

Ethical Decision-Making Among Hospital Social Workers

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Abstract

The purpose of this study was to examine ethical decision-making among hospital social workers. The primary intent was to examine the extent to which social workers in health care identify an ethical dilemma, provide a rationale for the basis of their decision, and subsequently follow a process for ethical resolution. A pattern that emerged was reliance on rules and laws rather than using systematic frameworks. The findings suggest the need to understand ethical decision-making as part of a thoughtful, ongoing process.

Keyterms: Ethical Decision-making; Medical social workers; Ethical resolution paradigms; Frameworks for ethical resolution

Introduction

The concept of ethics in health care is not new. Since the days of Hippocrates, medical ethics have been concerned with the ethical obligation of health care professionals in meeting the needs of the sick and injured (Beauchamp & Childress, 1994). However, impressive technological developments in medicine, the rapid emergence of managed care in the delivery and reimbursement of health care costs and expanding information systems have contributed to the increased frequency and complexity of bioethical dilemmas for all health care professionals, including social workers (Blumenfield & Lowe, 1987).

Several factors have had an impact on the growing frequency of ethical dilemmas in health care. While scientific developments in medicine have offered expanded opportunities for treatment choices and the potential for longer life, they have additionally created ethical dilemmas involving issues related to quality of life, informed consent, end-of-life decision-making including the provision for or withdrawal of life support, access to health care, and resource allocation (Blumenfield & Lowe, 1987; Cossom, 1992; Manning, 1997; Reamer, 1998). These developments

have raised questions for social workers as to what should be done in life-or-death situations, who should decide, and what criteria should be used in the decision-making process (Blumenfield & Lowe, 1987). Social work in today's health care environment not only requires an awareness of the clinical and ethical concerns that arise in practice, but it demands a demonstration of a reasoned response toward ethical analysis and decision-making.

Literature Review

Advancements in medical technology and related ethical issues and questions affect social work practice on a daily basis. Traditionally, the function of hospital social work focused on the development of a viable post hospital plan to meet the medical and social service needs of patients (Blumenfield & Lowe, 1987; Cummings & Cockerham, 1997). Current hospital social work also requires grappling with issues related to patient autonomy, confidentiality, refusal of services, and informed consent as well as assisting families in decision-making about treatment and quality of life (Csikai & Sales, 1998; Manning, 1997). These issues often present the social worker with the task of initiating ethical discussion and deliberation and demonstrating a level of ethical competence which is best approached using a reasoned process for ethical resolution (Reamer, 1998).

Additional ethical dilemmas in health care stem from the cost containment measures currently affecting reimbursement for hospitals. The prominence of managed care as a primary means to control cost and health care delivery has raised new ethical dilemmas for social workers. Concerns of confidentiality, conflicts of interest, client abandonment, and negligent care (Strom-Gottfried, 1998) present difficult choices for social workers when confronted with the need to comply with managed care guidelines. Often social workers believe that compliance with managed care requirements can result in ethical problems related to compromises in quality of care and in potential violation of ethical standards in social work (Reamer, 1997).

Moreover, further reductions in hospital stays, less than adequate discharge plans, disposition problems and delayed discharges create many ethical conflicts for social workers' attempting to balance the competing needs of client best interest and responsibilities to the health care organization, the third-party payer, the medical staff and the patient's family members (Abramson, 1981; Cummings & Cockerham, 1997). As these ethical issues in health care continue

to challenge social workers professionally, the processes and strategies for ethical resolution need to be studied and clarified in order to understand the resolution options used by social workers to address ethical issues. What remains as an area in research is, once an ethical dilemma is identified, what rationale is used to make the decision that a situation is an ethical one and what processes are used to facilitate resolution of the dilemma. It is the intent of this research to go beyond the identification of an ethical dilemma and to test a model of decision-making developed for this study to understand what social workers do to attempt to reach the optimal solution to the ethical quandary.

Ethical decision-making

Ethical decision-making is contingent upon a number of factors. The first step in decision-making is recognizing that a practice situation has competing values, obligations, or principles, which for the purposes of this study will serve as the definition of an ethical dilemma. Once the ethical issue is recognized, the second step is understanding the rationale used by practitioners to determine the presence of an ethical dilemma which can involve a variety of responses to the identified ethical dilemmas.

The third step in ethical decision-making is the resolution process used to facilitate ethical outcomes. The resolution process can encompass a variety of ways social workers resolve ethical dilemmas. What is considered an optimal approach is one that establishes the ethical facts, possible alternatives available, applies ethical theory and principles and considers consequences of different courses of action for resolution (Hebert, 1996; Reamer, 1990). Understanding how practitioners identify the presence of an ethical dilemma and how they make decisions regarding the resolution of the ethical dilemma provides the conceptual underpinnings for this study.

