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Contents

Using Evidence-Based Decision-Making: Should JSWVE Offer Online Video Interviews with Book Authors?

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The Journal of Social Work Values and Ethics

An online journal offers a number of advantages to print journals, including faster review and publication time, greater accessibility, lower cost, and ability to incorporate media other than print, such as hyperlinks, animation, and video. An online audience also promotes faster and easier communication between the editors, board members, authors and the readership through e-mail, an online forum, and listservs. The openness and speed of electronic communication can be used to create greater inclusiveness in decision making by gathering information from constituencies and promoting evidence-based decision making. Therefore, when one editor of the Journal of Social Work Values and Ethics (JSWVE) proposed the use of video-based interviews with book authors instead of written book reviews, the editors sought input from readers about their support for this idea.

This brief report describes the results of an online survey designed to solicit user feedback about having video-based interviews with authors as part of the JSWVE content. It is hoped that this process of data collection from constituencies will be an important source of evidence-based decision making for JSWVE development.

Method

A brief 4-question survey was developed to assess respondents' interest in watching online video interviews with authors and the barriers they face to watching online video. Respondents were asked:

* How interested would you be in viewing an online video interview with the author of a social work book? on a 4 point scale with 1 = no interest and 4=very interested.
* I would rather read a traditional book review commonly found in an academic journal than view a digitized interview with an author of a book, on a 5 point scale from 1=Strongly Disagree to 5 = Strongly Agree.
* Which of the following are barriers to your accessing online video?
* From which listserv did you receive this questionnaire?

The survey was available online from April 23 to June 13, 2007. An e-mail link to the survey was posted to various listservs and mailing lists. 406 respondents answered the question, How did you hear about this questionnaire? Of these, 238 (58.6%) were from the JSWVE subscriber e-mail list; 66 (16.3%) from the BPD listserv; 41 (10.1%) from the SOCWORK listserv; 36 (8.9%) from the JSWVE Board listserv, and 9 (2.2%) from other sources [see Figure 1].


Figure 1
Sample Results
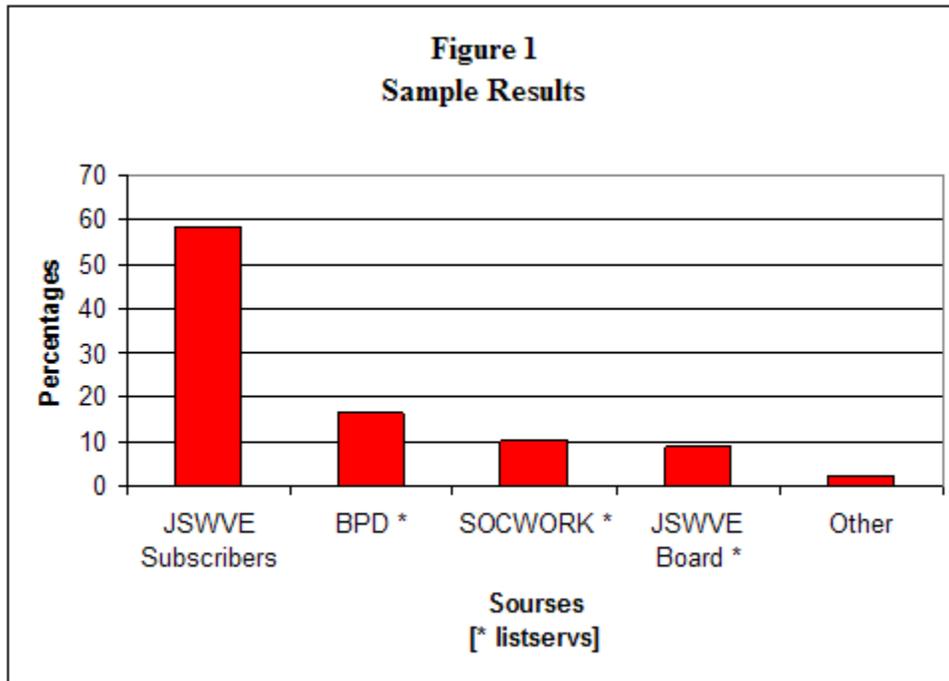
Results

Interest in viewing online interviews with authors was mixed, with approximately 70% favorable. The majority of respondents (69.5%) were interested, with 146 (35.7%) being somewhat interested and 137 (33.6%) responding that they were very interested. About one-third, 30.4%, reported little or no interest [see Figure 2]. (The mean = 2.9, SD .95)

Figure 2
Survey Results
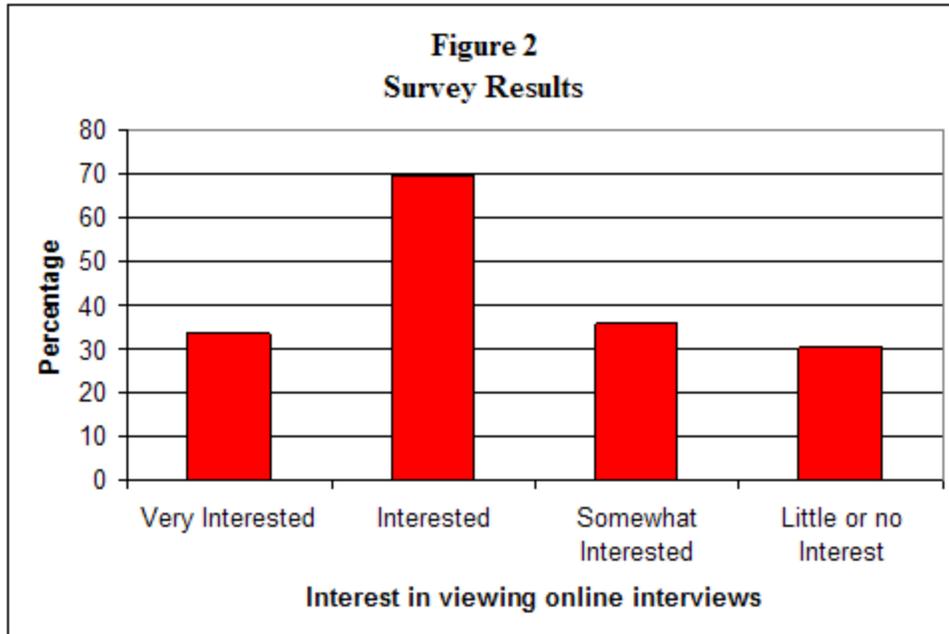
Independent sample t-test was used to test differences in interest between groups of respondents. Members of the JSWVE subscriber e-mail list (`X =3.03, SD=.97) were significantly more interested in online video that the JSWVE Board listserv (`X =2.61, SD=.87) (t (273) -2.24, p<.016.) Members of SOCWORK (`X =3.2, SD=.79) were also significantly higher in interest than the JSWVE Board (t (273) -2.82, p<.006). There were no differences between the JSWVE Board and BPD respondents.

Approximately half of respondents, 203 (50.1%) disagreed that they would read a traditional book review rather than watch a video interview; 145 (35.7%) agreed that they would rather read an interview than watch it; and 14.3% had no preference [see Figure 3]. (Mean =2.82, SD 1.2). There was no difference between respondent groups on this question.

Figure 3
Survey Results
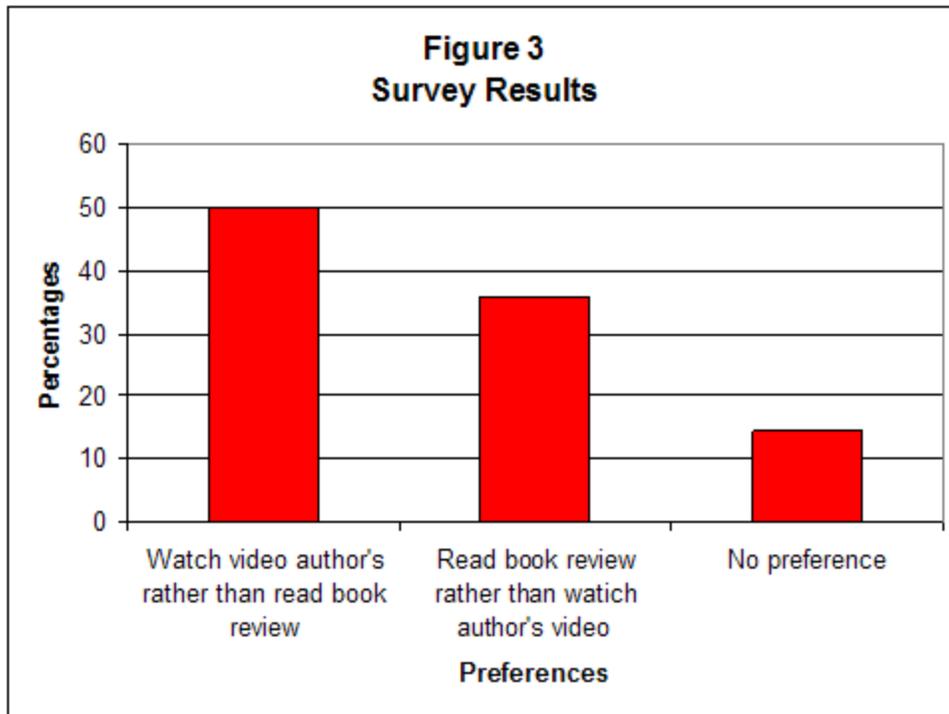
Respondents were asked to check "which are barriers to accessing online video." Approximately half, 206 (50.7%) reported no barriers. The most frequently reported barrier was lack of time to watch videos, reported by 130 (32%) respondents. 63 respondents (15.5%) lacked high speed connection. Lack of interest in watching author interviews was reported by 38 (9.4%). Lack of knowledge does not appear to be a factor for most respondents; only 27 (6.7%) reported this barrier. Approximately 20% of respondents listed more than one barrier. Finally, 29 (7.1%) respondents report a different barrier through an open-ended question. These included: lack of video software, lack of control over which software is installed on the computer, language barrier, need for closed caption, lack of audio, sense that watching a video takes longer than reading a review, convenience and portability of the written word, lack of objectivity by author on video, and "laziness" [see Figure 4].

Figure 4
Survey Results

What are the barriers?
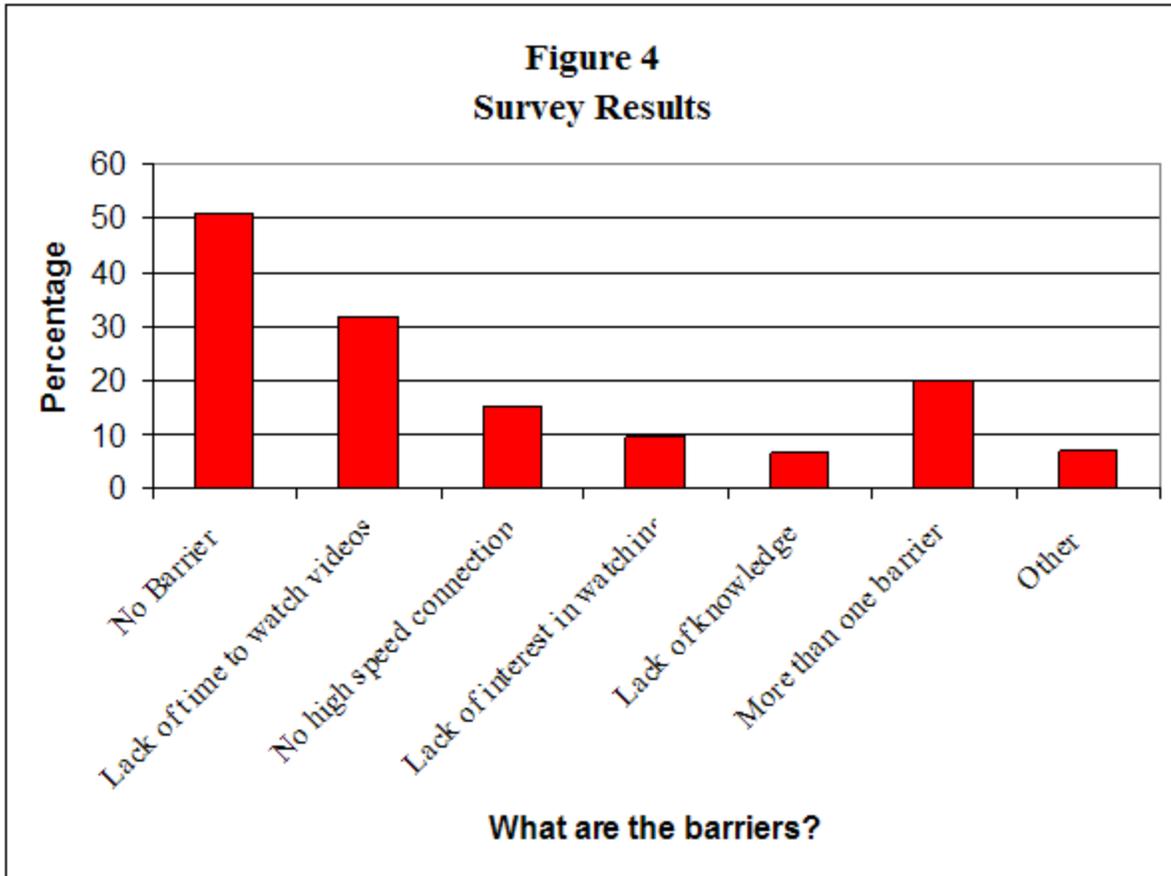
Discussion

An online journal offers new choices in content format for subscribers. One of these new choices is the use of online video to supplement written communication. These new choices, however, require additional resources for the journal, and so decisions about their use should be based on value and interest for readers as well as available resources. An electronic journal also permits greater input from readers through ease of online communication. This brief study polled readers of JSWVE about their interest in having video-based interviews with authors of social work books rather than the more traditional book review format.

The results of the study indicate that a significant portion, about 70%, of respondents would be interested in having video-based interviews available, with one-third being very interested. Given available resources, this level of interest warrants a test period in which video-based interviews are made available online as part of JSWVE offerings. Barriers to viewing videos are not problematic for the majority of users. Clearly, a significant minority of respondents were not interested in online video. For the most part, barriers that were

mentioned were related to lack of time, inconvenience, or lack of interest, rather than to technology-related factors such as lack of high speed Internet access or lack of knowledge about how to view online video. The majority of readers have both the interest and the ability to view online video-based interviews.

The use of an online survey of users is both informative and problematic. First, the survey is likely to have significant sample bias. It is likely that those who are more comfortable with technology and have fewer barriers to its use will be more likely to answer the survey. In addition, those interested in the issue will be more likely to take the survey than those who do not have strong opinions about it. The response rate is very small, given the number of potential responders. For example, only 238 of approximately 2,300 (10%) JSWVE e-mail subscribers and only 66 of approximately 1100 (6%) BPD listserv subscribers answered the survey. The survey is likely not representative of the entire readership, but may represent those most interested in the journal and/or those with better access to technology.

The JSWVE Board will ultimately make the decision about whether to use online video-based interviews with book authors. It is interesting and instructive to note that in this survey the Board is less interested in having online video than the readership. Thus, the Board's perspective may be more conservative on this issue than many who read the journal. This survey will help the Board to more accurately weigh readers' interest and concerns.

