

Conscientious Objection in Social Work: Rights vs. Responsibilities

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Abstract

This paper reports on a national study that explored the complexity surrounding ethical conflicts related to conscientious objection in social work. Specific focus was on the extent to which practitioners have a right to remove themselves from professional services and situations that conflict with a religious or moral worldview.

Key Words: Conscientious objection, value conflicts, duty to treat, Code of Ethics, health care legislation

1. Introduction

A hallmark of a true profession is the presence of a code of ethics (Greenwood, 1957; Reamer, 2006; Wilensky, 1964). Although social work has several codes of ethics, the code most subscribed to, and that contains the most comprehensive statement of ethical standards, is the National Association of Social Worker's (NASW) Code of Ethics (Reamer, 2006). The NASW code sets out guidelines and responsibilities that consolidate the values and ethical behavior underlying the profession. In some ways, the code provides specificity with regard to ethical conduct; in other ways, the code has been deemed too broad

(Loewenberg, 1988).

In recent years, a number of professions have modified their codes to address specific emergent ethical and legal issues. One area that has resulted in code changes for a number of health-related professions relates to conscientious objection (CO) and the rights of professionals to opt out of 'duty to treat' obligations as a result of conflicts with religious or moral convictions (Anderson, Bishop, Darragh, Gray, & Poland, 2006).

This paper reports on a national study that explored the complexity surrounding ethical conflicts related to CO in social work. In general, research questions focused on the ethical obligations of social workers when faced with conflicts between personal and professional values, such as the extent to which practitioners have a right to remove themselves from professional services and situations that conflict with a religious or moral worldview. An Internet-based survey was used to reach a broad spectrum of social workers (n = 3300) across the United States.

2. Clarification of Terms

A conscience clause (also termed objector legislation, noncompliance clause,

opt-out clause, refusal clause, and/or religious exemption) is a policy statement or provision, typically related to health care, which exempts professionals from providing health-related services that are found to be personally, morally, or religiously objectionable. These provisions, drawn from philosophical, legal, and theological perspectives (Anderson, Bishop, Darragh, Gray, & Poland, 2006) may be expressed in a number of different ways-- for example, a physician who refuses to prescribe birth control to unmarried women, or a pharmacist who refuses to dispense ECPs (emergency contraceptive pills). The most familiar illustration of CO is refusal to perform military service on grounds of freedom of thought, conscience, or religion. CO has been extended to various health professions, allowing professionals to "opt out" of participating in health-related services that are found to be objectionable. For the purposes of this paper, the focus will be on the ethical dimensions surrounding CO in social work.

The definition of *social worker* has been the subject of considerable debate. For this study, the term *social worker* will be defined as a graduate of a social work education program at the bachelor's or master's degree level who uses his/her knowledge and skills to provide social services for clients (Gibelman & Sweifach, 2008). Although social workers share in common a belief in and commitment to the principles of the profession's *Code of Ethics*, personal beliefs are quite diverse. Some social workers are politically liberal, and others are conservative. Some are devoutly religious, and others are atheists. Nevertheless, adherence to the *Code of Ethics* should distinguish social workers from other professional groups in regard to compatible beliefs and actions between professional and personal behaviors (Gibelman & Sweifach, 2008).

Since the inception of the profession, social workers have clung religiously to professional values; "we seem to cling to them intuitively, out of faith, as a symbol of humanitarianism" (Vigilante, 1974). The profession's deep value-based roots serve as the foundation of the profession's mission, the relationships social workers have with clients and society, methods of interventions used, and for resolving ethical dilemmas (Reamer, 2006a). Some suggest that social workers are the defenders of social morality (Glasser, 1984). The NASW Code of Ethics, in addition to providing guidelines and responsibilities for ethical conduct, serves as the basis for the general public's expectations of professional conduct for social workers (Strom-Gottfried, 2003). The Council on Social Work Education mandates that every MSW and BSW program infuse values and ethics throughout the curriculum (Council on Social Work Education, 2004).