The ethical decision-making process rests largely on the ability of a practitioner to recognize that an ethical dilemma exists in a given practice situation. Recognizing that a situation has competing values, principles and obligations helps to separate the ethical components from practice or nonethical components (Reamer, 1990). Identifying the ethical components of a situation also serves to reduce the tendency of social workers to see ethical issues as merely practice problems which lead to resolution strategies based on practice techniques rather than on sound ethical inquiry (Joseph, 1989).

The identification of ethical dilemmas can also be influenced by practitioners who rely on personal value preferences or on an ordinary morality screen that is based on intuitive levels of thinking rather than on a reflection of ethical principles, theories, or codes of ethics (Foster, Sharp, Scesny, McClellan & Cotman, 1993). A personalized moral sense is rooted in an individual's belief of what is right or wrong rather than on moral rules or principles. As a result, certain practice situations will not be perceived as involving conflicting moral issues (Goldstein, 1987). For example, a belief system that does not accept euthanasia of any kind would not view situations involving end-of-life decision-making as an ethical quandary.

Practitioners who tend to follow rules, agency policy, or legal obligations may find themselves unwilling to identify and subsequently unwilling to act upon ethical dilemmas (Kugelman-Jaffee, 1990). Often agency policy, obligations, and even organizational work roles in the agency may influence the priorities that a practitioner will consider in identifying ethical dilemmas (Mattison, 2000). Organizational rules and constraints frequently make a social worker's obligations unclear as to whom the social worker has primary obligation: the client or the agency (Abramson, 1981). For practitioners in health care social work where the focus is on medicine rather than on social work, the influence of the organization can be problematic in relationship to the complex ethical issues emerging in health care (Abramson, 1990; Abramson & Beck Black, 1985; Foster et al., 1993; Reamer, 1985).

For social workers grappling with the magnitude of contemporary ethical challenges in health care, a reasoned reflective approach to identifying ethical dilemmas is critically important. Identifying ethical dilemmas in terms of competing values, principles, and obligations provides an ethical rationale for initiating the next step toward ethical issues in terms of value tensions, competing obligations and ethical principles which foster a systematic approach to determining a course of action for achieving the best possible solution for resolution.

Ethical decision-making may be approached by practitioners in a number of ways. The reliance of social workers to resolve ethical dilemmas from an intuitive sense rooted in their own internalized ethical code may lead to biased solutions that rest generally on a practitioner's own personal values. Decision-making based on moralistic beliefs of practitioners is viewed as a

subjective ethical decision-making style that is not grounded in a careful consideration of the fundamental moral issues of the situation (Foster et al., 1993; Goldmeier, 1984).

Similarly, ethical decision-making that is based on rules, organizational influences, or legal obligations that guide ethical analysis may also result in a practitioner's favoring different priorities a bias which can lead to different courses of action for ethical resolution. Reliance on rules, obligations, or agency policy reflects an ethical-decision-making style that attempts to resolve ethical dilemmas through the use of technical skills rather than through reasoned ethical inquiry (Joseph, 1991).

Because of the tendency of social workers to resolve ethical dilemmas either by reliance on their own individualized ethical styles or by adherence to agency policy, rules or legal obligations, several social work researchers have proposed resolution paradigms as a way to formalize and clarify the reasoning that needs to occur for appropriate ethical decision-making (Abramson, 1981; Blumenfield & Lowe, 1987; Loewenberg & Dolgoff, 1996; Mattison, 2000; Reamer, 1990). These models for ethical decision-making have been developed as a method to analyze ethical issues, to establish the ethically relevant facts and to determine what needs to be addressed for adequate resolution of a moral quandary (Hebert, 1996; Manning, 1997). While each resolution model emphasizes a different aspect of decision-making, all the models offer some general commonalties such as identifying the ethically relevant facts, determining a decision-making process, identifying relevant value issues and examining the various alternatives and options in order ultimately to select a plan of action. These common features offer ways to organize the various dimensions of ethical analysis and to guide practitioners toward practical resolutions that are sensible and insightful (Hebert, 1996; Mattison, 2000). While these models are not intended to be simple formulas or technical tools to be applied for ethical resolution, they are ways to provide rationale for making choices (Abramson, 1981; Mattison, 1994).