Conclusion

This survey of JSWVE readers indicated interest in having online video-based interviews with authors of social work books. The use of an online journal makes it possible to avoid an "either/or" dichotomy. Many readers still prefer to have written reviews of books, since they are perceived as more objective and more convenient to access. Others would like to see an author discuss her/his work in a video-based interview. An online journal allows easy access to both formats. Our survey indicates that there appears to be sufficient interest in having both options online.

Editorial Comment: A Video on Teaching Social Work Ethics

Editorial Video

(Note: Video is no longer available.)

Below is the editorial for Volume 4, Number 2 of *The Journal of Social Work Values and Ethics.* This experimental video was originally the keynote speech presented at the 8th annual Internship Supervisor Certificate Program Workshop on April 20, 2007 at Slippery Rock University (Cranberry, PA). The film was produced by student social workers without professional technical support. Thus, the presentation is FAR from perfect. Based on our survey, we will continue to do video presentations. As time progresses, the quality of this work will improve!

Let me know what you think.

Stephen M. Marson, Ph.D., Senior Editor
Journal of Social Work Values and Ethics

Preparing BSWs for Ethical Practice: Lessons from Licensing Data

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Key Words: Ethics, Licensing, Undergraduate Education, Social Work Profession, Ethics Complaints

Abstract

A continuing challenge for BSW educators is to adapt ethics education to the changing environment of the social work profession and to prepare graduates for ethical challenges they face. Yet, little research has explored the ethical challenges specific to BSW level practice. This article examines ethics complaints submitted to a state licensing board over a nine year period, and comparisons were made between BSW and MSW licensees. The most frequently reported violations for BSWs were related to poor practice, boundary issues, and honesty. The authors indicate that we are generally doing a good job of ethics education and suggest ways in which we may improve ethics education for baccalaureate social work.

1. Introduction

One of the key elements of a profession is a code of ethics to guide member conduct (Reamer, 1998). Consequently ethics education for baccalaureate students is an important responsibility for undergraduate social work educators. Ethics education is considered important enough by the Council on Social Work Education that integration of values and ethics content is required in the social work curriculum (CSWE, 2003) . The Association of Social Work Boards views annual education in ethics as one of six core content areas for demonstrating continued competence in social work (Association of Social Work Boards, 2006) . The National Association of Social Workers (2002) sets standards for continuing professional education that reflect a commitment to professional values and ethics.

A continuing challenge for BSW educators is to adapt ethics education to the changing environment of the social work profession and effectively prepare graduates for the ethical challenges they will face. Ethics and ethical behavior may indeed be one of the important criteria for gate keeping in undergraduate programs (Miller and Koerin, 1998; Moore and Urwin, 1991) . The issue of ethical practice for baccalaureate social workers is increasingly important as state licensing boards have assumed responsibility for regulating the practice of BSWs in thirty-five states (Ginsberg, 2001) by creating codes of ethics or conduct and establishing procedures to adjudicate violations of these codes by licensees.

Knowing just what the ethical challenges are that face baccalaureate social work students may help us to select appropriate students and better prepare them as social workers. Empirical analysis of risk behaviors can also help us to better understand and strengthen both ethical practice (Strom-Gottfried, 2000) and social work ethics education.

To date, there have been three major studies of ethical violations by social workers (Berliner, 1989; McCann and Cutler, 1979; Strom-Gottfried, 2000), and all have used information on NASW members who were found to have violated the NASW *Code of Ethics.* The information learned from these studies and the practical experience of enforcing the *Code of Ethics* have helped the profession to strengthen and modify its ethical code and to keep it relevant for current practice.

Despite the contributions of previous research, the literature offers little information about the ethical risks facing baccalaureate social workers, since the NASW database used contained very low percentages of BSWs (Gibelman and Schervish, 1993). Thus, the findings primarily reflect the behavior of MSWs, and we can only guess whether the ethical issues for BSWs are similar. Yet, we know that there are differences in the level of BSW and MSW practice, differences that could influence ethical challenges and risk (U.S. Department of Labor, 2006).

If we are to provide the best education for baccalaureate social workers, we should prepare them for the realities of the ethical challenges they are likely to face. This study reports on an analysis of ethics complaint data submitted to the Texas State Board of Social Worker Examiners over a nine-year period. The Texas database of licensees contains information on a large number (5,369) of social workers for whom the BSW is the highest reported social work degree. Comparisons are made between the ethical risks for BSW and MSW level social workers for whom the risks are better known, and information from this

comparison is used in framing suggestions to enhance baccalaureate ethics preparation in social work is discussed.

2. Review of the Literature

In a study of ethics complaints filed with NASW, McCann and Cutler (1979) reviewed 154 cases between 1955 and 1977. Thirteen per cent (21) of these cases concerned the client-worker relationship, but insufficient detail was provided to further categorize the nature of what occurred. The authors also reported 10 violations of confidentiality (7%) and eight sexual violations (5%), which may be worker-client related. The relatively low level of worker-client complaints reported by McCann and Cutler may have resulted from the past pattern of reporting cases of agency personnel standard violations, which was much more common in the past than in more recent years. The authors also indicated that the official complaints they examined likely under-reported the actual number of violations because of the broad nature of the *Code of Ethics* (NASW, 1967) in existence during that time period. Subsequent *Code* revisions have expanded the code and provided more specificity (NASW, 1999).

Berliner (1989) also used NASW data to examine 292 cases of ethical misconduct by social workers. The cases reviewed were from 1979 to 1985 and included behavior addressed by the 1979 NASW *Code of Ethics* (NASW, 1979). Twenty percent (19) of the 96 validated complaints were for worker-client violations. Included in the worker-client violations were sexual misconduct (eight cases, or 42%), breaches of confidentiality (six cases, or 32%), fee splitting (three cases, or 16%), and soliciting others' clients (two cases, or 10%).

Strom-Gottfried's (2000) research picked up where Berliner's ended and used NASW data to analyze complaints of unethical behavior from 1986 to 1997. This research reviewed 276 cases in which ethical violations were substantiated. Often, each case contained multiple violations of the *Code*, and she found 785 violations in the cases reviewed.

To facilitate analysis of the violations, Strom-Gottfried (2000) developed a classification scheme based on the literature about ethics violations. Using the categories she developed in this classification, case records were reviewed for content and violations were assigned to one of ten categories composed of related violations. The categories used in this study were: *Violating Boundaries (32.4%), Poor Practice (20.4%), Competence (12.0%), Record Keeping (8.9%), Honesty (6.5%), Confidentiality (5.2%), Informed Consent (4.7%), Collegial Actions (4.2%), Reimbursement (2.9%), and Conflicts of Interest (2.8% of cases).*

Whereas these three studies represent important contributions to understanding the ethically problematic behavior of social workers, this research is of limited value in understanding the ethical behavior of baccalaureate social workers. Each study relied on data from the National Association of Social Workers, and BSW membership in NASW is very low. During the time period reviewed by Strom-Gottfried (2000), BSWs, including regular and transitional members, represented only 4.5% of the NASW membership (Gibelman and Schervish, 1993). During most of the period reviewed by McCann and Cutler, (1979),

BSWs could not be members of NASW, as they were first admitted to membership in 1970 (Popple and Leighninger, 2005). Thus, it is very likely that more than 95% of the violations examined in these studies were by MSWs, not BSWs. However, since prior research on NASW ethics violations is the primary source of empirical information, it does provide a useful context for interpreting the behavior of BSW practitioners.

3. Methodology

This study is based on data collected from the Texas State Board of Social Worker Examiners (TSBSWE) about ethics complaints filed from 1995 though 2003, as this was the most recent period for which consistent data was available. TSBSWE licensed approximately 23,000 social workers at five levels during this period. Three of these levels required a MSW, one a BSW, and one is a pre-professional classification requiring a general bachelor's degree.

The authors' analysis contains information on 594 ethics cases collected from TSBSWE. Each of these cases represents individuals who were reported to TSBSWE for ethics and code of conduct violations during this period. Specific data retrieved included both the licensing law and rules that social workers were alleged to have violated, as well as the social worker's license category, gender, and community of residence. It is common for each complaint of unethical behavior to contain multiple allegations of ethics violations. In this study, the specific alleged violations, not individual social workers, are used as the unit of analysis.

Complaints data from three categories of license are used for comparative analysis to provide a context for the ethical violations reported against BSW social workers. The categories compared are the BSW (LBSW) and two of the Master's degree categories: the general master's license (LMSW) and the LMSW-ACP or clinical license. These comparisons were viewed as most relevant, as previous ethics research on NASW members had primarily reported on the behavior of MSWs, and comparisons between the MSW and BSW groups could possibly identify differences specific to the BSW social worker.

The LMSW is a license for social workers who hold the MSW degree, and the LMSW-ACP is the advanced clinical license (TSBSWE, 2006a). Data from the two additional categories of Texas license, the Social Work Associate (SWA) and the LMSW-AP (Licensed Master Social Worker – Advanced Practice), were excluded from the analysis. The SWA category was excluded because it is a mixed group without relevant professional education, and the LMSW-AP because this category has a low number of licensees.

Information about the alleged ethics violations was collected, evaluated, and coded based on either the TSBSWE Code of Ethics or the Code of Conduct specified in administrative regulations (TSBSWE, 2006a). Neither of these codes matched categories familiar to social workers outside of Texas. The Code of Ethics used by TSBSWE (2006b) is similar to but not identical to the NASW Code of Ethics (1999). Specifically, the TSBSWE code focuses only on behavior related to worker-client relationships. In that sense, the TSBSWE code uses language that is similar, but not identical to the NASW *Code of Ethics*, section 1. TSBSWE also uses additional regulations that define a code of conduct for social workers. The public may file a complaint about suspected violations of either the Code of

Ethics or the code of conduct. The focus of TSBSWE regulations is public protection, particularly protection of clients.

The Texas code of ethics and code of conduct violation data were categorized by the authors using the classification method developed by Strom-Gottfried (2000) in a study of NASW ethics complaints. Strom-Gottfried's classification method was used because the methodology was the most recent and comprehensive study of social work ethics violations reported in the literature.   Although this classification scheme was developed from an NASW database, the categories proved useful in classifying reported ethical violations from the TSBSWE database.   The nine categories of ethics violation used in this study were *violating boundaries*, *poor practice*, *competence*, *record keeping*, *honesty*, *confidentiality*, *informed consent*, *reimbursement*, and *conflicts of interest*. Strom-Gottfried's *collegial actions* category was not used, as this type of behavior is not covered under Texas regulations.   In general, matching Texas violations to appropriate categories (Strom-Gottfried, 2000) was straightforward, although further detail was occasionally needed about the specific wording of the complaint. Several alleged violations that were non-specific and other violations related to specific licensing requirements were too vague and could not be classified. These allegations of violations were excluded from the analysis.

4. Results

Specific ethics complaints that were reported to TSBSWE resulted in 1,272 allegations of unethical social work behavior for the three types of license used for comparison in this analysis. Specific allegations of unethical behavior were used as the unit of analysis. Because data on confirmed cases of ethical violations were not available for study, the analysis was based on alleged behavior. The allegations of unethical behavior varied among very specific behaviors like *practicing without a license* or *having sexual relations with a client* to vague reports of *unethical conduct* or *conduct discrediting the profession*.

Descriptive information on reported unethical behavior was analyzed within each license category, resulting in percentages for each category of violation. The BSW licensees were compared with MSW licensees and with the MSW clinical licensees to look for evidence of similarities and differences among the groups. The two MSW categories were broken out separately based on their different qualifications and the assumption that these groups might tend to be engaged in different types of practice activities.

In analyzing the ethics violations, simple percentages are used for comparison purposes across categories. Given the nature of the data and the unit of analysis (the specific complaint), simple tests of statistical significance between the license categories could not appropriately be used. Tests of statistical significance are based on the assumption that each observation is independent, which is not true with this data. Frequently, there were multiple reports of violations for a single individual, often for the same set of behavior. The assumption that the data points are independent is not valid. Thus, the comparisons reported are descriptive and should be interpreted with caution. Yet, since this research represents an exploratory step in examining BSW ethical behavior, the observable differences between BSWs and MSWs may prove useful in guiding future

research and in shaping the educational preparation of undergraduate students in social work ethics.

Descriptive information about the social workers against whom complaints were filed may be seen in Table 1. Of the complaints filed, 76 were against social workers licensed at the BSW level. Sixty of these social workers (78.9%) were female, and sixteen (21.1%) were male. At the MSW level there were ethics complaints filed against one hundred seven social workers, seventy-nine (73.9%) of whom were female and twenty-eight (26.1%) were male. The highest incidence of complaints was against social workers licensed at the clinical level with two hundred forty. One hundred sixty-four (68.3%) of the complaints against clinical licensees were against females and seventy-six (31.6%) against males. Ninety-one and one-half percent of the complaints were filed against social workers who lived in urban communities and 8.5% against licensed social workers in rural communities. The proportion of BSW level social workers in rural counties is approximately double the statewide average. The data indicated that 44.7% of the ethics complaints in rural communities were against BSW level social workers and that the most frequently reported type of complaint was for poor practice (Daley and Doughty, 2006).

TABLE 1

DESCRIPTIVE CHARACTERISTICS OF SOCIAL WORKERS

REPORTED FOR ETHICS VIOLATIONS

License Category

BSW	76
MSW	107
MSW-ACP	240

Gender

	Male		Female	
BSW	16	21.1%	60	78.9%

MSW	28	26.1%	79	73.9%
MSW-ACP	76	31.6%	164	68.3%

Residence

	Pct. of Licensees	Complaints
Urban	90.7%	91.5%
Rural	9.3%	8.5%

Analysis of complaint data reveals that 18.2% (231) of the allegations of unethical behavior were lodged against social workers licensed at the BSW level. At the time the data was collected, Texas had 5,369 (26.8%) of its licensees in the BSW category. The ethics complaint rate is only 0.4 % per year, but each individual who was reported was alleged to have committed an average of 3.03 violations. Twenty-three and three tenths percent of the complaints (297) were lodged against licensees in the MSW category. This category had 8,082 licensees, and complaints averaged 2.78 violations. Fifty-eight and five tenths percent (744) of the complaints were against clinical social work licensees. There were 7,343 licensees in this category, and complaints alleged an average of 3.1 violations.

Results of the comparison between BSW and MSW licensees are reported in Table 2. This table indicates that BSW social workers had higher complaint rates for *poor practice* (25.9% vs. 20.9%) and *record keeping* (6.1% vs. 2.4%) than their MSW counterparts. The MSW licensees had higher complaint rates for *honesty* (21.9% vs. 16.4%) and *confidentiality* (7.7% vs. 3.5%) than the BSWs. Otherwise, the BSW and MSW social work complaint profiles appear to be similar.