Commentators suggest that clashes between personal and professional values are inevitable (Reamer, 2006a). The conflict emanates from the clash between two or more values, each of which can be substantiated as morally correct and ethically grounded (Linzer, 1999; Mattison, 2000; Rokeach, 1973). Although social workers are admonished to limit the influence of personal values on professional practice, commentators suggest that for some social workers, especially those for whom their personal worldview is fundamentally religious or informed by a particular moral order, putting aside values regarded as immutable is an especially difficult challenge (Linzer, 1995; Spano & Koenig, 2008). Discrepant opinions permeate the literature with regard to the actions that professionals ought to take when personal and professional values collide. Some of the literature suggests that when conflicts between personal and professional values develop, social workers must suspend

their personal values. “To be a professional practitioner is to give up some of one’s autonomy and to relinquish some of one’s rights as a freely, functioning being” (Levy, 1976, p. 113). One writer suggests that “in conflicts between personal values and professional values, the professional is duty-bound to uphold professional values. Upholding professional values represents ethical action” (Linzer, 1999, p. 28). Pumphreys (1959) stated that new recruits to social work must accept the profession’s values before being considered bona fide professionals.

Other opinions within the literature suggest that there is not necessarily one set of values to which all social workers subscribe (Guy, 1985; Timms, 1983). Commentators explain that the application of any code of ethics’ provisions involves a certain degree of interpretation and judgment (Franklin, Harris, & Allen-Mearns, 2006). For example, the NASW Code of Ethics states that the social worker’s primary responsibility is to promote the well-being of clients. The National Association of Christian Social Workers (NACSW) endorses this principle, but emphasizes that loyalty owed to a client is secondary to harm to self or others (Ressler, 1997).

The literature explains that what is “best” for the client may be left to how “best” is translated by the worker. A social worker who believes that a fetus is a living being, may be compelled to act differently from a colleague who believes that life begins after birth (Loewenberg, 1988). The choice is not usually between one good option and one bad; each option typically contains both positive and negative attributes (Dolgoff, Loewenberg, & Harrington, 2008). Commentators suggest that at the most general level, there is most likely agreement on a common value base. However, when dealing with values on an

action or practical level, this unanimity fades (Loewenberg, 1988).

For centuries, ethicists and philosophers have struggled to establish guidelines for choosing among competing values (Reamer, 1982). Commentators have proposed models for resolving value conflicts and ethical dilemmas [see for example Levy’s (1976) ‘classification of values’; Mattison’s (1994) ‘framework to analyze ethical dilemmas’; and Dolgoff, Loewenberg, & Harrington’s (2008) ‘hierarchies of ethical principles’]. Many of these models are best used to analyze dilemmas when professional values conflict with other professional values. Few models focus on resolving conflicts between personal moral/religious worldviews, and the code of ethics (Spano & Koenig, 2007). Despite these guides, models, and ethical codes, practitioners continue to contend with dissonance when faced with a choice between two values, both of which can be substantiated as right and good.

In part, a profession is defined by its code of ethics. Professional codes of ethics are guidelines that reflect the moral ideals and values of a profession, as well as required attitudes and conduct. In general, professional codes of ethics are based on universal moral principles such as justice, autonomy, beneficence, veracity, fidelity, respect for persons, and nonmaleficence (avoiding harm).

3. Duty to Treat

The ‘duty to treat’ is grounded in several moral principles. Its origins can be found in medicine’s Hippocratic Oath and other ethical writings. It obliges the professional to use skill and judgment to benefit the patient. The obligations are centered around principles of beneficence, nonmaleficence, and autonomy. Beneficence is expressed as the moral obligation to

promote the welfare, health, and wellbeing of others (Beauchamp & Childress, 2001; Schroeter, 2008). The principle asserts an obligation to help others further their unique interests. The principle of nonmaleficence requires that harm is not inflicted upon others; it derives from the maxim *primum nil nocere* (first do no harm). This principle asserts an obligation to consider the possible harm that an intervention might cause. The principle of autonomy derives from the Greek *autos* and *nomos*, meaning self-rule. The principle refers to the rights of an individual to be treated in accordance with his/her own decisions and goals. The principle asserts an obligation to support self-determination and the respect of personal preferences.

Although there are some philosophical differences among the various ethical codes of health professions, there is general theoretical consistency in how these principles are conceptualized. For example, the Code of Ethics for Nurses, which combines beneficence and nonmaleficence, articulates that the nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient, including the right of competent patients to determine what will be done with their own bodies (ANA, 2001). For the American Pharmacists Association's (APhA) Code of Ethics, beneficence is quite pronounced; the code states that "a pharmacist promotes the good of every patient in a caring, compassionate, and confidential manner." The principle of nonmaleficence requires that pharmacists refrain from acting in ways that could potentially harm or injure others and they "have a duty to maintain knowledge and abilities as new medication, devices, and technologies become available and health information advances" (APhA, 1994).