Ethical decision-making influences

The process of ethical decision-making may be influenced by a number of factors such as internationalization of social work values, education, and experience in social work, prior ethics training and professional identification. The presence of these factors may guide a practitioner toward a decision-making process that is based on an examination of the value conflicts present,

the establishment of the ethically relevant facts, the consideration of ethical theory, principles and codes of ethics and the examination of all possible alternatives and options available to resolve the ethical dilemma.

A key component to ethical decision-making is the identification of the value conflicts present in a situation. Ethical problems and dilemmas that occur have a value-based component that includes issues such as client autonomy, confidentiality and distribution of resources (Watt, 1992). These value conflicts are often the most problematic for social workers particularly when faced with determining which value should be considered primary among competing interests. Competing obligations often raise questions such as, are there primary obligations to self-determination or are there situations where disclosure of confidential information is justified (Mattison, 2000). Often these value conflicts involve choosing among courses of action where none of the options or alternatives appear to offer a satisfactory resolution.

The question of whether social workers understand how to use values in professional practice and how these values influence the ethical dimensions of practice remains largely unanswered. Despite the importance of social work values to professional practice and to the existing empirical study on values and the impact of social work education on values assimilation (Abbott, 1988; Varley, 1963), little research has been focused on the internalization of social work values and its influence on ethical decisions. As ethical dilemmas are typically defined in terms of competing values, the internalization of professional values should lead a social worker to identify readily ethical issues when confronted with conflicting values and use those conflicting values as a way to initiate ethical discussion and deliberation.

As values are an integral part of social work education, the educational background of practitioners may also influence the use of a decision-making process. Consequently, the educational background of practitioners has been examined as a possible correlate in previous studies on ethics and social work practice (Dobrin, 1988; Mattison, 1994; Watt, 1992). At least one researcher has suggested that education not only improves practice skills but that graduate education can also improve the ethical skills needed for ethical decision-making (Dobrin, 1988). Dobrin's suggestion (1988) is that years of formal social work education, exposure to systematic

learning, and participation in the educational process may lead practitioners to develop principled ethical judgments based on resolution paradigms.

Coupled with a practitioner's education background, the years of experience in social work practice may also influence the use of a process for ethical decision-making. Experience in social work has been suggested as a possible factor that increases knowledge about the multiple issues that come into play with ethical dilemmas (Congress, 1986), a suggestion implying that more experience equals an improved use of a process of ethical decision-making.

Preparedness in ethical analysis and decision-making through prior training in ethics, ethical theory, and ethical principles has also been found to improve competence in ethical deliberation (Foster et al., 1993; Joseph & Conrad, 1989). Prior education and training in ethics increase a social worker's awareness of the moral components of situations and provide a framework to help practitioners analyze and resolve ethical conflicts in practice (Foster et al., 1993, Joseph & Conrad, 1989; Watt, 1992). Previous studies have demonstrated that social workers without prior ethics training report a lack of preparedness to resolve ethical dilemmas and lack a general ability to make decisions based on the ethical content of the dilemmas, thus relying on personal rather than professional ethics for guidance (Kugelman-Jaffee, 1990; Felkenes, 1980; Mattison, 1994).

A worker's professional identification with the social work profession may be a final factor that influences the use of an ethical decision-making process. Organizational influences have been demonstrated to affect the ethical decision-making ability of practitioners (Congress, 1986; Kugelman-Jaffee, 1990; Walden, Wolock & Demone, 1991). The organizational setting can influence health care workers to adopt professional roles consistent with the hospital organization thus fostering an attitude risking a loss of identity with respect to professional disciplines (Chambliss, 1996). At least one researcher found that practitioners will identify with concrete organizational policy first when they regard professional obligations as too abstract to be useful in practice (Felkenes, 1980). When ethical decision-making and the organization have been studied empirically, researchers found that those who rely on organizational rules deliberate somewhat differently on ethical issues than do those practitioners who use ethical principles to guide their decision-making (Kugelman-Jaffee, 1990). Thus, the challenge for hospital based social workers,

where the primary organizational emphasis is on medicine, is to maintain their professional identification which can lead to ethically informed positions and to increased quality in the provision of social work services. Further maintenance of professional identity which begins during the educational process is fostered through professional organization memberships, attendance at social work sponsored conferences, participation in social work meetings and maintenance of appropriate licensure and/or certification. A continued sense of professional connection to social work allows for a more fully integrated professional identity that fosters a greater commitment to the social work profession rather than to the values of the employing organization (Compton & Galaway, 1984). A continued commitment to the profession may influence a practitioners' ability to demonstrate ethical skills and use a reasoned process for ethical resolution rather than to rely on organizational authority or power held by others in a multidisciplinary setting (Kugelman-Jaffee, 1990).