TABLE 2

ETHICS COMPLAINTS: BSW-MSW COMPARISON

	BSW		MSW	
Category	N	Pct	N	Pct
Boundary Issues	39	16.9%	50	16.8%
Poor Practice	60	25.9%	62	20.9%

Category	N	Pct		N	Pct
Competency	21	9.1%		27	9.1%
Record Keeping	14	6.1%		7	2.4%
Honesty	38	16.4%		65	21.9%
Confidentiality	8	3.5%		23	7.7%
Inform. Consent	14	6.1%		12	4.0%
Billing	13	5.6%		14	4.7%
Conflict of Inter.	24	10.4%		37	12.5%
Total	231	100.0%		297	100.0%

Table 3 reports the results of the comparison between BSW and MSW clinical licensees on alleged ethics complaints. Results of this comparison indicate that the greatest differences between the two groups were that BSWs had a higher complaint rate for *poor practice* (25.9% vs. 21.4%) and h*onesty* (16.4% vs. 9.3%) than clinical social workers, and clinical social workers had higher rates of complaints for *boundary issues* (24.6% vs. 16.9%) and *confidentiality* violations (12.2% vs. 3.5%) than BSW licensees. In other categories of alleged complaints, the profiles of BSWs and MSW clinical social workers were similar.

TABLE 3

ETHICS COMPLAINTS: BSW-MSW CLINICAL COMPARISON

	BSW		MSW Clinical	
Category	N	Pct	N	Pct
Boundary Issues	39	16.9%	183	24.6%
Poor Practice	60	25.9%	159	21.4%
Competency	21	9.1%	52	7.0%
Record Keeping	14	6.1%	39	5.2%
Honesty	38	16.4%	69	9.3%
Confidentiality	8	3.5%	91	12.2%

Inform. Consent	**14**	**6.1%**		**35**	**4.7%**
Billing	**13**	**5.6%**		**36**	**4.8%**
Conflict of Inter.	**24**	**10.4%**		**80**	**10.8%**
Total	**231**	**100.0%**		**744**	**100.0%**

5. Discussion

Information from this analysis of ethical complaints to the Texas State Board of Social Worker Examiners can assist us in strengthening the preparation of undergraduate students for ethical social work in assessing educational gate keeping procedures and in guiding future research on ethical practice. Whereas the results of analysis are descriptive and should be interpreted with some caution, better understanding of ethical behavior at undergraduate level may suggest ways in which we may more effectively shape the educational preparation for the actual types of ethical problems that BSW social workers face. Through better understanding the areas of ethical risk for BSW social workers, we may adjust the preparation to address the areas of highest risk.

There are several conclusions that we may draw from this study, including the knowledge that we may be doing something right in preparing BSW social workers for ethical practice. With an annual report rate of only 0.4% for alleged ethics infractions, not confirmed findings, our data suggest that unethical behavior among licensed BSWs does not appear to be widespread. As a result, the ethics education we provide our students may only need some fine tuning to address areas of high risk.

Although the rate of complaints for ethical infractions for BSWs is low, we should remember that all alleged ethical infractions are potentially quite serious. There are several specific areas of behavior that should be examined to best prepare BSWs for ethical practice. The most frequently reported unethical behaviors for BSW social workers were *poor practice* (25.9%), *boundary issues* (16.9%), and *honesty* (16.4%). Almost sixty percent of the ethics complaints fell into these three categories.

The *poor practice* category includes basic practice related activities in the provision of direct services, from initial contact to assessment, through termination. Reports in this category were consistently higher for BSWs than for either of the MSW categories. This may indicate a need for more attention to this aspect of ethics in baccalaureate education. The *poor practice* category reflects either direct acts or omissions by the social worker that fall outside of a reasonable standard of practice. The majority of complaints in this category were of a general nature, but the category also included specific reports of failure to meet accepted practice standards, such as inappropriate treatment methods, not respecting self-determination, derogatory treatment of a client, and inappropriate termination (either premature or prolonged). For example, social workers who terminate services prematurely or without appropriate follow up and social workers who deliver services in areas for which they are not adequately prepared may be at risk for this type of violation. Poor practice suggests a poor match of knowledge and skills with the needs of the client, which some

might term competence. However, in the classification method that was used in this study, the behavior was captured as poor practice, since the competency category tended to reflect impairment.

Reports of *boundary violations,* including sexual and dual relationships, constituted almost one-sixth of the ethics complaints against BSWs.   This rate of reporting is essentially the same as for the MSWs licensees and actually lower than that for the MSW clinical category. Interestingly, two-thirds of the boundary violations for BSWs are for dual relationships. The dual relationships include personal, financial, and exploitive relationships of a non-sexual nature.

Allegations of *honesty* violations, which represent either fraudulent actions or intentional misrepresentations of information, were the third most frequently reported ethics violation for baccalaureate licensees. Specific examples of *honesty* complaints included falsifying or encouraging clients to falsify records and misrepresentation of credentials. This category of complaint was alleged more frequently for BSWs than for the MSW clinical licensees, but was made less frequently for the BSW than for the MSW licensees.

Baccalaureate social workers were also reported much more frequently than MSWs for *record keeping* violations. *Record keeping* violations included both the failure to keep accurate records and/or withholding records from clients. However, the proportion of total reports was low at only six percent. Given the educational difference between BSW and MSW social workers, some of these problems may relate to writing skills in that BSWs may have more difficulty in keeping clear and accurate case records.

Interestingly, reports of *confidentiality* violations by BSW licensees were made at a much lower rate than for either of the MSW categories. Only three and a half percent of the BSW reports related to confidentiality, as opposed to 7.7% for the MSW and 12.2% for the MSW clinical social workers.

The analysis suggests that job functions of the BSW may vary from those of the MSW in ways that create a differential risk in regard to ethical challenges. Without specific job data, we cannot say specifically what these differences are for the BSWs in our population, but there do tend to be differences between what BSW and MSW social workers do in terms of job function and areas of practice (Center for Healthy Workforce and NASW Center for Workforce Studies, 2006b; Gibelman and Schervish, 1993; US Department of Labor, 2006). BSWs are more likely to be involved in direct service and in areas of practice such as public assistance, working with the aged, and developmental disabilities than their MSW counterparts, who are more likely to work in a mental health field (Gibelman and Schervish, 1993).

These job related differences may translate into differential ethical risk factors for social workers. The risk profiles contained in Tables 2 and 3 indicate that the risk profiles of BSWs and MSWs have more in common with each other than either has with the MSW clinical group. The tendency is for BSWs to have a higher rate of employment in public agencies (Gibelman and Schervish, 1993), and this may affect the types of cases they handle, the socioeconomic status of their clients, their job function, and their ethical risk. If, for example, social workers work in highly structured employment settings, such as public agencies, where there are likely to be more formal rules about handling confidential information, perhaps the risk of confidentiality violations is reduced. Employment in public settings may mean social workers have more involuntary clients, and the risk for complaints about either poor practice or honesty might be expected to be elevated. In addition, since

MSW level social workers tend to be more likely to be employed in supervisory and management positions with less direct client contact (Gibelman and Schervish, 1993), they would be less likely to be reported for some types of violations related to direct services.

6. Conclusion

To better understand ethical risks specific to the baccalaureate social worker, this study examined reports of unethical behavior made to the Texas State Board of Social Worker Examiners. Although the results provide some interesting data on those risks, they should be interpreted with some degree of caution. Since the data used in this study are drawn from only one state, the ability to generalize from their findings is limited, and some of the findings may be idiosyncratic to Texas, as the legal regulation of social work differs from state to state (Strom-Gottfried, 2003). Since the Texas data did not reflect whether MSW licensees also had BSW education, there is the additional possibility that these groups may be entirely independent. In other words, knowledge, values, and behaviors learned at the BSW level could continue to play an important role in the behavior of MSW social workers. It is also possible, given the time span of this study, that a BSW cited for ethics violations could be the same MSW cited for violations some years later. There is nothing in our data that would indicate this and allows us to control for it.

Because this population of licensed social workers includes proportionately more BSWs than is reflected in previous research based on NASW members, it is useful for examining ethical behavior specific to BSW social workers. Because of the nature of the data, it could only be reported descriptively, and the significance of the differences that were observed may be illuminated by future research, and the differences reported here are comparative tendencies that may suggest future courses of action. It should also be remembered that the ethical complaints used are just that-- reports--and that some are unfounded. But, these reports do provide a good perspective on what the public believes to be the unethical behavior of social workers, and all are potentially serious in that they represent violations of the worker-client relationship that could undermine public trust in the profession.

Acknowledging the limitations of the study, what conclusions can we draw, and how could we strengthen what we teach undergraduate students about the ethical practice of social work? Whereas there are two areas of ethical risk, boundary and confidentiality violations, that are commonly understood as important subjects for ethics education, there appear to be additional aspects of professional practice identified in this study that are important to consider in baccalaureate education. The areas of poor practice and honesty are two of the three most frequently reported areas of ethics violation that were identified, but these aspects of practice do not appear to be cited frequently in the ethics literature. Thus, poor practice and honesty may not be especially emphasized in BSW education or continuing education as ethical issues.

It appears that the greatest ethical risk for baccalaureate social workers lies in the area of poor practice. These are situations in which the social worker inappropriately applies professional knowledge and skill or lacks the appropriate knowledge and skill to meet client needs. An example of this type of behavior might be a social worker attempting to provide

therapeutic interventions for which the social worker has not received appropriate training. Perhaps, in these situations, the BSW social worker is involved in services beyond his or her expertise and is reluctant to ask for consultation or supervision or to refer for services. The effective use of supervision may be more important for BSW level workers, as they average less experience than their MSW counterparts (Center for Healthy Workforce Studies and NASW Center for Workforce Studies, 2006a). Ethics education should reinforce methods to achieve quality service and to act appropriately in providing services in areas outside of the worker's strength or competence.

Risks associated with failure to seek appropriate supervision, consultation, or to make referrals may be heightened by contextual factors, such as physical distance from or access to a supervisor, issues frequently confronted in rural social work (Daley and Doughty, 2006). In a previous study based on this data, the authors found that 54.3% of the rural social workers in Texas who were licensed were at the BSW or pre-professional level. In addition, the greatest differences between rural and urban social workers were in the poor practice category (Daley and Doughty, 2006). Given the high concentrations of BSWs (Daley and Avant, 1999) and the continuing demand for social workers in rural areas (US Department of Labor, 2006), it appears that educational programs may need to examine how they address both the quality of practice and use of supervision for BSWs who are likely to practice in rural areas.

Ethics complaints alleging poor practice may also result from the characteristics of the clientele seen by BSWs. Given the greater tendency for BSWs to work in public settings and the possibility of work with involuntary clients, the likelihood for client dissatisfaction and complaints is higher. Poor practice may also be a function of the amount of social work experience, as we might expect social workers with fewer years of supervised experience to have practice skills that are less well developed than experienced workers. Unfortunately, the database for this research did not contain information on the social worker's field and type of practice or amount of practice experience that would have helped us explore these issues further.

From an educational standpoint, one way to address the risks associated with poor practice is to reinforce the need to use supervision and consultation effectively. Supervision and consultation may help workers to avoid ethical concerns in service areas outside their areas of strength and may help to prevent some types of complaints from disgruntled clients. The NASW *Code of Ethics* guides social workers to use supervision and consultation in areas of practice that are new to them as a means of providing the best service to clients (NASW, 1999). Dolgoff, Loewenberg, and Harrington (2005) indicate that consultation is essential to ethical social work, and Reamer (1998) says that able supervision improves the quality of social work services. Issues related to the effective use of supervision and consultation from distant sites may be needed.

Boundary violations are a second area of ethical risk to be addressed. Ethics education currently in place likely covers boundary violations already, particularly sexual relationships, because of the seriousness of these violations. But we should also be attuned to the fact that dual relationships are a more likely source of risk for baccalaureate social workers. Violation of appropriate boundaries in dual relationships may also represent a serious breach of the worker-client relationship that is less obvious, as engaging in business relationships, personal relationships, and exploiting clients can prove equally damaging. Social workers in rural areas appear to be at the greatest risk for dual relationships (Miller, 1998; NASW, 2003; Strom-Gottfried, 2005), as social workers have greater opportunity for non-professional contact with clients in smaller communities. Whereas there may be higher

concentrations of BSWs in rural areas (Daley and Avant, 1999), the critical issue for practice is appropriate management of dual relationships (Galbreath, 2005) rather than entirely avoiding the opportunity for them. Developing ethics education that emphasizes strategies to identify and manage dual relationships could prove valuable preparation for undergraduate practice.

Honesty is another area of ethics education where we may look to improve the ethical preparation of BSW social workers, and this is a complex concept. Often honesty related complaints involve the accuracy of written records. Strengthening of student preparation in writing, accuracy of recording, and timely record keeping may be an important aspect of the educational process to consider in this regard. Indeed, accurate and detailed records are often one of the best protections against ethics allegations and liability claims that a social worker can have. But altering records or misrepresentation of information in records represent potentially serious problems that can negatively affect clients and public trust in the profession.

Another aspect of honesty may relate to maintaining appropriate professional limits and boundaries when acting as a client advocate. In agencies where there are strict bureaucratic requirements to receive services, there is often a need for social workers to act as client advocates and reframe information to get essential services. In this type of advocacy, social workers must make decisions about how to reframe client information and what information to omit. Shaping information too much, even with good intentions, may be perceived as dishonesty. One way to address this issue is to address setting appropriate professional limits when teaching students about advocacy.

Undergraduate programs must pay attention to both who they teach and what they teach, and this study may have implications for the gate keeping procedures used to screen students for suitability as social work students. This study suggests that programs would be well served, at least from an ethics perspective, to review their gate keeping procedures to insure that they screen students for issues related to potential practice competence, boundaries, and honesty. The results reported here may suggest ways of fine tuning gate keeping procedures to screen out students who are inappropriate for the profession.

We hope that this research has added to our understanding of the ethical risk factors for BSW social workers. This understanding can help to strengthen both the methods and content that we deliver to BSW social workers and students to prepare them to practice ethically. This research is exploratory but does raise some additional questions about ethical challenges faced by baccalaureate social workers for future research. An important question is whether the differences in ethical complaint profile between BSWs and MSWs are significant or just serendipitous. We know that there tend to be differences in the practice of baccalaureate and master's level social workers, and these differences may present varying issues of ethical risk. Additional studies of the unethical behavior of baccalaureate social workers may help to may shed light on this issue.

Important considerations for future research might be to explore the relationship between the type of violations, educational level, the social worker's gender, professional experience, field of practice, rural or urban residence, and job responsibilities. This type of analysis could add much to our identification of a profile for ethical risk. Another important research question centers on the clustering of ethics complaints. We know that social workers tend to be reported for multiple violations. The composition of the factors that make up these complaints could tell us more about the offending behavior. For example, do

boundary and competency issues tend to be reported together? Since ethics is such an important aspect of preparing professionals for social work practice, future research may add considerably to our understanding of the kinds of ethical challenges and risks for which we need to prepare baccalaureate social workers.

References

Association of Social Work Boards. Model social work practice act. Retrieved March 15, 2006, from http://www.aswb.org/Model_law.pdf , 36-38.

Berliner, A. (1989). Misconduct in social work practice [Briefly Stated]. Social Work, 34, 69-72.

Center for Healthy Workforce Studies & NASW Center for Workforce Studies. (2006a). *Who are licensed social workers?* Ch. 2, Retrieved February 19, 2007, from

http://workforce.socialworkers.org/studies/supplemental/supplement_ch2.pdf

Center for Healthy Workforce Studies & NASW Center for Workforce Studies. (2006b). *Who are licensed social workers?* Ch. 3, Retrieved February 19, 2007, from

http://workforce.socialworkers.org/studies/supplemental/supplement_ch2.pdf

Council on Social Work Education (2003). *Handbook of accreditation standards and procedures*, 5th ed. Alexandria, VA: Author, 34.