Although these standards of care are seemingly clear and self-evident, application

is highly interpretive. For example, the principle of nonmaleficence (do no harm), can be viewed in abortion cases as doing no harm to an unborn child. A clinician working with a gay client may interpret restorative therapy as a "beneficent" way of improving a client's wellbeing.

4. Non Compliance Clauses

The first conscience clause was the "Church Amendment" which was enacted shortly after *Roe v. Wade* in 1973 as a response to the supreme court's decision to legalize abortion. This amendment states that public officials may not require individuals or agencies that receive public funds to provide or assist in abortions or sterilization procedures if doing so is contrary to personal moral or religious beliefs. By 1978, almost every state had implemented some variant of conscience clause legislation (Feder, 2005).

5. Methodology

Drawing from the accumulating literature on CO in professions such as medicine, pharmacy, and nursing (e.g., Anderson, Bishop, Darragh, Gray, & Poland, 2006; Curlin, Lawrence, Chin, & Lantos, 2007; Wernow, 2008; Wilson, 2008), a survey instrument was constructed to examine perceptions and opinions of respondents about social workers who wish to "opt-out" of duty to treat obligations. Exempt status was received for conducting the research through the Albert Einstein School of Medicine's internal review board. The survey was developed using Survey Monkey, a web-based platform for conducting surveys. All responses were anonymous, and no method of tracking individual identity was utilized; as a result, informed consent was waived.

A database of social work administrators was created using staff directories from social work agency

websites. Each administrator was asked to forward a cover letter, soliciting participation, and a survey link to personnel at his/her agency. The cover letter invited respondents to forward the survey link to colleagues. This is a mechanism similar to convenience and snowball sampling (Babbie, 2001) or word-of-mouth communication, termed in the literature as the “pass-along” approach (Norman & Russell, 2006). In addition, a survey link was posted on an array of social work-based web pages (e.g., NASW, Facebook, social work blogs), inviting users to participate in the survey.

Prior to conducting the study, a draft survey was sent to a pilot group of social workers to evaluate the face and content validity of the instrument. The social workers were alumni at the University where the researchers work. Respondents taking the pilot test did not remain eligible to participate in the actual study. Suggested changes were incorporated into the final version of the survey.

Of the 3,300 surveys sent, 2,650 surveys were successfully delivered electronically; 650 bounced back as undeliverable. Of the successful transmissions, 923 of those surveyed returned completed useable questionnaires for an overall 35% response rate.

5.1 Instrument

The questionnaire opened with a case revolving around a gay couple interested in adopting a child. At the center of the case was a social worker who was charged with conducting a home visit to assess adoption suitability. After realizing that the couple was gay, the social worker requested to be removed from the case, citing moral opposition. The first section of the questionnaire referred to the case and asked respondents their opinion about personal and professional value conflicts. The second section of the questionnaire

asked respondents to reflect on ethical or religious conflicts personally experienced within their own past practice experiences. The third section of the questionnaire asked respondents to identify their views on an array of contemporary ethical issues such as stem cell research, first trimester abortion, gender re-assignment surgery, contraception, and others. The fourth section of the survey asked respondents about their own personal religious practices, as well as their ideological and political views. The final section focused on general socio-demographic areas.

In addition to multiple choice and likert-scale response items, several open-ended questions were included to better understand how respondents feel about CO within social work. Analyses were conducted to compare demographic sub-groups in terms of their religiosity, age, income marital status, sexual orientation, gender, moral attitudes, and political orientation.

5.2 Data Analysis and Measures

Data analysis was conducted using SPSS version 16.0. Means, standard deviations, frequencies, and percentages were used to generate descriptive results. A significance level of .05 was used for all inferential statistics. To establish the significance between variables, both nonparametric (chi squares) and parametric (t-tests, ANOVAs, and Pearson product moment correlation coefficients) tests were conducted. Several indices were constructed from survey items. Each index was dichotomized at the mean. Each index was comprised of items with five ordinal categories, all logically compatible. For each scale, items were re-coded to maintain consistency in direction and clarity of interpretation with the other scales. Responses were dichotomized as high or low based on original rating scales, with

high to low corresponding with “important” to “unimportant,” “agree” to “disagree,” “often” to “rarely.” A Cronbach’s alpha was conducted to assess the reliability of the indices. Cronbach’s alphas were all above .70.