In general, the literature indicates that social workers have learned content on the recognition of ethical dilemmas but have not learned to apply ethical skill to difficult decisions or are lacking in the knowledge of the use of a formalized process for ethical decision-making.

Method

The purpose of this study was to assess ethical decision-making among hospital social workers. The dependent variables were the extent to which social workers in hospital settings identify the presence of ethical dilemmas, the rationale used to determine their decision, and the extent to which a decision-making process is used to resolve ethical dilemmas in health care. Independent variables in this study included the internalization of Social Work Values (as measured through Abbott's 1998, Professional Opinion Scale) educational background, experience in social work, prior training in ethics and professional identification. Additional demographic variables such as age and gender as well as employment variables of current job position, location of hospital (urban/rural), type of hospital (medical/surgical, rehabilitation or pediatric), presence of a formal social work department and size and structure of the social work department were included as variables. A descriptive survey design was used for this study. An anonymous mailed questionnaire was sent to a random sample of Directors of Social work in acute care, medical surgical hospitals affiliated with the American Hospital Association.

Population and Sample

The study population was hospital based social workers practicing in acute care hospitals that were affiliated with the American Hospital Association (AHA), excluded from the study were hospitals that did not belong to the AHA. For the purposes of this study, an acute care hospital was defined as a general medical surgical hospital with a primary mission to meet the urgent health care needs of seriously ill and hospitalized patients. The Directors contacted for the study sample were selected using a random list of one thousand hospitals affiliated with the AHA. The list was purchased by the researcher through American Medical Information, Inc. The requested membership list of 1,000 hospitals generated 800 usable addresses of acute care hospitals across the country. The research package was mailed to the Directors of Social Work with the request to have two members of the department complete the survey instrument. The director may or may not have personally completed the survey. The cover letter instructions were provided to the Director stating that they could include themselves in the selection of staff to complete the surveys. This non- probability method of relying on available subjects (Babbie, 1986) following the simple random selection of AHA member hospitals is characterized as an accidental, self-selected sample and is recognized as a limitation of the study. The selection of two respondents from the department as a representative number of social workers is based upon the AHA statistical information. This information reflected that the largest percentage of hospitals have a total number of hospital beds between 100 and 199, therefore requiring two or more social work staff. Additionally, smaller hospitals (those with fewer than 100 beds) which make up approximately 44 percent of all hospitals in the AHA listing typically have smaller social work departments than larger teaching hospitals that generally have social work staff assigned to specialty areas or clinics accounting for larger departments.

The research package was mailed to 800 acute care hospitals throughout the country. A total of 282 questionnaires were returned; forty-three questionnaires were not included in the data analysis as they were completed by non-social work professionals, thus the total number of usable surveys was reduced to 239 which represented a 15% response rate. Of the 239 responses used for data analysis, 36% of the hospitals returned one survey, 32% returned two surveys. This non-

probability sampling plan and low response rate does not allow for generalization beyond the parameters of the study sample.

Instruments

The survey instrument included three sections. Section I contained four case scenarios which asked respondents to indicate whether the case represented an ethical dilemma, how they chose their answer, and what process would be used to resolve an ethical dilemma. Section II contained the standardized measure, the Professional Opinion Scale (Abbott, 1988). Section III contained demographic data that included gender, age, size of the department responsible for social work, location of the hospital, and type of hospital. In addition, information regarding the respondent's educational background, years of experience, prior ethics training, and professional identity was also collected.

Dependent Variable

There are three components of the dependent variable, namely ethical competence. Ethical competence is further defined as the ability to identify an ethical dilemma, the rationale used to determine the presence of an ethical dilemma, and the process used for ethical resolution.

The recognition of an ethical dilemma was measured through the use of four case scenarios designed to reflect two cases representing advances in medical technology and two cases depicting issues of cost containment in health care.

Previous studies reviewed in the literature showed use of a variety of case scenarios that depicted various practice situations containing ethical dilemmas. Some studies had selected cases that represented situations such as medical truth-telling, but none of the studies used vignettes related specifically to this study: the issues of advancing medical technology and the issues arising out of the cost containment efforts currently faced in health care. The decision to develop original case vignettes based on actual hospital practice situations resulted from a review of the literature that indicated that contemporary hospital practice was concerned with issues of advancing medical technology and cost containment issues (Csikai & Sales, 1998; Manning, 1997).