Daley, M. R., & Avant, F. (1999). Attracting and retaining professionals for social work practice in rural areas: An example from East Texas, in *Preserving and strengthening small*

towns and rural communities (335- 345), Iris B. Carlton-La Ney, Richard Edwards, and P. Nelson Reid, eds., NASW Press: Washington, DC.

Daley, M. R., & Doughty, M. O., (2006). Ethics complaints in social work practice:

A rural – urban comparison, *Journal of Social Work Values and Ethics, 3*, (1).

Dolgoff, R., Loewenberg, F. M., & Harrington, H. (2005). *Ethical decisions for social work practice*, 7th ed. Belmont, CA: Thomson, 187.

Galbreath, W. B. (2005). Dual relationships in rural communities. In Lohman, R. & Lohman, N. (Eds.), *Rural social work practice* (pp. 107). New York: Columbia University Press.

Gibelman, M., & Schervish P. H. (1993). *Who we are: The social work labor force as reflected in the NASW membership*. Washington, DC: *NASW Press*, 41, 91.

Ginsberg, L. H. (2001). *Careers in social work.* 2nd ed. Needham Heights, MA: Allyn & Bacon, 245-251.

McCann, C. W., & Cutler, J. P. (1979). Ethics and the alleged unethical. *Social Work, 24*, 5-8.

Miller, J., & Koerin, B., (1998). Can we assess suitability at admission? A review of MSW application procedures. *Journal of Social Work Education, 34*, 1.

Miller, P. J., (1998). Dual relationships in rural practice: A dilemma of ethics and culture. In Ginsberg, L. (Ed.), *Social work in rural communities* (pp.55), 3rd ed. Alexandria, VA: Council on Social Work Education.

Moore, L. S., & Urwin, C. A. (1991). A model for screening baccalaureate

students for field education. *Journal of Social Work Education, 27*, (1).

National Association of Social Workers. (1967). *Code of ethics of the National Association of Social Workers*. Washington, DC: Author.

National Association of Social Workers. (1979). *Code of ethics of the National Association of Social Workers*. Silver Spring, MD: Author.

National Association of Social Workers. (1999). *Code of ethics of the National Association of Social Workers*. Washington, DC: Author.

National Association of Social Workers. (2002). *NASW standards for continuing professional education*. Washington, DC: Author.

National Association of Social Workers. (2003). Rural social work. In *Social work speaks* (pp. 301)*.* Washington, DC: Author.

Popple, P. R., & Leighninger, L. (2005). *Social work, social welfare and American society*. Boston: Pearson, Allyn and Bacon, 87.

Reamer, F. G. (1998). *Ethical standards in social work: A critical review of the NASW code of ethics*. Washington, DC: NASW Press, 1, 178.

Strom-Gottfried, K. (2000). Ensuring ethical practice: an examination of NASW Code violations, 1986-97*. Social Work, 45*, (3), 251-261.

Strom-Gottfried, K. (2003). Understanding adjudication: origins, targets, and outcomes of ethics complaints. *Social Work, 48*, (1), 86.

Strom-Gottfried, K. (2005). Ethical practice in rural environments. In Ginsberg, L. (Ed.), *Social work in rural communities* (pp. 148), 4th ed. Alexandria, VA: Council on Social Work Education.

Texas State Board of Social Worker Examiners. Title 22 Texas Administrative Code, Part 34, Chapter 781, Subchapter C, Rule 781.301, Retrieved March 15, 2006, from

http://info.sos.state.tx.us/pls/pub/readtac$ext.ViewTAC?tac_view=5&ti=22&pt=34&ch=781&sch=C&rl=Y

Texas State Board of Social Worker Examiners. Title 22 Texas Administrative Code, Part 34, Chapter 781, Subchapter D, Rule 781.401-781.411, Retrieved March 15, 2006, from http://info.sos.state.tx.us/pls/pub/readtac$ext.ViewTAC?tac_view=5&ti=22&pt=34&ch=781&sch=D&rl=Y

US Department of Labor Bureau of Labor Statistics. Occupational outlook handbook. Retrieved February 8, 2006, from http://www.bls.gov/oco/ocos060.htm .

JSWVE Student Term Paper Contest 2007

The winners were selected based on the paper's critical analysis of social work ethics and values, thorough review and incorporation of the literature, the overall quality and organization of the paper, and the perceived educational value to the reader. We wish to extend our warmest congratulations to the top three winners:

- *First place:* Amber McGuigan, Catholic University of America. The social worker as shopper: applying a model for ethical decision making to a dilemma in resource management. This paper focuses on an ethical dilemma related to whether nonprofits should shop for goods and services with socially responsible companies even if doing so reduces the budget for direct services.
- *Second place:* Leslie Green, Simmons College. Social work ethics and values considered in the case of a 15-year old leukemia patient facing peripheral blood stem cell transplantation. This paper focuses on issues common in pediatric medical social work including the constant reconsideration of who to define as the primary client, the collaboration and negotiation needed when working on a medical interdisciplinary team, and the legally-defined medical decision-making rights of a minor.
- *Third place:* Andrea B. Bauman, University of Wisconsin, Milwaukee. The value of the incompetent: Application of social work values. This paper focuses on the social work commitment to the rights and dignity of all people. The paper describes the application of social work ethics and values at the macro-level, in an exploration of policy formulation through the inclusion of persons with intellectual and developmental disabilities in the state of Wisconsin.

As social work educators, we are gratified at the content and quality of the work in these papers. We are sure that they will be of interest to you and to your students in further examining the ways in which social work values and ethics are fundamental to our practice.

Jerry Finn, Ph.D., Co-Editor
The Journal of Social Work Values and Ethics

The Social Worker as Shopper: Applying a Model for Ethical Decision Making to a Dilemma in Resource Management

Amber McGuigan, MSW

Sponsored by Professor Ann P. Conrad of the Catholic University of America

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Key Words: ethical decision making; social work management; resource allocation; client well-being; social responsibility

Abstract

This paper applies the steps of an ethical decision making model for social work to a management situation involving resource allocation in a nonprofit organization. The ethical dilemma is presented by way of a hypothetical case study, in which a social worker's responsibility to clients is in conflict with the worker's responsibility to society.

1. Introduction

In their 1994 article, [Applewhite and Joseph](#) apply an ethical decision making model for social work to a clinical practice situation involving self-harming clients. The purpose of this paper is to apply the steps of their model to a management situation involving resource allocation in a nonprofit organization. The present analysis is applied to an ethical dilemma, presented by way of a hypothetical case study, in which a social worker's responsibility to clients is in conflict with the worker's responsibility to society. Following Applewhite and Joseph's model, this paper will discuss the following: relevant literature, the role and rank of relevant values and principles, personal biases, the relative merits of various options, a chosen ethical position, and strategies for implementation. Although the case example used is in the field of nonprofit management, this paper is primarily concerned with a social worker's ethical obligations, not techniques of effective management. Whereas in actuality social work managers must weigh carefully their responsibilities to staff members and boards as well as to clients and the broader society, this paper will focus on the particular ethical conflict between client well-being and social responsibility.

A social worker was recently named executive director of a small community-based nonprofit organization serving immigrant families who have left their home country primarily as a result of war, extreme poverty, or oppressive labor conditions. The agency provides case management, therapy, childcare, food and clothing, referrals, and transportation to agency programs and outside appointments. It is the only agency of its kind in the area and receives funding from the government, philanthropic foundations, and churches.

For the length of the social worker's employment at the agency, there has been an implicit agency policy of socially responsible shopping. Food for the childcare program, as well as office furniture and supplies, are purchased from a local fair trade co-op, and gasoline is purchased only from a company that participates in human rights agreements.

In recent months, the community has experienced a rapid increase in immigration, raising the demand for services. The social workers, who have already increased their work hours, suggested that the agency hire a part-time social worker to take on additional cases, and expand childcare facilities by converting storage space.

The volunteer board of directors has been looking into possibilities for expanding services. Some board members have suggested that the agency could significantly cut costs by buying gas from a cheaper supplier and getting all food, office supplies, and additional furniture required for the expanded childcare room from the cheapest retailer. In addition to freeing up current funds, they argue that such measures would increase the agency's cost-benefit ratio, enhancing its competitiveness for future funding. The board is split on the issue. Having a high level of trust in the professional opinion of the executive director, they have requested she submit a statement of her recommendation.

The social worker sees the decision before her as an ethical dilemma. She recognizes not only the current potential to serve more members of the community who are in need, but also the agency's need to achieve increasing levels of efficiency for donors. She is also aware that the cheaper retailer has had verified accusations of child labor, hazardous working conditions, and low wages, and that the only cheaper gas company hires paramilitary groups with histories of human rights abuses to provide security at its foreign plants. She sees a direct connection between such practices and the previous life circumstances of the agency's clients.

In essence, the social worker is faced with a conflict of responsibilities. There is a clear responsibility to manage resources efficiently and to provide services for the client base, but agency employees are in agreement that there is also a responsibility to the broader society, particularly to challenge social injustice and promote the well-being of those around the world who are at risk for oppression and maltreatment.

2. A Review of Consumer Responsibility Ethics for Nonprofits

2.1 Responsibilities of Nonprofit Agencies

Although attention to Corporate Social Responsibility (CSR) has been steadily increasing since at least 1989 (Kapstein, 2001), there is no apparent literature on the issue of whether nonprofit organizations should take CSR into account in their purchasing decisions. An extensive abstract keyword search of several major nonprofit journals, as well as diverse databases, revealed a wealth of articles on relevant topics, but none on this ethical issue. While the absence of literature on this topic presents challenges for analysis, discussion of related issues sheds light on its complexity.

In their study of nonprofit executives, Jurkiewicz and Massey (1998) found that a preference and capacity for ethical reasoning was associated with leader effectiveness in nonprofit organizations. The authors claimed that a perception of ethical practice on the part of the board and director is critical to both public trust and donor support. In this situation, the social worker is asked to fill an ethical leadership role, as well as the role of advisor to the board of directors, whose responsibility to ensure sound financial management in agencies is widely recognized (Inglis, Alexander, & Weaver, 1999) .

The motivation for cutting program costs is described as two-fold: maximizing current client services and ensuring funds for the future; however, these can be treated together in discussion because what donors expect is precisely that client services will be maximized with given funds. There is no shortage of evidence for the necessity of proving

organizational efficiency in order to maintain support. Commentators frequently note that nonprofits are under intense pressure due to the combination of increasing competition for grants, declining government funds, business savvy donors who demand measurable outcome achievements, and expectations of enhanced performance with low costs (Hodgkinson & Nelson, 2001; Moxley & Bueche, 2002; Alexander, 2000).

As the ethical dilemma illustrates, survival in this type of environment can preclude decision-making based solely on agency values. Lindenberg (2001) has suggested that the value-based culture of the nonprofit sector is often in conflict with the demands of the new business model. He firmly asserts that NGOs that fail to "adapt their strategies and promote greater impact, efficiency, and accountability" will not survive, despite their "good intentions" (p. 248). Efficiency is generally conceptualized in cost-benefit terms (cost per client or cost per service), so expanded services and lower program costs are clear goals. Accountability and impact can be harder to grip. Koppell (2005), in his discussion of "Multiple Accountabilities Disorder," claimed that organizations are operating under demands for various types of accountability, and that it is impossible (and unhealthy) to attempt to fulfill them all. In a simple statement of accountability, he stated that it "reflects the ideal relationship among leaders, contributors (living and dead), the community, and society" (Five Dimensions section, para. 2).

The nonprofit's relationship to the broader society is central to this ethical analysis, and there is some support in the literature for the possibility of including impact on society (through responsible shopping) in an evaluation of agency effectiveness. For example, Richmond, Mook, and Quarter (2003) discussed two models of social accounting that include the effect of agency services on non-clients. In a study of nonprofit adaptation, Alexander (2000) found that organizations often expanded their mission or client base as a strategy to attract more funds. In the case under discussion, the agency could potentially work consideration of foreign workers into its mission. The risk here, as Alexander's study subjects revealed, is of alienating donors who are faithful to the current mission.

2.2 Socially Responsible Consumer Behavior

The literature discussed thus far clarifies the dilemma in terms of risks and possibilities regarding budget allocations. A separate issue requiring investigation is the meaning, purpose, and effectiveness of socially responsible consumer behavior (SRCB). Analysts and commentators are in agreement that the rising focus on CSR has forced corporations to take ethics into account and to prove ethical conduct in order to stay competitive; several have noted that SRCB is often viewed as a more effective tool for addressing social injustice than petitioning the government (Kapstein, 2001; Springen & Miller, 1991; Muldoon, 2006; Mohr, Webb, & Harris, 2001 ; Hertz, 1999) .

This recognition of success is usually tempered, however, by skepticism that pressure results in only superficial marketing ploys, or in real changes with significant negative side effects. Kapstein (2001) has questioned whether the CSR "crusade" has the capacity to effect positive change in the lives of workers, because of what he perceives as Western ethnocentrism and the difficulty of operating a firm under intense pressure. Kapstein offered the case of Nike's decision to not employ anyone under 18, to avoid accusations of child labor, which he claimed forced poor Asian young people (who finish school well before that age) to seek less desirable employment. He also noted that monitoring procedures employed by corporations are often severely inadequate.

Even if SRCB is taken as effective and feasible, it must be recognized that, as one shopper out of millions, it is nearly impossible for a small agency to change corporate behavior on its own. However, an interesting theme that occurs in the literature is that of responsible shopping as a civic duty. As previously noted, some view SRCB as more effective than government involvement. Hertz (1999) suggested that in Britain, shopping replaced voting as the primary form of civic engagement. Muldoon (2006) asked the logical question, "Can product choice be reframed as another arena for participatory democracy?" In response, she quoted Jeremy Rifkin's affirmation that by doing so "we assure our responsibilities as active participants in the decisions that affect the future course of our society, civilization, and ultimately, the planet" (All by Myself section, para. 4).

The last relevant question concerning SRCB that the literature addresses is how to set a standard of adequacy. If the agency decides to make an explicit policy in favor of SRCB, how would it distinguish a responsible company? Mohr et al. (2001) noted that information can be a stumbling block to SRCB, because most people are ignorant about the companies from which they buy. To address this problem, several groups have developed CSR rating scales. For example, the RepuTex Social Responsibility Rating System includes measures of the following categories: corporate governance, workplace practices, social impact, and environmental impact (Grossman, 2004). The problem with this system has been illustrated by Muldoon (2006): any given corporation may score high in some areas and low in others. Purchasing from fair trade distributors may seem safe in this way, since social responsibility is their central mission; however, there are some groups, such as the education group Worldwrite, who contest that fair trade certification fails to make any significant difference in the income of the poor (Das-Gupta, 2005).

