowledge relevant to social work.
3. The social worker should contribute to the knowledge base of social work and share research knowledge and practice wisdom with colleagues.

VI. The Social Worker's Ethical Responsibility to Society

P. Promoting the General Welfare—The social worker should promote the general welfare of society.

1. The social worker should act to prevent and eliminate discrimination against any person or group on the basis of race, color, sex, sexual orientation, age, religion, national origin, marital status, political belief, mental or physical handicap, or any other preference or personal characteristic, condition, or status.
2. The social worker should act to ensure that all persons have access to the resources, services, and opportunities which they require.
3. The social worker should act to expand choice and opportunity for all persons, with special regard for disadvantaged or oppressed groups and persons.
4. The social worker should promote conditions that encourage respect for the diversity of cultures which constitute American society.
5. The social worker should provide appropriate professional services in public emergencies.
6. The social worker should advocate changes in policy and legislation to improve social conditions and to promote social justice.
7. The social worker should encourage informed participation by the public in shaping social policies and institutions.

APPENDIX B

LETTER TO HOSPITAL SOCIAL WORK DIRECTORS

APPENDIX B

Letter to Hospital Social Work Directors

XXXXXXX, 1993

Xxxxxxxxxx Xxxxxxxx
Director, Department of Social Work
Xxxxxxxxxxx Hospital
Xxxxxxxxxxx Street
Xxxxxxxxxxx, Michigan xxxxx

Dear xxxxxxxxxxxx,

My name is Jerry Clark. As you may recall, I was Director of Social Work at Xxxxxxxxx Hospital for the past two years. I resigned that position earlier this year.

I am currently a doctoral student at Michigan State University and am in the process of writing my dissertation. That is the reason for this letter.

My dissertation topic has to do with hospital social workers. I am conducting interviews with social workers in this area and would like to ask your assistance. Would it be possible to interview social workers in your department for this purpose?

I am very aware of how busy hospital social workers are. I am also aware of their commitment to scholarship and practice excellence.

I will contact you within the next two weeks to talk with you further. Please consider this request.

Sincerely,

_____
Jerry L. Clark

APPENDIX C

CONSENT

APPENDIX C

Consent

Ethical Problems Faced By Hospital Social Workers

To Participants in this study:

I am a graduate student at Michigan State University in East Lansing. The subject of my doctoral research is the practice of social work in a hospital setting. I am interviewing hospital social workers in the metropolitan area. You are one of approximately thirty participants.

As part of this study, you are being asked to participate in an interview. The interview should last approximately one hour. In the interview you will be asked to discuss your experience with ethical problems you have encountered in your practice. Your responses will be audiotaped and transcribed. The audio tapes will be erased and transcriptions shredded three months following defense of this dissertation. There will be no fee paid for your participation.

I am interested in objective details of your practice. I will not use your name, the names of people you mention, or the name of your hospital. Your confidentiality will be strictly preserved. You may withdraw from the interview at any time without penalty.

In signing this form, you are assuring me that your participation is voluntary.

I _____ have read the above statement and agree to participate as an interviewee under the conditions stated above.

_____
Signature of participant

_____ _____
Signature of interviewer Date

APPENDIX D

LETTER OF INTRODUCTION

APPENDIX D

Introduction

My name is Jerry Clark and I am a graduate student at Michigan State University in East Lansing. The subject of my doctoral research is the practice of social work in a hospital setting. I am interviewing hospital social workers in the metropolitan area. You are one of approximately thirty participants.

Specifically, I want to talk with you about ethical problems you have encountered in your practice. I am interested in the nature of these problems. An ethical problem exists when your professional values conflict with those of someone else. Ethical problems may develop between you and another professional or between you and an individual with whom you are working.

An example of an ethical problem would be when the members of a health care team know a patient is terminally ill and the physician does not inform the patient of this. In this example the ethical problem is between the physician's value that to inform the patient would do him or her more harm than good and the social work values of the right to know and the right to self-determination.

There are three main questions I would like to discuss with you. First, have you encountered such problems in the course of your practice? Second, what individuals were involved? Finally, how did you reconcile the problem.

If at any time you become uncomfortable and wish to withdraw from the interview, you may do so. Thank you very much for your time and consideration.

Jerry Clark

APPENDIX E

INTERVIEW PROTOCOL

APPENDIX E

Interview Protocol

The purpose of this interview is to talk with you about ethical problems you have encountered in the course of your professional practice. Ethics represent values in operation. An ethical problem exists when your professional values conflict with those of a colleague or with those of an individual with whom you are working. Do you have any questions?