Vignettes

Vignette one was constructed to depict the conflicts inherent in end-of-life decision-making and the withdrawal of life support. The issue centered on the request of a spouse to disconnect life

support for his wife who had suffered a paralyzing brain stem stroke. The advanced medical technology that included life support measures, such as mechanical respiration, tube feeding, and a special hospital bed to prevent skin breakdown were the only means of keeping this woman alive following this usually fatal type of stroke. There was no written advance directive or health care power of attorney and an unwillingness on the part of the physician to withdraw life support as the patient's wishes could not be communicated. This case represents conflicts over the emerging societal issue of the right- die and personal, professional, and organizational values.

Vignette two highlighted the tension between upholding confidentiality, informed consent, and duty to warn in order to protect an infant. The issue of holding in confidence the information obtained in the delivery of professional services (NASW, 1996) and the decision to share the confidence for protection of life, raised questions of who the client is in situations involving HIV and AIDS (Abramson, 1990). The ethical tension also reflected the need to balance competing principles while systematically analyzing the justification for choosing one principle (confidentiality) over another (Duty to warn) (Abramson, 1990). This case raised issues over what to do when medical technology was available to a newborn who may have been exposed to HIV in utero but was not given the opportunity to utilize advance medical treatment and care.

Vignette three addressed competing commitments made to the employing organization versus commitment to clients as delineated in the Code of Ethics (NASW, 1996). Conflicts between a social workers' professional obligations and organizational policies were a part of this dilemma that highlighted the strain between two competing obligations. Additional tensions included the allocation of scarce resources in the form of bed availability in a neonatal intensive care unit and the continued economic viability of an organization in providing care for a patient no longer in need of acute care hospitalization.

Vignette four reflected current marketplace values that conflict with professional values in a managed care environment. The case depicted the conflict between allocation of resources and distributive justice and quality of life. This situation also illustrates the complexity of discharge planning in an environment that is affected by fiscal constraints and cost containment issues (Abramson, 1981; Conrad, 1988). It raises several questions regarding to whom the social worker has primary obligation: the patient, the hospital, or to the third-party payer (Abramson, 1981).

To establish reliability and validity of the case scenarios, in July 1999, the researcher mailed the cases to a sample of ten social work educators with expertise in ethics with a letter explaining the purposes of the research. Each educator was asked to indicate whether the case depicted an ethical dilemma and whether he/she could identify the value conflicts inherent in each case. To provide additional input into the review of the cases, one educator also shared the cases with two colleagues, one with medical social work experience and one with experience in child welfare. Each reviewer identified competing values inherent in the cases, identifying value conflicts such as self-determination and end-of-life decision-making (Vignette One), informed consent and protection of others against harm (Vignette Two), quality of life and rationing and conflicts arising in meeting the NASW Code of Ethics standards (Vignette Three), and conflicts in professional obligations arising between scarce resources and quality of life (Vignette Four). All cases were deemed as representing ethical dilemmas and all reviewers agreed on the competing values in each of the ethical dilemmas.

Independent Variables

Social Work Values

The 40-item version of the Professional Opinion Scale (Abbott, 1988) was used to measure the independent variable of internalization of social work values. The goal of this instrument is to measure respondent concurrence with the underlying ideology or value base of social work (Abbott, 1988). The selection of the Professional Opinion Scale was based on the instrument's measurement of consistency with social work values and the ease of administration to large numbers of people. The 40-item version of the Professional Opinion Scale is based upon the 121-item version developed in 1988 and is arranged as a 5-point Likert-type scale with responses ranging from strongly agree to strongly disagree. Higher scores indicate greater consistency with social work values. The content of the Professional Opinion Scale comprises items reflecting the variety of public social policy issues identified by members of NASW to assess the degree of commitment to four basic social work values: respect for basic rights, sense of social responsibility, commitment to individual freedom, and support of self-determination (Abbott, 1988). The four values of the Professional Opinion Scale were initially identified in a 1988 exploratory factor analysis with Abbott's 1998 study reaffirming the relevance of the Professional Opinion Scale as

a viable instrument for assessing commitment to social work values (Abbott, 2000). The 1998 version of the scale reflected the reassignment of several items to different factors that resulted in a forty-item scale (Abbott, 2000). The 1998 confirmatory factor analysis provided evident that the four factors (value dimensions) are valid and reaffirms the reliability of the 1988 generated factors (Abbott, 2000). The forty items comprising the four Professional Opinion Scale value dimensions resulted in the following reliability scores: Factor One: Respect for Basic Rights, Cronbach Alpha reliability, .7680; Factor Two: Support for Self-Determination, Cronbach Alpha reliability, .6806; Factor Three: Sense of Social responsibility, Cronbach Alpha reliability, .7609; and Factor Four: Commitment to Individual Freedom, Cronbach Alpha reliability, .7947.