3. Ethical Framework for Consumer Responsibility for Nonprofits

3.1 Salient Values and Ethical Principles

Investigation of this dilemma surfaces quite a few relevant values and ethical principles. The general values derived from society are well-being, efficiency/stewardship, justice, and

integrity. This dilemma can be viewed as a choice between increasing the well-being of clients or of non-clients. Since well-being is a value intended for all people, this is a conflict. Efficiency is highly valued in American society, so cutting costs and serving more clients can be viewed as upholding efficiency and being a responsible steward of donated resources and taxpayer dollars. The elements of justice most salient in this situation are fair terms of trade and just labor conditions for workers, values we uphold with domestic and international laws. Lastly, the value of integrity is important to those in management positions. Integrity in this case could be viewed as maintaining the trust of donors through responsible budgeting, or as avoiding hypocrisy by not contributing to practices that cause the problems faced by the clients being served.

Both sides of the issue are also supported by various ethical principles. If the focus principle is the greatest good for the greatest number, the choice seems in favor of cutting costs. Changes in a single small organization's spending patterns will not change the business practices of corporations. Cutting costs will, however, lead to a real change in services, making the clients better off. A principle of subsidiarity (meeting human needs at the lowest possible level of social organization) supports putting clients' needs first, because they are in the agency's community and can be better served by its resources. A human rights principle could support both sides, including rights to life, liberty, dignified working conditions, and social services. If rights are hierarchical, however, the former rights would trump the latter, suggesting a preference for foreign workers. An egalitarian principle, which seeks to benefit those in the worst circumstances, seems to preference the good of foreign workers, because in the sense that the clients have moved to a place of relative safety and freedom, they are now better off. Lastly, the social work principle of challenging social injustice suggests that social workers should not support or benefit from the exploitation of others.

Standard 3.07(b) of the NASW Code of Ethics (1999) states that resource allocation in an agency should be "open and fair" and that in cases of scarcity "appropriate and consistently applied principles" should be used. Figuring out what is fair and appropriate in this case is the goal of this paper. The very first ethical standard, 1.01, states that "[i]n general, clients' interests are primary" and that "social workers' responsibility to the larger society" is only supreme "on limited occasions." This may suggest that, when in doubt, one should side with the client. In addition, standards 3.09(b) and 3.09(g) state that "social workers should work to improve… the efficiency and effectiveness of their services" and "be diligent stewards of the resources… wisely conserving funds… [and never] using them for unintended purposes". It could be argued that donors intend funds to be used to maximize services for clients and expect efficiency in this matter. However, standard 3.09(d) states that social workers should practice ethically, regardless of agency policies, and promote policies within their agencies that are consistent with social work principles. According to standard 6.01, social workers "should promote social, economic, political, and cultural values and institutions that are compatible with the realization of social justice" "from local to global levels."

It is also important to consider the values of the clients in this situation. It is well recognized that SRCB is a phenomenon focused on affluent citizens of developed countries. Clients at the agency are unlikely to hold consumer responsibility as a value or perhaps even to

understand it conceptually. Even if they were educated about the issue, it is unlikely that they could afford to spend their own money anywhere but the cheapest retailer.

In establishing a hierarchy of values, it seems most appropriate to do so in light of the purpose, standards, and ethical mandate of the social work profession. Considering the presented situation and the opportunities and limitations of the role of executive director, it seems that well-being is the highest value, followed by integrity, justice, and lastly efficiency and stewardship. Enhancing human well-being is the primary mission of the social work profession. Integrity follows because it encompasses all of an individual or agency's ethical behavior. Justice, broadly construed, is more removed from the social worker's control, but is more important than efficiency, which tends to be valued more in the broader society than in social work.

3.2 Personal Bias

Before moving on, it is appropriate to consider potential biases that may affect the social worker's ethical deliberation. The first recognizable bias stems from personal experience and lifestyle. The social worker in this case has been incorporating social responsibility into her spending decisions for many years; it is a part not just of her own lifestyle, but of the agency's culture. There is, however, a counter bias: the tendency to be more concerned about the people in one's own community than about people one has never met. The social work profession tends to be focused on domestic problems; the lack of social work literature on the issue of unethical foreign business practices illustrates this. While social workers ought to try to be aware of the needs of poor and vulnerable people around the world, it is often difficult to have as much compassion for anonymous "others" as for the people in need that we meet.

3.3 Options for Managerial Action

While there are innumerable possible ways to respond to this ethical dilemma, it is best to narrow discussion to a few of the most viable and ethically attractive options. There seem to be three broad categories of possibility—keeping current policy, changing shopping behavior, and a combination of both—as well as some steps within these categories that could potentially mitigate the weaknesses of each option. As well as highlighting the strengths and weaknesses of each in terms of upholding the values given in the hierarchy, the ethical theory that is seemingly compatible with the option is noted: pure consequentialist, deontological (rule-based), virtue-based, or classical teleological (considering the intention, act, circumstances, and consequences).

The first option available to the social work manager is to recommend that the agency uphold the current policy of socially responsible shopping. This approach favors the principle of challenging social injustice, siding with the social worker's responsibility to the broader society over the responsibility to clients. In this approach, a global responsibility principle is favored over a principle of subsidiarity. This option maximizes the value of well-being from an egalitarian perspective because it favors the well-being of the worst off, but minimizes the value of well-being from a utilitarian perspective because it sacrifices definite and significant gains in the well-being of clients for unlikely and insignificant gains in the well-being of foreign workers. As some members of the board will surely recognize, this option minimizes the value of efficiency, choosing to incur higher costs for the provision of fewer services. It could be seen as maximizing integrity by keeping the worker and agency from any complicity in atrocities and human rights violations, or as betraying integrity by not using resources to maximize services, as donors who have put their trust in the agency expect.

If the social worker were to choose this option, there are several ways that she could improve upon the current policy. The first would be to make the policy explicit, so that it could be defended in the event that the agency's purchasing practices were questioned. The second would be to establish a system for evaluating which companies have acceptable levels of CSR. As Lindenberg (2001) highlighted, it is not enough for the agency to have good intentions when it comes to governance. Adopting a system would be a move toward accountability. The agency could also write letters to make companies aware of their spending decisions, which would potentially increase the impact of such decisions, though most likely not by much. These steps would make SRCB easier to defend if it were to be questioned, but the social worker would have an additional decision to make: whether to reframe the agency's mission statement to include SRCB. Not drawing attention to the choice for higher spending minimizes risks to future funding, thereby upholding client well-being. The option to publicize the decision, however, has the ethical advantage of maximizing integrity, because it notifies donors up-front about how money will be spent by the agency. It could also mitigate concerns about efficiency by including SRCB as a program benefit, as discussed above in reference to Richmond, Mook, and Quarter's work (2003). The downside of this option is that it has potential to alienate donors and discourage future funding (Alexander, 2000) .

Overall, this option seems to be best supported by a deontological (rule-based) ethical perspective. The social worker could decide that the responsibility to uphold social justice should not be compromised and that under no circumstances should the social worker support human rights violations. SRCB could be construed as a civic duty incumbent upon the worker. A deontological perspective would place the integrity of the worker as a higher value than the consequences of the decision for client well-being, which would be the strength of this ethical option, particularly in the last form discussed.

The second option the social worker could choose would be to recommend that the agency change its spending patterns in order to cut costs. This approach maximizes client well-being by enabling the agency to provide more and better services to current clients and to expand its client base to serve more people in need. This option also maximizes efficiency

by getting the most services with the allotted budget. It upholds the responsibility for stewardship of finances by spending donors' contributions in a way that maximizes outcomes specified in the agency's mission and objectives. Since donors tend to value efficiency, this both maximizes client services in the present, and makes the organization more competitive for future funds (Hodgkinson & Nelson, 2001; Moxley & Bueche, 2002; Alexander, 2000). As the inverse of the above situation, this approach could be seen as maximizing integrity by honoring the trust of donors, or as betraying integrity by indirectly contributing to practices that are the cause of client problems. This approach does not uphold the responsibility to the broader society or the principle of challenging social injustice; in this case, the agency benefits from lower prices gained partly at the expense of worker maltreatment.

It is possible for the agency to attempt to uphold the principle of challenging social injustice within the significant constraints imposed by the decision to buy from cheaper retailers. An alternative approach to encouraging CSR through boycott is to attempt to influence corporations as a customer. Members of the agency could commit to writing letters to corporations from whom they buy encouraging them to improve their business practices. This may even be preferable to the previous agency policy, which was to boycott but leave the boycott unnoticed by the corporation. This approach attempts to uphold both responsibilities—to clients and to the broader society—but maximizes client well-being. This approach may be liable to a claim of hypocrisy for asking for change while simultaneously benefiting from low prices; however, as long as it is the clients who benefit (no one at the agency gets a raise because of it), the staff can avoid that accusation.

A choice for this approach seems like a better fit with a consequentialist ethical perspective. Spending conserved resources on clients will improve client well-being, and changing spending will, in reality, have little or no impact at all on the retailer and gas company's practices. The utilitarian principle of the greatest good for the greatest number is upheld and the approach is more justifiable through a utilitarian cost-benefit analysis. This option could also be compatible with a deontological approach if the primary rule was to maximize client well-being. A combination approach, such as the classical teleological, would also be compatible with this decision, as it does not ignore principles, but treats the consequences of action for human well-being as morally relevant.

The third option the social worker could choose would be to maintain the current policy of socially responsible shopping in some priority areas, and adjust spending in others to cut costs. The ethical strength of this option is that it seeks compromise between the prevailing views of the board members and staff and seeks to uphold the values of both positions. The weakness of this approach, of course, is that because it splits between the two sets of values it fails to maximize any of them. It results in a dilution of the effect of either option, the positive effect on clients of cutting costs and the positive effect on corporate practices of SRCB. It may be easier to justify because it represents an honest effort to meet competing demands, but it also seems like a less principled position.

If the social worker were to choose this option, it would be necessary to establish a ranking of issues of concern to staff and a system for evaluating CSR, as discussed above. The difficulties of establishing a system for rating CSR were highlighted in the literature; establishing agency priorities would add to this complexity. Overall, this approach seems most easily justified by a teleological approach with a particular emphasis on the worker's intentions, or by a virtue framework which would value the social worker's desire for moderation, balance, and compromise in decision-making.

4. Conclusion

Based on the systematic analysis presented in this paper, the social work manager in this situation recommends adjusting spending to cheaper retailers in order to cut costs and expand client services. In order to maximize as much as possible the value of social responsibility and the principle of challenging injustice within this decision, the social worker suggests that staff write periodic letters to the corporations from whom they buy.

The primary reason for siding with this option is that it maximizes, in actuality, the value of human well-being, which was given first priority in the value hierarchy. This option also seems most ethically defensible from the classical teleological approach. It seems in this case that a deontological approach is not adequate, because there are competing duties that cannot be equally fulfilled. Since a social worker has responsibilities to *both* clients *and* society, there seems to be no reason to prefer the rule of social responsibility, as was suggested above in the discussion of the option for SRCB.

The circumstances of agency service are also ethically relevant. First, the social worker is not acting by herself, but on behalf of the agency and its clients. As a manager, the social worker in this situation is ethically obligated to consider the impact the decision will have on the well-being of clients. If, as is assumed, the agency's shopping decisions have no real impact on the well-being of foreign workers, then the social worker would be sacrificing actual client well-being for a principle with only hypothetical impact. Second, even if SRCB is a civic duty, it would seem to be morally defensible to sacrifice other low-impact civic duties for good cause (for example, to miss voting in order to address a client crisis).

Although there is some suggestion to the contrary, this decision need not be seen as a violation of integrity. In reality, it is highly unlikely that a donor or client would question the integrity of this decision, because SRCB is not, as of now, a widely held value in American society. More importantly, the manager stands to gain nothing personally from this decision, but only to benefit clients; the manager has acted with good intentions and tried to resolve the issue in the best way. Based on the literature, this option is more efficient and preferable for securing future funding, although these aspects played a smaller role in the ethical deliberation. The only value sacrificed with this option is social responsibility, which

the manager will still attempt to uphold through letter writing. The reasons for choosing this approach over the compromise approach are the weakness noted above: it fails to maximize any values, dilutes the positive impact on client well-being, and is difficult to implement.

Since the social worker in this case is asked to weigh in on a disagreement, any option she chooses will need to be implemented with skill and consideration of potential reactions. Since the social worker is in a management position and has board support, it seems her first step would be to address the concerns of staff members, who were not consulted. It is the staff who implement the implicit policy for SRCB and who will be implementing the new policy, including shopping adjustments and probably letter writing. It is important to be sensitive to the staff's values regarding social responsibility, and to the differences in power among the staff, the manager, and the board.

The first thing the social worker would do in this case is to discuss the issue openly at the next staff meeting, first explaining the board's concerns, then laying out her opinion, supported by the research. In this explanation she would emphasize her concern for clients and her own sense of inner conflict. After summarizing her intended recommendations and listening to staff response, she would encourage staff members who are concerned about this decision to collectively write a statement to the board, which she would agree to submit with her own. She would encourage them to make it a positive statement, rather than argumentative.

The manager would then notify the board members if they would be receiving an additional statement, and explain her reasons for getting staff input, emphasizing good management practice. She would volunteer to meet with the board to further discuss the issue. Knowing that the board highly values the social work manager's professional opinion, it is assumed that they will choose to change the policy. The manager would then cooperate with staff to craft an agreeable implementation plan. The submitted statements, plan, and policy would be kept on file as documentation of the policy-changing process.

References

Alexander, J. (2000). Adaptive strategies of nonprofit human service organizations in an era of devolution and new public management. *Nonprofit Management & Leadership, 10*(3), pp. 287-303.

Applewhite, L. W. & Joseph, M. V. (1994). Confidentiality: Issues in working with self-harming adolescents. *Child and Adolescent Social Work Journal, 11*(4), pp. 279-293.

Das-Gupta, I. (2005). Fair trade 'will not stop poverty'. *Third Sector,* (399), p. 5. Retrieved October 14, 2006 from Academic Search Premier database.

Grossman, L. (2004). Rating corporate social responsibility. *Businessdate*, *12*(4), pp. 5-7. Retrieved October 12, 2006 from Academic Search Premier database.

Hertz, N. (1999). Better to shop than to vote. *New Statesman, 128*(4441), pp. 7-8. Retrieved October 14, 2006 from Academic Search Premier database.

Hodgkinson, V. A. & Nelson, K. E. (2001). Major issues facing America's nonprofit sector. *Nonprofit Review, 1*(2), pp. 113-118.

Inglis, S., Alexander, T., & Weaver, L. (1999). Roles and responsibilities of community nonprofit boards. *Nonprofit Management & Leadership, 10*(2), pp. 153-167.

Jurkiewicz, C. L. & Massey, T. K. (1998). The influence of ethical reasoning on leader effectiveness: An empirical study of nonprofit executives. *Nonprofit Management & Leadership, 9*(2), pp. 173-186.

Kapstein, E. B. (2001). The corporate ethics crusade [Electronic]. *Foreign Affairs, 80*(5). Retrieved October 11, 2006 from Academic Search Premier database.

Koppell, J. G. S. (2005). Pathologies of accountability: ICAAN and the challenge of "Multiple Accountabilities Disorder" [Electronic]. *Public Administration Review, 65*(1), pp. 94-110. Retrieved October 9, 2006 from EconLit database.

Lindenberg, M. (2001). Are we at the cutting edge or the blunt edge? Improving NGO organizational performance with private and public sector strategic management frameworks. *Nonprofit Management & Leadership, 11*(3), pp. 247-270.