I would like to ask you about four broad areas that concern ethical problems in your practice.

1. Have you experienced ethical problems in your practice within the last six months?

   If yes: Would you please tell me about it (them)?

   If no: What types of problems do you encounter in your practice?

2. Who are the idividuals are involved in these problems?

3. How successful are you in addressing these problems? Please elaborate.

   What obstacles do you encounter in your efforts to address these problems?

4. As you deal with these problems, what guides you? (e.g. own moral philosophy, code of ethics)

During the course of the interview other questions may be asked to probe responses or elicit elaboration.

LIST OF REFERENCES

References

Abramson, M. (1990). Ethics and technological advances: Contributions of social work practice. Social Work in Health Care, 15, 5-17.

American Hospital Association (1992). 1992 A.H.A. guide to the health care field. Chicago: American Hospital Association.

Argyris, C. & Schon, D. (1974). Theory in practice: Increasing professional effectiveness. Boston: Addison Wesley.

Bailey, R. & Brake, M. (1975). Radical social work. New York: Pantheon Books.

Barker, W. H., Williams, T. F. & Zimmer, J. G. (1985). Geriatric consultation teams in acute hospitals: Impact on backup of elderly patients. Journal of the American Geriatrics Society, 33, 422-428.

Bartlett, H. M. (1975). Ida M. Cannon: Pioneer in medical social work. Social Service Review, 49, 208-229.

Beckerman, N. L. (1991). Ethical dilemmas facing hospital social workers: Implications. Unpublished doctoral dissertation, Yeshiva University, New York.

Belkin, L. (1993, January 31). The high cost of living. The New York Times Magazine.

Bloom, M. (1990). Introduction to the drama of social work. Itasca, IL: F.E. Peacock Publishers.

Bloom, M., Wood, K., & Chambon, A. (1991). The six languages of social work. Social Work, 36, 530-534.

Blumenfield, S. and Lowe, J. (1987). A template for analyzing ethical dilemmas in discharge planning. Health and Social Work, 12, 39-46.

Blumer, H. (1969). Symbolic interactionism: Perspective and method. Englewood Cliffs, NJ: Prentice-Hall.

Bogdanich, W. (1991). The great white lie. New York: Simon & Schuster.

Boud, D., Keogh, R. & Walker, D. (1985). What is reflective learning? In D. Boud, R. Keogh, & D. Walker (Eds.), Reflection: Turning experience into learning. London: Kogan Page.

Bracht, N. F. (Ed.) (1978). Social work in health care: A guide to professional practice. New York: Haworth Press.

Brekke, J. S. (1986). Scientific imperatives in social work research: Pluralism is not skepticism. Social Service Review, 60, 538-554.

Cabot, R. C. (1919). Social work: Essays on the meeting-ground of doctor and social worker. New York: Houghton Mifflin.

Cabot, R. C. (1931). Treatment in social case work and the need of criteria and of tests on its success or failure. Proceedings of the national conference of social work, (pp. 3-24). Minneapolis, Minnesota. Chicago, IL: The University of Chicago Press.

Cannon, I. M. (1923). Social work in hospitals: A contribution to progressive medicine. New York: Russell Sage Foundation.

Colaizzi, P. F. (1973). Reflection and research in psychology: A phenomenological study of learning. New York: Hunt Publicaitons.

Cooley, C. H. (1962). Social organization. New York: Scribner's.

Coulton, C. J. (1979). Social work quality assurance programs: A comparative analysis. Washington, DC: National Association of Social Workers.

Coulton, C. J. (1990). Research in patient and family decision making regarding life sustaining and long term care. Social Work in Health Care, 15, 63-78.

Coulton, C. J., Dunkle, R. E. & Good R. A. (1982). Discharge planning and decision making. Health and Social Work, 7, 253-261.

Epstein, W. M. (1986). Science and social work. Social Service Review, 60, 145-160.

Fischer, J. (1981). The social work revolution. Social Service Review, 60, 145-160.

Fleck, L. (1989). Speech to the American Hospital Association. Catholic Health World, 5, 3.

Glaser, B. G. (1978). Theoretical sensitivity. Mill Valley, CA: The Sociology press.

Glaser, B. G. and Strauss, A. L. (1967). The discovery of grounded theory: Strategies for qualitative research. New York: Aldine De Gruyter.