6. Findings

Of the respondents who indicated their gender, 75.7% were female, 23.6% were male, and .7% indicated other. This ratio is consistent with other data on the human services labor force, which reflects a growing trend of feminization (Bureau of Labor Statistics, 2003; Gibelman & Schervish, 1997). The mean age of the sample was 48 years old. The mean annual family income was approximately \$75,000.00.

The vast majority of respondents self-identified as White (84%), 5% African American, 3.5% Latino, and 7.5% other. In regard to marital status, 67.5% of

respondents indicated they were married or living with a partner, 2.6% were widowed, 10.8% were divorced or separated, and 19.1% were single. With regard to sexual orientation, 83% indicated that they were heterosexual; 11.4% indicated gay/lesbian, 3.8% indicated bisexual; 0.4% indicated that they were questioning/unsure. Thus, the sample was primarily white, near 50 years old, middle class, heterosexual, and female.

Of the respondents who answered the question about religion, 42.5% indicated that they were Christian; 24.7% indicated Jewish, 6% indicated Unitarian, 19% indicated Agnostic or “no religion.” Other religions, all 1.5% or less, included: Hindu, Islam, Mormon, Sikh, Buddhist, Bahai, and Atheist. In regard to highest degree obtained, 3.5% hold the BSW as their highest degree, 81.9% the MSW, 11.9% a PhD or DSW, and 2.7% other. Respondents provided their state of residence. Table 1 shows their geographic distribution.

Table 1

Table 1. Geographic Distribution of Respondents (n=788)

| Re-Coded Region | Sample Representation |
|---|-----------------------|
| Region I and II = Northeast | 40% (n=324) |
| Region III and IV = South | 18% (n=142) |
| Region V and VI = Mid and Southwest | 18% (n=146) |
| Region VII and VIII = Central and North Central | 6% (n=44) |
| Region IX and X = West | 17% (n=132) |

6.1 Professional Characteristics

Respondents are an experienced group of social workers. The vast majority (69.1%) reported having ten or more years of work experience in the social work profession. Only 6.3% reported having 0-5

years of experience. A primary function of direct service was indicated by 35.6% of respondents. An additional 18.2% of respondents indicated that their primary function is in private practice, the majority of whom provide direct services. Only 7.6% of respondents reported working in

executive (senior) management, and another 15.1% reported their primary function to be middle management. Such findings mirror those of other labor force studies of social workers (see, for example, Gibelman & Schervish, 1997). The majority of respondents work full-time (75.3%), 18.9% work part time, and 5.8% indicated that they are unemployed or retired.

6.2 Religious, Moral, and Socio-Political views

According to the moral views scale, the respondents of this study do not tend to object to contemporary moral issues such as abortion, stem-cell research, euthanasia, and same-sex marriage. The religiosity scale suggests that respondents fall along a wide continuum of religiousness. According to the socio-political scale, respondents lean more toward liberal political and social views than conservative (see Table 2).

Table 2

Table 2 . Moral views, religiosity, and socio-political scales

| | Description of scale | # of items | n | a | Mean (SD) | Potential Score Range | Interpretation of scale | |
|------------------------|--|------------|-----|-----|------------|-----------------------|-----------------------------------|--------------------------------------|
| | | | | | | | LOW | HIGH |
| Moral Views Scale | Moral or religious objections to controversial issues (e.g., same sex marriage, abortion, etc.). | 11 | 733 | .86 | 1.13 (.57) | 1 to 3 | Less moral or religious objection | Greater moral or religious objection |
| Religiosity Scale | Religious Practices (e.g., religious service attendance, adherence to religious laws, and rituals, etc.). | 5 | 733 | .89 | 2.03 (.63) | 1 to 3 | Less religiosity | Greater religiosity |
| Social Political Scale | Social and Political Views (e.g. how would you describe your political views, your views on social issues; your views on economic issues). | 5 | 733 | .84 | 1.3 (.52) | 1 to 3 | More Liberal Views | More Conservative Views |

6.3 Conscientious Objection

Respondents (n=905) were asked a series of attitudinal questions about CO within the social work profession. The large majority of respondents (n=714; 79%) believe that social workers “ought to work with all clients regardless of whether the social worker has a religious/moral objection to the client's issue.” Over 71% (n=642) of respondents believe that “opting out” of working with a client as a result of a religious or moral objection is not acceptable.