Education

Educational background in social work was measured by asking respondents to identify their highest academic degree. This information indicated to the researcher when the respondent was exposed to course work on ethics, an indication supporting the previous research that suggests graduate education provides preparation to handle ethical issues (Dobrin, 1988; Watt 1992). The Education Index will result in a single score ranging from 0-3 (0 = no response, 1 = BSW degree, 2 = MSW degree, 3 = Ph.D./DSW).

Experience in Social Work

Respondents were asked to identify their number of years' experience in social work and their number of years' experience in hospital social work. The data was presented as the actual years reported for both social work experience and health care social work experience.

Prior Ethics Training

Information pertaining to prior ethics training was measured to examine the relationship prior exposure to ethics content has on practitioners' ability to recognize ethical dilemmas, and to follow a process for ethical resolution. Respondents were asked to identify what ethical training they had received in terms of social work values, ethical decision-making models, professional codes of ethics, ethical principles and theories, and the date such training was received. The inclusion of these questions related to ethics training and its date are intended to evaluate when such training occurred.

For purposes of data analysis, the responses to ethics training were coded using the Ethics Training Index developed for this study based on the research that suggests prior ethics training is a positive factor in ethical decision-making (Joseph & Conrad, 1989). The Ethics Training Index used a Yes/No scoring format for each of the four questions related to social work values, decision-making models, codes of ethics, and ethical principles and theories with *Yes* being 1, and *No* being 0 with a range of scores from 0-4. Higher scores reflect increased ethics training.

Professional Identity

Respondents were asked whether they belonged to professional organizations such as the National Association of Social Workers (NASW) or the Society for Social Work Leadership in Health Care (SSWLHC). Additionally, they were asked if s/he holds a state license and/or certification, ACSW or other professional social work membership. Questions about attendance at regular social work meetings and attendance at NASW or social work sponsored conferences were also included. The responses to the questions were coded using the Professional Identity Index developed for this study to assess the extent to which respondents maintain a professional identity to social work. The Professional Identity Index assigned a 1 to indicate a *Yes* answer or a 0 for a *No* answer for State Licensure or certification, each membership in a professional organization, and each type of social work sponsored conference. The assignment of a *Yes/No* format related largely to the absence of any supporting literature that suggests additional professional memberships or attendance at professional conferences is of greater value than another. Higher scores suggest increased professional identity.

Additionally demographic and employment related variables were also measured to examine their relationship on practitioner ability to recognize an ethical dilemma, the rationale used for recognition, and the extent to which a process was used for ethical decision-making. The employment related variables were current job position, location (urban/rural) and type of hospital (medical/surgical, rehabilitation or pediatric), presence of a formal social work department or department responsible for social, and size and structure of the social work department. Respondents were asked to identify their age and gender. This section provided the identifying characteristics of the social workers' participating in the study. Demographic and employment related questions were located at the end of the instrument to minimize respondent fatigue as the

questions are presumed to be less demanding than the assessment of the ethical dilemma, resolution process, internalization of social work values, prior training in ethics, professional identity and social work education and experience.

Furthermore, identification of contemporary ethical issues in practice was assessed to see whether practitioners' perceptions of ethical dilemmas are consistent with the current literature. Respondents were asked to list what they perceive to be the current ethical issues in today's hospital social work practice. The responses were grouped around similar themes.

Pilot Study

A pilot study of the survey was administered to social workers practicing in ten acute care hospitals. The pilot study completed in December 1999 consisted of a sample of hospital based social workers located in acute care hospitals, three in Pennsylvania, two in New York, and one each in Texas, Vermont, Mississippi, Montana, and California. Thirty surveys were mailed with a letter of explanation about the study, a consent form, and a self-addressed stamped envelope for returning the questionnaire. The pilot study yielded a 63% response rate and helped to assess the amount of time needed to complete the instrument and the readability of the items. No questions were identified as problematic for the respondents. Respondents were asked for comments about the questionnaire; this feedback included three responses that indicated the survey was lengthy, one respondent who commented that the vignettes made her think about the issues, another noted that the answers were in the context of the moment but in actual practice would take more time to examine the issues. Based upon the results of the pilot study and feedback received, no changes were made to the survey instrument.