Mohr, L. A., Webb, D. J., & Harris, K. E. (2001). Do consumers expect companies to be socially responsible? The impact of corporate social responsibility on buying behavior. *Journal of Consumer Affairs, 35*(1), pp. 45-72. Retrieved October 14, 2006 from Academic Search Premier database.

Moxley, D. P. & Bueche, L. (2002) Ethical issues in agency resource development: Implications for social administration. *Families in Society, 83*(3), pp. 265-273. Retrieved October 11, 2006 from Social Services Abstracts database.

Muldoon, A. (2006). Where the green is: Examining the paradox of environmentally conscious consumption. *Electronic Green Journal*, (23), p. 3. Retrieved October 13, 2006 from Academic Search Premier database.

National Association of Social Workers. (1999). *Code of Ethics.* Available online at http://www.socialworkers.org/pubs/code/code.asp.

Richmond, B. J., Laurie, M., & Quarter, J. (2003). Social accounting for nonprofits: Two models. *Nonprofit Management & Leadership, 13*(4), pp. 308-324.

Rosen, M. J. (2005). Doing well by doing right: A fundraiser's guide to ethical decision-making. *International Journal of Nonprofit and Voluntary Sector Marketing, 10*(3), pp. 175-181.

Springen, K. & Miller, A. (1991). Doing the right thing. *Newsweek, 117*(1), pp. 42-43. Retrieved October 14, 2006 from Academic Search Premier database.

A 15-Year-Old Leukemia Patient Facing Peripheral Blood Stem Cell Transplantation (CE Article)

Social Work Ethics and Values Considered in the Case of a 15-Year-Old Leukemia Patient Facing Peripheral Blood Stem Cell Transplantation

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Key Words: social work ethics, social work values, medical social work, peripheral blood stem cell transplantation (PBSCT), Code of Ethics, rights of a minor, interdisciplinary team

Abstract

The application of social work values and ethics, as defined by the NASW Code of Ethics (1999), in work with a 15-year old acute lymphoblastic leukemia patient facing the possibility of Peripheral Blood Stem Cell Transplantation (PBSCT) is explored. Highlighted are issues common in pediatric medical social work: both the constant reconsideration of who to define as the primary client, the patient or the parents, and the intricacies of working on a medical interdisciplinary team. Also considered are the legally-defined medical decision-making rights of a minor. Following the outlining of several possible courses of action, one scenario is presented as the best course to follow.

1. Introduction

Josiah is a 15-year old male who has spent the majority of his past eleven years in and out of treatment for acute lymphoblastic leukemia (ALL). His last hope of cure is peripheral blood stem cell transplantation (PBSCT), a newer procedure that has a survival rate of only 40% for children with disease histories like Josiah's. Whereas both Josiah's parents and his medical team are interested in pursuing PBSCT, Josiah current desire is to cease any further

attempts at cure. Wanting to serve both Josiah and his parents while also considering the desires of Josiah's medical team, how should a social worker proceed in her work with this family?

2. Presenting Information

Josiah was diagnosed with ALL when he was 45 months old. His medical history includes three years of initial chemo and radiation therapies, 28 months of remission, and a relapse at age nine. From ages nine to fourteen, Josiah received both highly aggressive and more moderate chemo and radiation therapies, depending on the lymphoblast cell count in his blood. However, during that time, he was never completely blast free.

For the past seven months, Josiah's health has worsened. His absolute neutrophil count, used to measure the body's ability to withstand infection, is erratic and can drop quickly and unexpectedly. He often develops fevers, twice he has contracted infections around his right atrial catheter, and he is now starting to show signs of kidney and possible liver failure. Of the past 245 days, he has spent 193 of them on the pediatric in-patient floor of one of Boston's leading teaching hospitals, and for almost half that time, he has been in isolation.

3. Identifying Information and Emotional Health History

Josiah is the third of three boys born to a middle-income couple. Although his two older brothers are both away at college--one a freshman, one a senior--he is well supported by his entire family: his parents are actively involved in all his medical care and decision-making, both his brothers call and write him frequently, and his maternal grandparents visit him in the hospital two to three times per week. Josiah also has peer support in his two or three friends who contact him regularly and in his classmates who ran a fund-raiser for him five months ago.

Throughout the time since his relapse, Josiah has had to battle mild to moderate depression. According to his parents, before his initial diagnosis, Josiah was an active child who found great excitement in outdoor activities. He loved to explore the nearby forest with his brothers and to act out imagined stories in his backyard with his friends. Once he became sick and was diagnosed with ALL, Josiah was often isolated from his germ-carrying friends and sheltered from the more rambunctious activities of his older brothers. Further, his debilitating treatments and frequent hospitalizations over the years have kept Josiah from successfully participating in the sports and other extra-curricular activities in which his peers have partaken. His thwarted efforts at participation have left him unwilling to try new activities or even hope for a day when circumstances would permit otherwise.

Frequent treatments and hospitalizations have also hindered Josiah's efforts at schoolwork, forcing him to repeat a grade twice in his academic career. While Josiah's delayed emotional development as a result of his chronic illness has enabled him to relate well to his current classmates, the fact of twice failing to move up to the next grade has negatively affected his self-esteem. Josiah claims that he now feels most at ease when he is at home, either alone or with a couple of close friends in his room, or when his brothers come home on holiday. Every other situation tends to bring anxiety about what might happen next physiologically or sadness about everything he is unable to do.

4. Introduction of PBSCT for Josiah

The current dilemma in Josiah's treatment is regarding whether or not he should undergo PBSCT. PBSCT is a procedure found to help restore a cancer patient's bone marrow stem cells (hematopoietic stem cells) that were destroyed either by high-dose chemo and radiation therapies or by the ALL itself. The hope in the procedure is that the transplanted healthy bone marrow stem cells will restore the marrow's ability to create healthy blood cells and platelets rather than cancerous lymphoblast cells, thereby eradicating the cancer (NCI, 2004, pp.1-2).

Talk of using this procedure for Josiah was initiated by the attending physicians who recognized the excitement and potential success of this newer procedure. Josiah's parents joined in the conversation as they saw the procedure as their only hope for chasing Josiah's leukemia into complete remission. Even Josiah entertained the idea, as he regarded it as his ticket back to a normal life, one that might be free from painful procedures and instead be full of typical adolescent activities. The talk went far enough to find an unrelated donor who is a good match for Josiah.

The physicians focused their talks of interventions on PBSCT, because while the benefits of conducting this procedure over a more traditional bone marrow transplant are few, they are significant. First, while the process of harvesting the hematopoietic stem cells is longer in PBSCT, it is less invasive and thereby less painful for the donor. Further, the donor requires no anesthesia for this process, eliminating the risks associated with anesthesia (NCI, 2004, p.4). Finally, the process overall is somewhat less costly, as recovery times for the recipient are generally quicker, reducing hospital stays and thereby hospital fees (NCI, 2004, p.6).

Stem cell transplants are not, however, without their difficulties and risks. The process alone is difficult, as it requires multiple weeks of hospitalization in which the patient's body has to not only recover from the high-dose pre-transplant radiation and chemotherapies given to kill the last of the blast cells, but also accept and adapt to the foreign cells being

introduced into it. Further difficulty comes in managing the cost of PBSCT. Lengthy hospital stays coupled with the technologically complex procedures (from harvesting cells from the donor through to the frequent blood tests of the patient) make PBSCT expensive. Costs can range from $700 for blood testing the donor to $25,000 for stem cell procurement (NMDP, 2005, pp.1-2). Typically, insurance companies only partially cover PBSCT procedures.

Moreover, PBSCT poses a number of risks for the patient. First, it is successful only 40% of the time in patients with relapsed ALL that has never again gone into complete remission (NMDP, 2005, p.3). Thus, the patient risks the emotional and psychological devastation that can follow enduring a long and difficult recovery process that does not produce hoped-for results.

Graft-versus-host disease (GVH) is another possible risk. GVH occurs when donated stem cells are perceived by the patient's white blood cells as foreign invaders and are, therefore, attacked. This disease is more likely when the donor is unrelated to the patient, as in Josiah's case, and can cause liver, skin, and intestinal damage (NCI, 2004, p.5).

Finally, the patient faces potential long-term risks that accompany high dose pre-transplant radiation and chemotherapies, such as infertility, cataracts, secondary cancers, and damage to multiple body organs (NCI, 2004, p.5). Because of all of the aforementioned risks, and because Josiah's blast count never went into complete remission, talk of PBSCT has never reached the final decision to proceed.

5. Presenting Problem

Despite the potential risks, within the past four months, Josiah's medical team has again intensified its pursuit of this procedure. The attending physicians now feel PBSCT is the only possible chance of cure for Josiah. However, in doctor's rounds, these physicians also have confided their desire to increase the number of PBSCTs performed at the hospital. This desire stems from the fact that the hospital's inclusion in the Children's Oncology Group (COG) is currently in question; they feel that an increase in the frequency of use of this procedure will lead to an increase in its chances of remaining a member of COG.

Josiah's parents also are still interested in pursuing PBSCT. They recognize that all other treatment options have been tried and have been, thus far, unsuccessful in leading to cure. They see PBSCT as their last hope for saving Josiah's life. Whereas they are emotionally close to their other sons, they claim a special connection to Josiah, their baby. Once while discussing the possibility of Josiah's death, his mother admitted to the social worker her fear

of becoming an empty nester and her willingness to do just about anything to preserve Josiah's life.

The complication comes, however, in that Josiah is no longer interested in pursuing PBSCT. He has stated a lack of desire to endure the risky procedure and difficult recovery when he feels fairly certain that it will not cure him. When asked about this lack of hopem he stated, "Nothing else has worked. Why should this?" He fears that more physiological complications will further hinder his already diminished capabilities.

Josiah has also communicated some discomfort around the mandated isolation during PBSCT recovery. He already carries a sense of isolation from the life he observes happening around him. He finds that while he enjoys his family, his friends, and his time at school, it is more the enjoyment of being entertained by what is going on around him than the enjoyment of participating in it. In his words, *life feels like something I get to watch but not be a part of. Whenever I am at school or even with my family, I feel like people like me and everything, but I'm not really one of them. I'm not ever going to be like them and I'm not going to ever do the same stuff they do.* Even Josiah's involvement in cancer support groups has not provided him with a strong feeling of inclusion. While participating, he finds himself saddened both by the children who have died and by the ones who, unlike himself, have stayed in remission. He has stated, *Even if this does work, I'll still be different. I'll still be on the outside. What's the point?*

These thoughts Josiah has voiced only to the social worker and nobody else on his medical decision-making team. With his parents and the physicians, he states that he understands the details of PBSCT, without ever indicating his lack of desire for pursuing it. The social worker has raised the issue of Josiah's lack of desire with the attending physicians, in the hope of facilitating conversation among the medical staff, Josiah, and Josiah's parents. However, their response has been more dismissing, believing that Josiah is too young to make that decision and that his depression is keeping him from wanting PBSCT. They believe that they only need the parents to agree to the procedure to be able to go forward. Further, they have suggested the need to act quickly, as Josiah's blast counts are currently low, and have requested that the social worker immediately begin helping Josiah's parents both to fill out necessary paperwork and to procure the funds needed to cover procedural costs.

6. Ethical Challenges to Social Work Values

The social worker must now decide how to go forward. What is the course of action that will best promote the interests of the patient, family members, and intervening medical team? Several scenarios are possible. However, she will need to consider how each scenario ethically challenges significant social work values.

6.1 Value 1: Commitment to Clients

The NASW *Code of Ethics* (the *Code*) stipulates that a social worker's first responsibility is to promote the well-being of clients; the client's interests are primary (NASW, 1999, p.5). However, in the case of Josiah, as is often true in pediatric social work, the social worker serves both the pediatric patient and the patient's family members, primarily the parents. Who, then, is the primary client in this setting, the patient or the parents? Whose well-being needs to be promoted? These questions become most poignant when promoting one party's well-being might mean compromising that of the other. In this situation, Josiah's parents' well-being could be compromised by watching him die when they believe they could have saved his life, or Josiah's well-being could be compromised by enduring yet another treatment and long recovery that might again prove unsuccessful.

One consideration in determining the definition of the client in Josiah's case is the medical decision-making rights of a minor. Could Josiah's desires legally override those of his parents? In December 1991, the regulations of the Patient Self Determination Act, which Congress had passed in 1990, went into effect. These regulations specified that patients have the right to make choices and decisions about the types and extent of medical care they wish for themselves (Hays, 2003, p.1). However, that act does not specify how these regulations pertain to minors and their ability to decide.

The state of Massachusetts, however, provides a bit more guidance, its courts having adopted the mature minor rule. Even though the age of majority in Massachusetts is legally 18, the mature minor rule allows for doctors to follow the desires of a minor if they believe that the child 1) is mature enough and 2) is able to give informed consent to the medical care (Children's, p.6). This latter stipulation, however, brings up the question of competency.

Competency must be considered from three angles: developmental achievement, emotional health, and knowledge capacity. With Josiah, the first two of these angles draw his competency into question. First, the length of his illness has caused some delays in his emotional development. When other children were starting the process of emotionally detaching from their parents and attaching instead to peers and other adults outside the home (teachers, coaches, friends, parents, etc.), Josiah was emotionally dependent upon his parents to help him through the bouts of sickness and painful medical treatments. Further, because his times of interacting with peers and other adults outside the home were interrupted or limited by sickness and hospitalizations, Josiah has had less experience in forming those attachments than his same-aged peers. He has now reached the emotional developmental level of a 12- or 13-year old, placing him approximately two years behind his chronological age. The question for Josiah becomes, then, not one of the emotional capacity of a 15-year-old for making a decision between life and death, but one of a 12-year-old.

Second, Josiah's emotional health can be currently defined as depressed. A common manifestation of depression is hopelessness, and without hope, it is difficult if not impossible for a chronically ill person to fight the battle of ongoing treatments and treatment complications. Josiah seemingly is no longer willing to face a life of medical complications, and he has little hope that any treatment is going to bring a life of cure and freedom from the complications. Is this recent state of hopelessness negatively affecting his ability to make a well thought out and rational decision about the procedure?

A third consideration of competency, knowledge capacity, is a strength for Josiah. His capacity for retaining and understanding knowledge about his condition seems to indicate a realistic understanding of his situation. From the earliest days of his treatments, Josiah's medical teams included nurses, child life specialists, and social workers who all worked to educate Josiah about everything that was happening to him, helping him feel more a participant in his treatments and less a victim. That early education created Josiah's tendency to ask questions and expect answers. Josiah's parents, as well, generally made an effort to answer his questions and to include him in the medical process whenever they felt it appropriate. After eleven years of dealing with leukemia, its complications, and the world of medicine surrounding it, Josiah appears to comprehend all of the ramifications of his current circumstances. Although he has not directly stated that he wants to die, he has stated that he knows of the likelihood of imminent death without PBSCT. His affect indicates no immediate concern with this understanding. Is this comprehension enough to warrant his right to decide to die?

Even if it is decided that Josiah is not mature or competent enough to make his own medical decisions, the *Code* does stipulate that social workers should take reasonable steps to safeguard the interests and rights of those clients who lack decision-making capacity (p.10). Thus, the social worker must still commit to bridging any divergent interests of the patient and the patient's family.