Over two thirds (69%; n=624) of respondents indicated that state clauses that protect health care providers, such as doctors, nurses, and pharmacists, from adverse consequences that may arise from

refusing to attend to client issues that violate their moral or religious conscience, should not apply to social workers. Respondents were also asked whether these types of clauses ought to apply to nurses and pharmacists. With regard to nurses, approximately 60% (n=542) felt that nurses should not have the right to refuse a patient’s request even if the request is inconsistent with the nurse’s beliefs (e.g., assisting in an abortion or organ retrieval), and 71% (n=645) felt that pharmacists should not have the right to refuse a patient’s request (e.g., contraception prescription, day-after pill). A substantial proportion of the sample expressed strong views regarding “opting-out” in social work (see table 3).

Table 3

Table 3. Views about opting out in social work

| | Somewhat agree % | Strongly agree % | n |
|--|---------------------|---------------------|-----|
| Social workers who are unable to move past moral/religious issues of conscience ought to consider another profession. | 13 | 56 | 640 |
| Social workers who opt-out of working with a client as a result of a conscientious objection, ought to be reprimanded in some way. | 20 | 28 | 136 |
| Social workers should learn to work with all clients regardless of whether he/she has a religious or moral objection to the client (client's issue). | 26 | 53 | 717 |

n=905

Pearson's Linear Correlations were used to measure the relationships between conservatism and "opt-out" views. The two indices (religious/moral, social/political) showed strong correlation ($r=.72$ & $.61$ respectively, $p=.005$), suggesting that conservatism and support for 'opting out' are correlated. Very weak or no correlation was observed between religious practice and 'opt-out' views ($r=.12$, $p=.65$), suggesting that religious practice does not have a decisive influence on "opt-out" views.

6.4 Experience with moral/religious conflict

By and large, this study's respondents have experienced challenges to

religious/moral beliefs, but have not chosen to remove themselves from these cases (93%, $n=841$). Just under a third of respondents (31%, $n=280$) have chosen not to work with a client for reasons other than religious objection. Whereas 11% of respondents ($n=99$) have chosen not to work with a client because of a religious/moral objection, 93.2% of these respondents ranked high on the moral views scale (indicating strong objection to the index of controversial issues). In general, open-ended comments were disproportionately negative in tone, critical of opting out in social work (see table 4).

Table 4

Table 4. Open-ended comments about opting out in social work

| |
|---|
| If a social worker's religious beliefs make it impossible to function ethically, he needs to reconsider his choices. He should immediately be removed from the case and his supervisor needs to be clear about agency expectations. |
| Social Workers should not discriminate no matter what their personal feelings. This is part of our code of ethics. |
| Social workers that can not separate personal/professional values, need to find a profession that does not require them to deny their own sense of morality or ethics and that does not put them in a position to offend, oppress, discriminate against vulnerable populations. |
| If social workers cannot extend compassion to all they serve, they should reconsider their profession. |
| Social Work is about working with these populations. The people who want a clause are not social workers. |

7. Limitations

There are a few limitations in this study that must be discussed. A modified convenience sampling method was used to collect the data. It is possible that this method led to a self-selection bias; that is, the study may have attracted only those social workers who have an interest in CO. Furthermore, reliability of self-reported attitudes are subject to the respondents' inclination to promote a favorable opinion of the social work profession. Finally, the use of a web-based online survey might result in obtaining a biased sample, as it unintentionally excludes potential participants who lack access to or comfort with the Internet.

8. Discussion

This study explored the complexity surrounding CO in social work. The large majority of this study's respondents believe that when personal moral/religious values conflict with professional duties, social workers are obligated to side with professional values; almost two thirds of respondents do not believe that "opting out" of working with a client because of a religious or moral objection is acceptable.

Although in many states, health care workers who choose the path of CO are protected, the respondents of this study appear to suggest that social workers should not be afforded these same protections.