Data Collection

The research package was mailed in March 2000 and consisted of two copies of the study questionnaire, a letter of explanation about the study, and informed consent form and a self-addressed stamped envelope for returning the survey instruments. A code number for tracking purposes only was assigned to the survey instruments to monitor returns. Two mailings were included in this study: the original questionnaire and one follow-up notice to all participants to thank them for participation and to serve as a reminder to complete the survey. The follow-up notice was intended to increase response rate and was sent out two weeks after the initial mailing

(Babbie, 1986). In addition, the name and telephone number of the researcher was included in the survey packet for respondents to contact if they had any questions. Approximately five respondents did contact the researcher to clarify questions regarding completing the survey. Two respondents questioned completion of the instrument when there was only one social worker in the hospital. One respondent inquired as to whether the survey should be completed when there were no social workers in the hospital; one hospital director telephoned to say that staffing was a problem in their facility, and they would be unable to complete the survey; and four respondents requested the survey findings and enclosed a business card for the researcher to follow-up with sending the completed survey results. Additional follow up included contact with five hospital social work directors regarding the selection of participants to complete the questionnaire. Two directors indicated that the questionnaire was presented at a staff meeting and volunteers were asked to complete and return the survey; one director indicated there was one social worker on staff and that person replied and returned the other survey uncompleted; one respondent completed the survey as the director and gave the other to the only MSW on staff; and one respondent was selected as she had additional training in ethics and served as the ethics liaison in the hospital. Prior to the pilot study, the research study was approved by the Institutional Review Board at Marywood University, which has established review procedures for the use of human subjects in research before undertaking this study.

Data Analysis

Respondents were asked to indicate whether each case vignette represented an ethical dilemma. *Yes* and *No* responses to this question were scored as 1 or 0 respectively. Scores for all vignettes were summed: based on the total score, respondents with higher scores exhibited greater competence in identifying ethical dilemmas. Face validity of both the case scenarios and scoring system was achieved by using a panel of three social work educators and a panel of ethics educators who reviewed all cases and determined each case represented an ethical dilemma.

The respondents were also asked to explain briefly in an open-ended narrative format what rationale they used in determining the ethical issues at work in each vignette. These responses were scored to a single category according to a coding scheme that includes five categories of possible responses: 0= no response; 1= rationale based on personal preference or feelings; 2= a skill-based

rationale based on agency policy or legal obligations to be followed; 3= a rationale that identified one side of the value conflict; 4= a rationale base on some elements of ethical analysis; or 5= a rationale grounded in ethical theory, principles or codes of ethics. Responses for each vignette were given a single score, a range of 0-5, with the higher the score reflecting greater competence in the use of a rationale grounded in ethical principles and values. Face validity of both the question asked, the rationale used in identification of an ethical dilemma and the Rationale Classification Index, the scoring system, was achieved by using three social work educators.

The respondents were also asked to select one of the four case scenarios that they believed represented an ethical dilemma and to explain in narrative form the ethical issues and the process used to resolve them. The responses to the vignette selected by the respondent were coded using the Resolution Process Index (RPI) developed for this study to reflect the extent to which respondents follow a process for ethical resolution. The coding index for the resolution process included five categories of possible responses: 0= no response; 1= avoids any attempt at conflict resolution; 2= bases resolution on personal values or on practice skills; 3= bases resolution on rules, agency policy or legal obligations; 4= bases resolution on identification of the value conflict and limited use of tools of ethical analysis; 5= bases resolution on ethical analytic techniques. The answer provided received a single score based on the Resolution Process Index. The higher the score from the Resolution Process Index, the greater the use of a systematic process for ethical resolution. Face validity of the question asked, the process used and the Ethical Resolution Index, the scoring system, was achieved using three social work educators.

Additionally, inter-rater reliability measures were used to assess the level of agreement between two separate judges to establish reliability of the Rationale Classification Index. The inter-rater reliability was completed by both the researcher and an MSW clinician with experience in health care social work, home health and mental health counseling. All responses were reviewed and coded twice by the researcher and coded by the MSW clinician. Two rationale responses were found to be different from the researcher's original score and the one assigned by the clinician. Both cases were reviewed again by both judges and agreement was found on the scoring, with one case retaining its original score and one case changed to reflect a more skill base response.

Inter-rater reliability measures were used by the researcher to assess the level of agreement between two separate judges using the Ethical Resolution Index. As with the other narrative responses the researcher scored the cases on two occasions and the MSW clinician also scored the resolution process reported by the respondents. The results of this inter-rater reliability showed a 100 percent agreement in the scoring using the Resolution Process Index.

Initially the three primary research questions were evaluated using frequency distributions to group responses. Descriptive statistics were also computed for the Ethical Identification Index, the Rationale Classification Index, and the Resolution Process Index. Pearson's Product Correlation and Spearman's Correlation were used to assess the individual hypotheses of the study. Finally, a regression analysis was used to evaluate the relationship between identification of an ethical dilemma, and the process used for ethical decision-making and internalization of social work values, educational background, years of experience, prior ethics training, and professional identification.