6.2 Value 2: Self-determination

Also stipulated within the *Code* is the social workers responsibility to promote the client's socially responsible self-determination, assisting him/her in identifying, clarifying, and pursuing his/her personal goals (NASW, 1999, p.5). Again, when multiple clients are involved, the same question arises: who is the primary client, and therein, whose goals should be identified, clarified, and pursued? This question is especially poignant when differing goals appear to conflict, as in the case of Josiah and his family. And even when a primary client can be identified, an important consideration is whether the client's desired acts of self-determination can be considered socially responsible.

Josiah's current determination is to stop medical interventions and allow his life to take its natural course toward death. However, it may be considered socially unacceptable for him to inflict his parents with grief and guilt of whether they did everything possible to save his life. Further, it could be questioned whether it is ethical to allow him to decide to make such a decision at a time of emotional depression.

The current determination of Josiah's parents, on the other hand, is to do everything possible to preserve his life. However, this option poses a number of ethical questions. One question is whether it is socially responsible to use limited medical technology resources on someone with Josiah's poor survival prognosis when they could be used on another patient with a better chance of survival. A second question to consider is whether it is in Josiah's parents' best interest to incur significant financial debt to pay for this procedure, especially if it is not successful. A final question to consider is whether it is socially acceptable for them to force their son through a difficult procedure that he has no desire of enduring.

6.3 Value 3: Privacy and confidentiality

The *Code* also requires that social workers protect the confidentiality of all information obtained in the course of professional service, except for compelling reasons (NASW, 1999, p.7). During private counseling times with the social worker, Josiah confided his desire to forego PBSCT. He also stated that he does not want his parents to know of his desire because it will generate a lengthy discussion toward which he has no energy to contribute. Although the social worker knows that communicating Josiah's desires could slow proceedings enough to address her concerns about his emotional state, she believes that Josiah would feel betrayed if she did so without his consent. She also hears him say that currently he would rather do whatever he is told than to be forced into a lengthy discussion over divergent goals. The dilemma comes in that the social worker believes that without breaking confidentiality and telling his parents, they will continue along with the physicians to push PBSCT to happen quickly. Such a pace will mean little time to get Josiah on board with their decision to go ahead with the treatment, or them on board with Josiah's decision to decline.

6.4 Value 4: Respect of medical colleagues and the interdisciplinary team process

Also stipulated within the *Code* is the need of social workers to respect the qualifications, views, and obligations of their colleagues. Further, it stipulates that social workers who are members of an interdisciplinary team should participate in and contribute to decisions that affect the well-being of the client (NASW, 1999, p.11-12). In the case of Josiah, do these two stipulations conflict with each other? For instance, in respecting her medical colleagues, the social worker needs to consider their obligation to the hospital. Could the hospital be sued by Josiah's parents if they do not perform PBSCT? In addition, she needs to consider

that their medical qualifications might merit her simply agreeing with them that PBSCT is a good thing for Josiah's family to try. However, if she remains silent in deference to her colleagues' qualifications and obligations, she could then fail in her responsibility to contribute to the team. Further, if she remains silent and Josiah is forced into PBSCT, she could be jeopardizing Josiah's emotional well-being.

7. Possible Courses of Action

The aforementioned values are all pertinent to Josiah's situation. All are important, yet it is impossible for all to be upheld simultaneously. Below are possible courses of action the social worker could take. Outlined within them are the ethical dilemmas created in trying to uphold these values.

7.1 Course 1: Say nothing more

In following this course, the social worker would follow the direction of the attending physicians. She would work with Josiah's parents to begin the process of filling out paperwork and procuring needed funds. She would help educate his parents about resources that may be helpful to them after the procedure, but never tell them of Josiah's desires. Moreover, she would continue to work with Josiah in addressing his depression and finding him sources of social support outside his family.

The social worker could only choose this course if she believes that it is in Josiah's best interest to go through with PBSCT and if she believes that Josiah's level of emotional development and state of health preclude him from having a voice in his medical decisions. This course of action would allow the social worker to uphold the values of respecting the self-determination of the parents and holding confidential the desires Josiah has shared. Further, it would allow her to respect her colleagues' qualifications and obligations to the hospital by not questioning their reasoning for going forward with the PBSCT, and she would be allowing them to do so in a timely manner. Finally, it would allow her to uphold the value of commitment to both Josiah as her client, in working to address his depression and his need of social supports, and Josiah's parents as her client, helping them proceed with the procedure they desire to pursue.

However, this course of action would not allow the social worker to support Josiah's self-determination: his desire to forego PBSCT would be ignored. By so overlooking his desires, catering to his current apathy, and allowing him to be forced into PBSCT, the social worker may be allowing a situation wherein Josiah's depression would worsen to the point of complete withdrawal. Such an emotional state could undermine Josiah's recovery. This

course of action, too, would draw into question whether, by being completely silent about Josiah's desires and her concerns about his emotional health, the social worker was truly upholding her responsibility to contribute to the interdisciplinary team.

7.2 Course 2: Keep Josiah's desires before the medical team

In this course of action, the social worker would communicate first to Josiah's medical team and then to Josiah's parents the importance of Josiah having more voice in what happens to him; chances of recovery improve if Josiah is more emotionally invested in the process than he currently is. In order to communicate this fully, the social worker would need either to explain or to convince Josiah to explain that he is currently not interested in pursuing this treatment. If more time were then granted, the social worker would spend more time in educating Josiah's parents about the ramifications of both PBSCT complications and possible death than in providing them resource management support. The social worker would also continue to do work with Josiah surrounding his depression while also encouraging him to stay open to the possibility of pursuing PBSCT.

Because asking for more time before proceeding with PBSCT could mean losing the opportunity to perform this procedure if Josiah's condition worsened, the social worker would choose this course of action only if she believes that in Josiah's current emotional state PBSCT either has little chance of success or runs the risk of tipping his precarious emotional well-being toward further decline. She would also need to believe that even at his level of emotional development and state of health, he should have some voice in medical decisions. This course of action would allow the social worker to uphold her commitment to supporting Josiah as her client in making sure his voice was heard, to respect her colleagues in trying to bring them to agreement first before going to Josiah's parents, and to fulfill her responsibilities in contributing to the interdisciplinary team. Further, it would allow her to uphold her commitment to Josiah's parents as her clients in working to prepare them emotionally for the potential risks of PBSCT, while also still supporting their desire to keep the option of PBSCT alive.

However, in choosing this course of action, the social worker might have to break confidentiality by telling Josiah's parents his desires without first getting his consent to do so. This breach could have long-lasting ramifications on her continued work with him, negatively affecting her efforts at getting him past his depression and able to embrace the idea of yet pursuing PBSCT.

7.3 Course 3: Talk to Josiah's parents about his desires

In this course of action, the social worker would first communicate Josiah's desires to his parents in order to convince them to give Josiah more time, and to ask them to convince the physicians to do the same. After so doing, she would then approach the physicians with Josiah's parents' new conviction and her concerns. Simultaneously she would begin conversations with Josiah and his parents together, with the intention of getting them to a place of agreement and understanding. These conversations might also include the physicians, depending on their initial responses to her expressed concerns. As in the first two courses of action, she would continue work with Josiah in addressing his depression.

Again, because she would recognize that waiting to start the procedure poses the risk of losing the opportunity to perform PBSCT, the social worker would choose to speak first to Josiah's parents only if she again has serious questions about the viability of PBSCT for Josiah. She would also need to believe that even at Josiah's level of emotional development and state of health he should have some voice in medical decisions. To choose this course of action, she would also have to believe that the only way to convince the physicians to give Josiah more time is to first convince his parents and then have them work to convince the physicians. This course of action would allow the social worker to uphold her commitment to Josiah as her client in making sure that his desires are heard and that he is able to exercise his right to self-determination. It would also allow her to uphold her commitment to Josiah's parents by helping them work with Josiah to emotionally prepare together for the possibility of giving up on treatments.

With this course of action, however, the social worker would not be upholding many social work values. She would have to breach confidentiality in talking to Josiah's parents, again putting at risk her relationship with Josiah. She would also show a lack of respect for her colleagues by first approaching the parents, thereby potentially undermining the physicians' relationship with them. Further, she would not be upholding her responsibility as a member of the interdisciplinary team by working counter to the team's desires, and not working to find agreement before going ahead with her plans.

8. Best Course of Action

Keeping Josiah's desires before the medical team appears to be the best course of action in this case. Although it holds the risk of both losing the window of opportunity for PBSCT and causing a serious breach in the social worker's relationship with Josiah, it yet contains the most promise for providing the best support to Josiah and his parents while also upholding social work values and responsibilities.

For Josiah, this course of action gives him the sense of having his voice heard and heeded, while also recognizing that his level of emotional development and state of health preclude him from having complete control over deciding between life and death. Also, should the

work around his depression prove at all successful, it gives him the best chance at successful recovery, as he will have more emotional energy to put toward recovery. Further, it allows him the opportunity to work with his parents in preparing for what lies ahead rather than feeling isolated either by being forced to comply with their desires or by forcing them to comply with his. It also allows him to feel like a participant in the procedure rather than a victim. Finally, it gives Josiah one last possible chance at living life for at least a couple of years, a possibility he would not have without PBSCT. The focus of the work with Josiah would be his depression and helping him envision a more positive, yet realistic, life post-PBSCT.

For Josiah's parents, this course of action upholds their determination to go through with PBSCT while also allowing them to work with their son, not simply decide for him. However, it would also help them prepare for the emotional difficulties that may come if the procedure is unsuccessful. Part of the focus of the work with Josiah's parents would be to help his mother address the issues underlying her grief of becoming an empty nester.

For the interdisciplinary team, this course of action allows the social worker to respect her colleagues' position to do the PBSCT, but also gives her space to contribute to the team by asking that the procedure wait until Josiah receives more treatment for his depression.

Although there are many benefits that come with this course of action, the risk of the broken relationship between Josiah and the social worker is worthy of serious consideration. If that breach becomes irreparable, it could undermine efforts to alleviate his depression, rendering him unable to ever fully embrace PBSCT and to find hope in a post-PBSCT life. However, that risk could be diminished if Josiah first talks through his fears and hesitations with his parents, the medical team, and a psychiatrist. It could also be diminished if he felt a sense of self-determination in the process.

And, again, giving Josiah time to become emotionally stronger might mean that the window of opportunity to perform PBSCT will close and Josiah will not get that one last chance at longer life. However, even if that happened, stepping through the process more slowly and intentionally, with all players in mind, has the promise of leading to a better ending, an ending wherein all those involved are left a bit less emotionally scathed than might otherwise be true.

9. Conclusion

As for a social worker in any other setting, the decisions facing a medical social worker are rarely, if ever, of black and white simplicity. Rather, the complexities of most cases bring

shades of gray that not only dictate thorough analysis of all possible ramifications but also mean often choosing an option that promises a less than ideal outcome for a client. However, by taking time to carefully consider the legal and ethical issues as well as the social work values pertinent to her client's situation, the medical social worker can more confidently make a decision, believing that though it might not be ideal, it is a significantly positive step toward the psychosocial well-being of all involved.

References

Children's Law Center of Massachusetts, Inc. Emancipation and the legal rights of minors in Massachusetts. Retrieved on 4 December 2005 on the World Wide Web at: http://www.clcm.org/minors_rights.htm

Hays, B.C. (2003). Patient Self Determination Act 1990. <u>Healthcare professions delivery systems</u>. Retrieved on 29 November 2005 on the World Wide Web at: http://www.nvcc.edu/home/bhays/dogwood/selfdeterminationact.htm

National Association of Social Workers. (1999). *Code of Ethics.* Retrieved on 30 September 2005 on the World Wide Web at: http://www.naswdc.org/pubs/code/code.asp

National Cancer Institute. (2004). Bone Marrow Transplantation and peripheral blood stem cell transplantation: Questions and answers. Retrieved on 29 November 2005 at: http://www.cancer.gov/cancertopics/factsheet/Therapy/bone-marrow-transplant

National Endowment for Financial Education. (2003). <u>Mapping the maze: A personal financial guide to blood stem cell transplant</u>. Retrieved on 29 November 2005 on the World Wide Web through: http://www.marrow.org/PATIENT/maze_financial_guide.html

National Marrow Donor Program. (2005). Beth Israel Deaconess Medical Center. Retrieved on 29 November 2005 on the World Wide Web at: http://www.marrow.org/cgi-bin/NETWORK/tc_idx.pl?ctr_id=447&p_src=state

Robinson, W.L., & Reeser, L. (2000). <u>Ethical decision-making in social work</u>, chaps 1-3. Retrieved on 25 November 2005 on the World Wide Web at:

http://www.rit.edu/~692awww/1.1.pdf, http://www.rit.edu/~692awww/2.1.pdf, and http://www.rit.edu/~692awww/3.1.pdf

Rothman, J.C. (1998). From the front lines: Student cases in social work ethics. Boston: Allyn & Bacon.

The Value of the Incompetent: Application of Social Work Values

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Abstract

The *Code of Ethics of the National Association of Social Workers* provides a framework for practice, including policy formation. This article explores the ethical principle, "Social workers respect the inherent dignity and worth of the person." The ethical principle is applied to practice at the macro-level, in a unique exploration of policy formulation through the inclusion of persons with intellectual and developmental disabilities, with persons under corporate guardianship in the state of Wisconsin.

1. Introduction

Social workers are expected to practice within the framework provided by the *Code of Ethics of the National Association of Social Workers* (1996) (the *Code*). The framework includes a set of core values and ethical principles along with ethical standards that provide guidance for their implementation. The core value of Dignity and Worth of the Person is defined in the *Code* as follows:

> Social workers treat each person in a caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity. Social workers promote clients' socially responsible self-determination. Social workers seek to enhance clients' capacity and opportunity to change and to address their own needs. Social workers are cognizant of their dual responsibility to clients and to the broader society. They seek to resolve conflicts between clients' interests and the broader society's interests in a socially responsible manner consistent with the values, ethical principles, and ethical standards of the profession. (NASW, 1996)

This article seeks to explore what this principle looks like in action, applied to practice with persons under corporate guardianship[1] in the state of Wisconsin.

2. Background

As a graduate student, I interned at Wisconsin's federally mandated protection and advocacy agency for persons with disabilities (such agencies receive authority under P.L. 99-319), where I was exposed to macro practice in a variety of venues. One such area was revision of Wisconsin's Administrative Code HFS85, which provides the rules for nonprofit corporate guardianship agencies in the state.

Wisconsin administrative code HFS 85 was initially promulgated in 1983. In September of 2006, the Department of Health and Family Services (DHFS) issued a statement of scope[2] to revise the code for the first time since its original promulgation. In the statement of scope, DHFS stated the following:

Policy Analysis

Chapter HFS 85 establishes criteria by which the Department of Health and Family Services finds a non-profit corporation suitable to serve as guardian of persons who are determined by a court to be incompetent. Criteria include the number of wards a corporation is authorized to assume for guardianship, the number of staff needed to carry out the responsibilities of a guardian, staff qualifications, either by training or by experience, proof of financial stability, conflict of interest standards and the frequency of personal contact with wards. The rule also contains provisions for the Department to withdraw its finding of suitability if the corporate guardian no longer meets the eligibility criteria, and the rule provides appeal rights for any party adversely affected by this action.