Commentators suggest that social work is one of the most value-based professions (Mattison, 2000; Noble & King, 1981; Osmo & Landau, 2003; Reamer, 2006; Timms, 1983). The respondents of this study agree with the literature. When asked to rank social work on a scale from 1 to 10 (high) with regard to how value-based they feel the profession is compared with other professions, 75% ranked social work 7 or higher. Perhaps the strong opinions regarding "opting out" expressed by the respondents of this study may result, in part, from an identification with social work's strong value base. Another tangential explanation is that social workers are committed to diversity, tolerance, and inclusion (Hodge, 2007), accepting these values as part of a professional oath. When engaged in professional activities, perhaps social workers feel that one's professional oath should override personal moral or religious allegiances.

Although respondents feel strongly

about the necessity of separating religious/moral values from professional duties, less than half believe that workers ought to be fired (46%; n=421), or reprimanded (45%, n=407) for refusing to serve those found to be morally or religiously repugnant.

9. Implications

Research shows that Americans overwhelmingly oppose laws that would allow religious or moral interests of health care providers to come between them and their health care needs (ACLU, 2002; RHTP, 2000). It appears that social workers share this belief, in that more than two thirds of respondents believe that laws protecting some health care providers should not extend to social workers.

Health care professions appear to be mixed about opt out laws. For pharmacists, each state has different regulatory policies. There are only a few states that require pharmacists to dispense every lawful prescription. New Jersey is the only state that explicitly prohibits pharmacists from opting out of filling prescriptions solely on moral, religious, or ethical grounds (Beal & Cappiello, 2008). Eleven states have laws that protect a pharmacist from any adverse action that may result from refusing to fill prescriptions based on a religious or moral objection (NCSL, 2009). The American Pharmacists Association (APhA) recognizes an individual pharmacist's right to conscientious refusal (APhA, 2008). Commentators have advised that in recent years, there is a growing list of pharmacists who have chosen to opt out of dispensing medication on grounds of moral or religious objection (Grady, 2006; Sonfield 2004).

With regard to physicians, several states have laws that protect health care providers from any adverse consequences that may arise from refusal to participate in medical services that violate their

conscience (Curlin, Lawrence, Chin, & Lantos, 2007). Principle VI of the AMA's (2006) Code of Medical Ethics states: "A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve..." According to the literature, ongoing debates among physicians continue about CO in medicine (Curlin, Lawrence, Chin, & Lantos, 2007).

The American Nurses Association states that nurses have a right to refuse to participate in cases, although they have an obligation to detail information about health-related options which are available (Sonfield, 2004). According to the literature, nurses must ensure that any CO relates to a procedure and not to a particular patient.

According to the NASW Code of Ethics, social workers are expected to "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, or mental or physical disability" (p. 27). The code of ethics also states that the "social worker's primary responsibility is to promote the well-being of clients" (NASW, 1999, 1, 1.01). Commentators explain that when clients' behaviors and practices conflict with a social worker's personal morals or religious beliefs, the social worker may be in need of peer support, supervision, or values clarification training to responsibly serve clients (Aronstein & Thompson, 1998; Ryan & Rowe, 1988).

Should the code be more specific? In general, commentators suggest that historically, codes of ethics were written in general terms; contemporary codes tend to be more specific. With greater specificity, however, comes a greater chance for conflict (Dolgoft, Loewenberg, & Harrington, 2009). Some commentators suggest that the core

values of the profession are too generalized and non-specific, and as a result they do not offer sufficient behavioral guidance (Jayartne, Croxton, & Mattison, 1997; Loewenberg, 1988). Congress (1999), on the other hand, explains that a code of ethics must be general.

For now, a great deal of variability exists in the way social work values and the NASW Code are interpreted and applied. Some commentators suggest that at a generalized level, personal and religious beliefs may have a more profound impact on practice than professional values (Faver, 1986; Kassel & Kane, 1980; Loewenberg, 1988). This, however, appears to run counter to key principles articulated in the NASW Code of Ethics, which advocates giving precedence to ethical duties and professional obligations over personal interests. Opting out does appear to be acceptable within other professions, although tight guidelines exist. For social work, however, which is “among the most value based of all professions” (Reamer, 2006, p. 4), the question remains unsettled as to whether CO has a place.

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