Goffman, E. (1961). Asylums. New York: Anchor Books.

Goffman, E. (1974). Frame analysis. New York: Harper & Row.

Gordon, W. E. (1965). Knowledge and value: Their distinction and relationship in clarifying social work practice. Social Work, 10, 32-39.

Goldmeier, J. (1984). Ethical styles and ethical decisions in health settings. Social Work in Health Care, 10, 45-60.

Goldstein, D. (1954). Readings in the theory and practice of medical social work. Chicago: University of Chicago Press.

Harrison, W. D. (1987). Reflective practice in social care. Social Service Review, 61, 393-404.

Hartman, A. (1990). Editorial: Many ways of knowing. Social Work, 35, 3-4.

Hartman, A. (1992). Editorial: In search of subjugated knowledge. Social Work, 37, 483-484.

Haworth, G. O. (1984). Social work research, practice, and paradigms. Social Service Review, 58, 343-357.

Heineman, M. B. (1981). The obsolete scientific imperative in social work research. Social Service Review, 55, 371-395.

Hewson, M. G. (1991). Reflection in clinical teaching: An analysis of reflection-on-action and its implications for staffing residents. Medical Teacher, 13, 227-231.

Hoult, T. F. (1969). Dictionary of modern sociology. Totowa, NJ: Littlefield, Adams.

Hubschman, L. (Ed.). (1983). Hospital social work practice. New York: Praeger.

Hudson, W. W. (1978). Notes for practice: First axioms of treatment. Social Work, 23, 65-66.

Hudson, W. W. (1982). Scientific imperatives in social work work research and practice. Social Service Review, 56, 247-258.

Imre, R. W. (1984). The nature of knowledge in social work. Social Work, 29, 41-45.

Inlander, C. B. & Weiner, E. (1991). Take this book to the to the hospital with you. New York: Wings Books.

Karger, H. J. (1983). Science, research, and social work: Who controls the profession? Social Work, 28, 200-205.

Kerson, T. S. (Ed.). (1982). Social work in health settings: Practice in context. New York: Longman.

Kondrat, M. E. (1992). Reclaiming the practical: Formal and substantive rationality in social work practice. Social Service Review, 66, 237-255.

Kottkamp, R. B. (1990). Means for facilitating reflection. Education and Urban Society, 22, 182-203.

Kugelman, W. (1990). Ethical decision-making processes of social work practitioners in orgational settings. Unpublished doctoral dissertation, City University of New York.

Kugelman, W. (1992). Social work ethics in the practice arena: A qualitative study. Social Work in Health Care, 17, 59-77.

Lemrow, N., Adams, D., Coffey, R., & Farley, D. (1990). The fifty most frequent diagnostic related groupings diagnosis procedures: Statistics by hospital size and location. Washington, DC: National Center for Health Statistics.

Levin, B. (1986). Caring choices: Decision-making about treatments for catastrophic illness in the newborn. Unpublished doctoral dissertation, Columbia University, New York.

Levy, C. S. (1976). Social work ethics. New York: Human Sciences Press.

Lincoln, Y. S. & Guba, E. G. (1985). Naturalistic inquiry. Newbury Park, Ca.: Sage.

Loewenberg, F. M. & Dolgoff, R. (1992). Ethical decisions for social work practice (4th ed.). Itasca, N.Y.: F.E. Peacock.

Mead, G. H. (1934). Mind, self and society. Chicago: University of Chicago Press.

Mizrahi, T. & Abramson, J. (1985). Sources of strain between physicians and social workers in health care settings. Social Work in Health Care, 10, 33-51.

Nacman, M. (1977). Social work in health settings: A historical review. Social Work in Health Care, 2, 408-416.

National Association of Social Workers, (1990). Code of ethics of the national association of social worers. Washington, DC: Author.

Oakland, J. (1989). Total quality management. London: Heinemann Professional Publishing.

Osterman, K. F. (1990a). Introduction. Education and Urban Society, 22, 131-132.

Osterman, K. F. (1990b). Reflective practice: A new agenda for education. Education and Urban Society, 22, 133-152.

Park, R. & Burgess, E. (1921). Introduction to the science of society. Chicago: University of Chicago.

Peile, C. (1988). Research paradigms in social work: From stalemate to creative synthesis. Social Service Review, 62, 1-19.

Polanyi, M. (1966). The tacit dimension. Garden City, NY: Doubleday.