The Department proposes to revise Chapter HFS 85 for the following reasons.

A. To reflect current standards of practice for corporate guardianships in the areas of staff qualification and training, caregiver background checks, adequacy of staff, contacts with wards and conflicts of interest standards.

B. To include requirements for corporate guardians to maintain agency policies in the areas of abuse and neglect prevention, complaint and grievance investigations, and advance directives.

C. To reflect the increase in the number of adults in need of guardianship and the increase in their acuity level.

D. To incorporate recent changes to 2005 Wisconsin Act 387 to ch. 880, Stats., relating to the limitation on the number of wards of a corporate guardian.

(State of Wisconsin Department of Health and Family Services, 2006)

The statement of scope recognized a need to bring the rule governing corporate guardianship in line with current practices and changes to other Wisconsin statutes related to guardianship.

As an intern, I had been involved in discussions regarding corporate guardianship with DHFS-Division of Quality Assurance (DQA) prior to the issuance of the statement of scope. This relationship afforded me an initial seat at the table when DHFS began planning an advisory committee to review and make recommendations for the new rule, and I continued in this role as an independent student after my placement concluded.

One of the first tasks the committee established was to develop a survey of the corporate guardianship agencies in the state. As one of 23 advisory committee members, I worked with other members to create a survey that was then sent to all of the corporate guardianship agencies operating in the state. The survey was developed to learn more about the practices that were taking place within the corporate guardianship agencies and to inform the advisory committee as it moved forward with the rule revision. The tool was designed to be used as a voice for the corporate guardianship agencies that would be affected by the rule revision. The survey asked for a breakdown of the populations served, the staff employed by such agencies, duties provided by the agency, and operational structure related to agency policies, procedures, and case files.

The advisory committee began meetings in January 2007. Representatives from DHFS, county probate offices, corporate guardianship agencies, county representatives, and disability advocates were present. The first meeting was an introduction for committee members and a brainstorming session to identify areas within the rule that committee members believed were in need of considerable revision. After reviewing the rule revision process, focusing on the stakeholders involved, a key participant group appeared to be missing—persons under guardianship. As a social work student and committee member, I felt that if I did not bring this matter to the committee's attention, I would be in conflict with my professional responsibilities to the wards that would be affected by changes to the rule.

After speaking to members of the advisory committee regarding this concern, DHFS-DQA staff agreed to develop a series of listening sessions to gather the input of current wards, a group that would be vitally affected by revisions. This article focuses on the application of the *Code's* ethical principle of Dignity and Worth of the Person to the ward listening sessions.

3. Application of the *Code* to Practice

Within the *Code's* ethical principle of "Social workers respect the inherent dignity and worth of the person," social workers are called to "…promote clients' socially responsible self-determination," and to "…resolve conflicts between clients' interests and the broader society's interests in a socially responsible manner…" Reviewing the *Code* further, the following ethical standards appeared to apply to my practice and goal of gathering input from the wards who would be most affected by HFS 85 rule revisions: (1.02) self-determination, (1.14) clients who lack decision-making capacity, (6.02) public participation, and (6.04) social and political action:

1.02 Self-Determination

Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals. Social workers may limit clients' right to self-determination when, in the social workers' professional judgment, clients' actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others. (NASW, 1996)

Self-determination recognizes the dignity and worth of a person. Mental health advocates define self-determination as:

…clients' rights to be free from all involuntary treatment; to direct their own services; to be involved in all decisions concerning their health and well-being; and

to have meaningful leadership roles in the design, delivery, and evaluation of services and supports. (Cook, 2002)

When analyzing the lack of ward input in the rule revision process, I recognized that advocate groups and corporate guardianship agencies could present information and concerns on behalf of the wards; however, they did not have the first hand experience of living under guardianship. My thought was that the wards might be able to shed light on how the rule affected their lives, as well as any areas of the rule that might be of concern to them.

Johnson (1999) purports that there has been a tendency of those in leadership roles to act in ways that conflict with this value and states, "…serious concerns have been raised in the disability community over discrepancies among public statements made by federal disability policy leaders in support of the self-determination of people with disabilities and their actual behavior, decisions, and actions." This statement clearly cautions policymakers to examine the ways in which they carry out their duties, and to be cognizant of their intent and action. The HFS 85 rule revision presented an opportunity to redefine how the policy formulation process proceeded. In this case, DHFS recognized the importance of including the voice of the wards in the rulemaking process.

1.14 Clients Who Lack Decision-Making Capacity

When social workers act on behalf of clients who lack the capacity to make informed decisions, social workers should take reasonable steps to safeguard the interests and rights of those clients. (NASW, 1996)

and,

6.02 Public Participation

Social workers should facilitate informed participation by the public in shaping social policies and institutions. (NASW, 1996)

In this case, although wards are considered incompetent, they retain their right to participate in decisions that will affect their care. Froemming & Abramson state:

> Even though a person is under guardianship, he or she retains the right to communicate with government officials about his or her treatment and to seek legal advice or court review concerning the need for guardianship, the guardian's actions, or any orders for protective placement or services. (Wisconsin Department of Health and Family Services Division of Supportive Living, 2000).

The inclusion of current wards under corporate guardianship was justified because the rule directly affects the practices of corporate guardianship agencies in relation to the care of the ward. To obstruct or disregard this right could result in an unintended omission or oversight within the rule that could have a detrimental impact on the ward. An example of the disconnect experienced between providers and consumers can be seen in Shumway's (1999) dialogue regarding an "open microphone" meeting with consumers that was used to inform policy revisions for person-centered care:

> Individuals stated their dreams and desires and compared them to their current circumstances. Increasingly, individuals were expressing where they wanted to live and the relationships they wanted to have. The discrepancy in satisfying individuals, in addition to the realization of the clarity of many individual's visions, were jarring for agency staff.

The consumers impacted by the policy did not share the same feelings as the agency staff, and this would not have been communicated if the consumers had not been invited to share their thoughts.

6.04 Social and Political Action

(a) Social workers should engage in social and political action that seeks to ensure that all people have equal access to the resources, employment, services, and opportunities they require to meet their basic human needs and to develop fully. Social workers should be aware of the impact of the political arena on practice and should advocate for changes in policy and legislation to improve social conditions in order to meet basic human needs and promote social justice.

(b) Social workers should act to expand choice and opportunity for all people, with special regard for vulnerable, disadvantaged, oppressed, and exploited people and groups…

(d) Social workers should act to prevent and eliminate domination of, exploitation of, and discrimination against any person, group, or class on the basis of race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, or mental or physical disability. (NASW, 1996)

Because persons who are most affected in their daily life by HFS 85 are persons who have been declared incompetent, and have no family member or friend willing or able to be guardian, I believe that this group represents one of the most vulnerable and disadvantaged groups in our society. As a result, I offered to work with DHFS-DQA to establish and facilitate the ward listening sessions to further inform the rule making process.

4. Method

A questionnaire was developed to guide the sessions and included questions in the following areas: Experience under guardianship, participation in decision-making, complaint and grievance processes, and contact with the corporate guardian.

Three ward listening sessions were held between March and April 2007. Attendance averaged 10 wards per session. A total of 31 wards were interviewed. All wards were over the age of 18. All participants appeared to be of European descent. Participants reported

various lengths of service provided by corporate guardians, from a few months to many years.

Two of the sessions were held at workshops where the wards were employed, and one session was held at a community drop-in center. All three locations were in rural counties of the state. Personal attendants and a few service providers sat in on the sessions as well.

The facilitator presented opening remarks about the reason for the session and how the information would be used to develop HFS 85 during its revision. Participants met as a group, where the facilitator went through the questionnaire with the group and proceeded to prompt each participant individually for his or her response. For wards that were able to read, the facilitator copied the questions onto a flipchart, and participants were informed of its availability during the session. Each session averaged one and a half hours in length. A DHFS-DQA staff member recorded participant comments to each question by hand. Audio and visual recording devices were not used to record responses.

5. Results

The comments of the wards were grouped into the four key areas that the questionnaire addressed: 1) experience under guardianship; 2) participation in decision-making; 3) complaint and grievance processes; and 4) contact with the corporate guardian.

5.1 Experience under guardianship

This area focused on general experiences under corporate guardianship and asked for input on what was working well and what could be improved. Most of the wards reported that

they liked having a corporate guardian and that their life had improved as a result. Some of the wards said they did not see their guardian often. A few stated they didn't know who their guardian was because the guardian was newly appointed and they had not met their guardian yet, and others stated they could not remember the last time they saw the guardian.

5.2 Participation in decision-making

Participation was discussed with an emphasis on how the ward participated in decisions related to their living arrangements, choice of doctor, day programming or work, and choice of worship. Many of the wards reported that they were satisfied with their current role in the decision-making; however, a few wards did have specific wishes for different living situations and stated a preference for more inclusion in the decision making process. One ward explained: "I'm 32 years old….I would like to live closer to my brother…I should not have to live with children…I'd like to visit my grandparents (who live in a neighboring state)." Another ward stated the residence she was at would not allow her children or parents to visit after 6 p.m. and this interfered with her being able to see them. One ward expressed an interest in moving to another state. Another ward stated she was told how many gifts her children could have, but that she wanted to buy them more.

5.3 Complaint and grievance processes

Participants were asked how they handled complaints or grievances about their living arrangement, doctor, or their daily activities. Participants were also asked whether they talk about these complaints with their guardian, and who else they contact if their guardian was not able to assist them.

As a whole, wards seemed unaware of any right to question decisions made by their guardians. A few wards stated they would call their guardian if they had a complaint; however, most of the wards did not express any knowledge of how to handle such a conflict.

5.4 Contact with the corporate guardian.

Finally, respondents were asked how often their guardian contacted them face to face or by phone and how often the ward contacted their guardian. Responses to these questions varied widely, with many wards reporting weekly and monthly visits or phone contacts, while a comparable portion reported bi-monthly, quarterly, or less frequent contact.

6. Analysis

The facilitator and DHFS-DQA staff met briefly after each session to discuss the listening sessions. After all the sessions were completed, the results were compiled into a document to be presented to the advisory committee. The document outlined the sessions and included information on how the data would be used during the rule revision process. Additionally, DHFS-DQA offered a statement on the usefulness of holding the sessions. The document states the following:

1. What common themes emerged from the Listening Sessions?

- Rights and grievances – Some wards did not know their rights and expressed wanting more information regarding their rights and how to follow up on a grievance.
- Contact with guardian – Some wards said they wanted more face to face visits at their residence with their guardian.
- Decision making – Some wards did not know why some decisions were made, such as where they live, and wanted to be involved in the decision making process.

2. How will the Division of Quality Assurance use the information obtained from the Listening Sessions in the rule development process?

The information obtained from wards who attended the Listening Sessions will be shared with the Advisory Committee at the next HFS 85 Rule Revision Committee meeting. Their views will be given the same consideration as the views expressed by other members of the Advisory Committee when drafting rule language. For example, comments by wards related to frequency and location of visits with their guardian, notification of rights and grievance procedure, involvement of wards in decision making and any other areas identified by the committee in which wards expressed comment, will be considered when drafting proposed rules.

3. How have the Listening Sessions helped the Division of Quality Assurance?

The Division stresses the importance of involving all persons who are affected by the rule in the rule making process. Wards are personally affected by the rule making, and it is important to obtain their comments and incorporate their ideas, to the extent possible, in any proposed changes to the rule.

In addition, the lessons learned by including wards directly in the rule making process for HFS 85 can be used when the Division revises other administrative codes by including residents, clients, patients, and family members to obtain their perspective of the rule. [(State of Wisconsin Department of Health and Family Services, 2007)](#)

7. Discussion

The three listening sessions with wards provided a venue for the voice of the wards likely to be affected by revisions to HFS 85. Their comments, while generally positive, did reflect some concerns in areas related to rights and grievances, contact with the guardian, and involvement in the decision making process. DHFS has recognized these problematic areas and plans to review sections of the code that can address these issues.

8. Limitations

The information gathered from the listening sessions is specific to Wisconsin and were most representative of the rural counties within. An effort was made to hold similar sessions in urban areas; however these sessions did not occur because of scheduling conflicts and time constraints. The results must be reviewed carefully because of this concern, as urban area corporate guardianship agencies may operate differently than those in rural areas.

Some of the participants may have had difficulty understanding or answering the questions, and this may have biased the responses. Additionally, some of the responses may have been affected by comments from peers or the influence of personal attendants or service providers in attendance.

Lastly, all of the wards who appeared at the sessions were of European descent, and may not hold the same views as wards of other ethnicities. It is difficult to ascertain whether this was due to the location of the sessions or some other reason.

9. Conclusion

The process described above provides an example of the application of the *Code's* core value of "Dignity and Worth of the Person" to practice. By applying the ethical standards presented in the *Code,* I was able to assess the need for input from the wards as well as develop a method of including them. Further, I was able to work with policymakers to ensure that the information gathered from the wards would be used to inform the rule making process. By including the wards in the policy formulation process, Wisconsin has made an affirmative statement that wards, although deemed incompetent, continue to retain dignity and worth as individual persons.

Social workers should continue to look for ways to involve their clients at the macro level of practice, to ensure that policies include the input of all stakeholders—including those who are vulnerable or oppressed.

Notes

[1] Corporate guardianship is considered a guardianship of last resort in Wisconsin. Persons who receive services from a corporate guardian have no family member, friend, volunteer, or other party that is interested or able to serve as their guardian. Many states utilize provide public guardianship, where the state acts as guardian for such persons. Corporate guardianship differs from public guardianship in that it relies on non-profit corporations to provide the guardianship services.

[2] The statement of scope is the first step in opening an existing rule up for revision. The statement of scope announces to the public the intent to revise the rule. The statement includes an analysis of the rule, statutory authority for the rule, an estimate of the time it will take to develop the rule, entities that may be affected by the rule, and comparable federal regulations if any.

References

Cook, J., and Jonikas, J. (2002). Self-determination among mental health consumers/survivors: Using lessons from the past to guide the future. *Journal of Disability Policy Studies*, 13(2), 87-95.

Johnson, J.R. (1999). Leadership and self-determination. *Focus on Autism and other Developmental Disabilities*, 14(1), 4-16.

National Association of Social Workers (1996). *Code of ethics of the National Association of Social Workers.* Washington, DC: NASW Press.

Shumway, D.L. (1999). Freedom, support, authority, and responsibility: The Robert Wood Johnson Foundation national program on self-determination. *Focus on Autism and other Developmental Disabilities*, 14(1), 28-35.

State of Wisconsin Department of Health and Family Services. (2006). *Administrative rules statement of scope for proposed rules*. (Doc. EXS-261, HFS 85, issued September 19, 2006). Wisconsin: Office of Legal Counsel.

State of Wisconsin Department of Health and Family Services. (2007). *Wisconsin administrative code HFS 85:Results from listening sessions with wards*. (issued April 26, 2007) Wisconsin: Division of Quality Assurance.

Wisconsin Department of Health and Family Services Division of Supportive Living. (2000). *Guardianship of adults: A decision-making guide for family members, friends and advocates*. Madison, WI: Author.