Powell, J. H. (1989). The reflective practitioner in nursing. Journal of Advanced Nursing, 14, 824-832.

Rakich, J., Longest, B., & Darr, K. (1992). Managing health services organizations (3rd ed.). Baltimore: Health Professions Press.

Reamer, F. G. (1979). Fundamental ethical issues in social work: An essay review. Social Service Review, 53, 229-243.

Reamer, F. G. (1980). Ethical content in social work. Social Casework, 61, 531-540.

Reamer, F. G. (1985). The emergence of bioethics in social work. Health and Social Work, 10, 271-281.

Reamer, F. G. (1990). Ethical dilemmas in social service. (2nd ed.) New York: Columbia University Press.

Reamer, F. G. (1993). The philosophical foundations of social work. New York: Columbia University Press.

Reichelt, P. A. (1982). A comprehensive model for hospital discharge planning. Discharge Planning Update, 2, 8-11.

Rein, M. & White, S. H. (1981). Knowledge for practice. Social Service Review, 55, 1-41.

Rhodes, M. L. (1986). Ethical dilemmas in social work practice. Boston: Routledge & Kegan Paul.

Richmond, M. (1917). Social diagnosis. New York: Russell Sage Foundation.

Roberts, C. S. (1989). Conflicting professional values in social work and medicine. Health and Social Work, 14, 211-218.

Rothman, D. (1991). Strangers at the bedside. New York: Basic Books.

Schlesinger, E. G. (1985). Health care social work practice: Concepts and strategies. Santa Clara, Ca.: Times Mirror/Mosby College Publishing.

Schon, D. (1983). The reflective practitioner: How professionals think in action. New York: Basic Books.

Shepard, K. F. & Jensen, G. M. (1990). Physical Therapist Curricula for the 1990's: Educating the reflective practitioner. Physical Therapy, 70, 566-573.

Shevlin, K. (1983). Why a social services department in a hospital? In L. Hubscham (Ed.), Hospital Social Work Practice. New York: Praeger Special Studies.

Shine, M. S. (1983). Discharge planning for the elderly patient in the acute care setting. Nursing Clinic of North America, 18, 403-410.

Simmons, W. J. (1986). Planning for discharge with the

elderly. Quality Review Bulletin, 12, 68-71.

Specht, Harry (1988). New directions for social work practrice. Englewood Cliffs, N. J.: Prentice-Hall, Inc.

Stevens, R. (1989). In sickness and in wealth. New York: Basic Books.

Strauss, A. & Corbin, J. (1990). Basics of qualitative research: Gorunded theory procedures and techniques. Newbury Park, CA: Sage.

Stryker, S. (1981). Symbolic interactionism: Themes and variations. In M. Rosenberg & R. Turner (Eds.), Social psychology: Sociological perspectives (pp. 1-29). New York: Basic Books.

Thomas, W. I. & Thomas, D. S. (1928). The Child in America. New York: Knopf.

Trattner, W. I. (1974). From poor law to welfare state: A history of social welfare in America. New York: Free Press.

Trattner, W. I. (1979). From poor law to welfare state: A history of social welfare in America (2nd ed.) New York: Free Press.

United States Bureau of the Census (1990). Statistical abstract of the United States, (111th ed.). Washington, DC: United States Government Printing Office.

United States Department of Labor, Bureau of Labor Statistics (1992). Occupational projections and training data. Washington, DC: United States Government Printing Office.

Vaines, E., Badir, D., & Kieren, D. (Eds.) (1988). The reflective professional: Reflecting on helping for the 21st Century. People and practice: International issues for home economists, 1, 1. Vancouver, Canada: University of British Columbia.

Vernon, G. M. (1978). Symbolic aspects of interaction. Washington, DC: University Press of America.

Volland, P. J. (Ed.). (1989). Discharge planning: An interdisciplinary approach to continuity of care. Owings Mills, MD: National Health Publishing.

Walker, M. (1993). Keeping moral space open: New images of

ethics consulting. Hasting Center Report, 23, pp. 33-40.

Walton, M. (1986). The Deming management method. New York: Putnum.

Wellington, B. (1991, March). The promise of reflective practice. Educational Leadership, pp. 4-5.

Wells, C. C. & Masch, M. K. (1991). Social work ethics day to day: Guidelines for professional practice. Prospect Heights, Ill.: Waveland Press, Inc.

Wohl, S. (1984). The medical industrial complex. New York: Harmony Books.