Results

The majority of the respondents were employed in urban (52%), medical surgical (94.6%), non-teaching hospitals with a formal social work department with four or fewer staff members (46%). The findings indicated that most of the respondents are female (87%) averaging 41 years. Most of the respondents indicated they are staff social workers (62%), having a Master of Social Work degree. On the average, the respondents indicated they have at least thirteen years of social work experience and an average of nine years of hospital social work experience.

Two cases out of four were most often reported as ethical dilemmas. More medical cases (94.6%) were identified as ethical dilemmas than cost containment cases. However, the responses from study participants suggest dilemmas involving self-determination, confidentiality and decision whether or not to intervene in patients' lives when faced with end-of-life decisions are readily recognized as ethical conundrums. Situations that reflect the need for organizational economic viability along with the expectation to adhere to institutional regulations appear to be routinized into practice as issues to be resolved through concrete discharge planning efforts. Additionally, as most respondents did not perceive cases of cost containment as an ethical dilemma, they obviously did not select these cases for which to propose a process for ethical

resolution. Most of the respondents typically selected cases that depicted ethical tensions such as decisions to prolong or end life, or disclosure of confidential information for ethical resolution. The difference found in the identification of ethical dilemmas is consistent with what practitioners currently identify as ethical quandaries. Ethical conflicts have been identified by practitioners as those that involve termination of life sustaining treatment, and patient's autonomy or self-determination rather than issues pertaining to managed care initiatives although these issues are confronting social workers with increased frequency in medical settings (Holland & Kilpatrick, 1991; Kugelman-Jaffee, 1991; Landau, 2000).

When asked to give a rationale for determining the ethical dilemma, respondents used a rules-based rationale over 50% of the time to both the cost containment cases and for one of the medical cases. For the other medical case, one third of the respondents used a rules-based approach and one-third identified at least one side of the value conflict. This rules-based approach is one that sees ethical dilemmas as conflicts between rules, policy or law. By way of example, this approach in confronting end-of-life decision-making would view the ethical conflicts as those involving legal aspects of decision-making capacity versus proper execution of an advance directive as required by state law and hospital policy. With this approach, the competing ethical imperative is the conflict between legal definitions of decision-making capacity versus the legal aspects of living wills or health care proxy.

Most (69%) of the respondents selected one of the medical technology cases when asked to propose a resolution process. The ethical decision-making process used by respondents (54.4%) was based more on skills and rules than on a systematic ethical process.

The relationships between the independent variables and the dependent variable identification of an ethical dilemma were not significant. The rationale used to determine the presence of an ethical dilemma, internalization of social work values ($r=137, p=.03$), experience in social work ($r=129, p=.04$), and professional identity ($r=146, p=.02$) were found to be correlated. These findings indicate that when a person has internalized social work values, more years of experience and a greater identification with the profession, a higher rationale process is used for identifying an ethical dilemma. The process used for ethical resolution did not differ for

respondents whether they identified one or all cases as ethical dilemmas. The majority of respondents used the same process, one that was rules based for ethical resolution.

A stepwise linear regression analysis identified those variables that were significant predictors of the rationale used for identifying ethical dilemmas and the use of a process for ethical decision-making. For the rationale used, professional identity was identified as a significant predictor ($R=148$, $R^2=0.22$). Prior ethics training was the only variable that was identified as a predictor of the use of a process for ethical decision-making ($R=137$, $R^2=.019$).

Additional findings revealed a significant difference between the two types of cases used in the case scenarios. Specifically, fewer responses were found in the cost containment case than expected and more in the medical case observed than expected in identifying the ethical dilemmas ($X^2=119.933$, $p=.000$). Further analysis using a post hoc analysis ($F=19.303$, $p<.000$) revealed a difference in the rationale used by respondents and the ability to identify cases as ethical dilemmas. Those respondents using a higher rationale process identified more cases as ethical ones. Although the variance explained by the variables is small these findings are substantive in understanding the role of professional identity and prior ethics training in ethical decision-making thus warranting further research in this area.

Respondents provided additional insight into the types of ethical concerns in hospital practice. Medical technology issues specific to end-of-life decision-making remain the most problematic followed by cost containment concerns related to third party payers and reimbursement strategies.

Discussion

In view of the tendency of health care practitioners to rely on rule-based approaches for identifying and resolving ethical dilemmas, a tendency which suggests other aspects of resolution paradigms may be ignored; the profession must consider the need to adopt a framework for identifying, gathering, and assessing the information necessary to make informed ethical decisions. Although there are several resolution paradigms available (Abramson, 1981 ;Abramson, 1983; Blumenfield & Lowe, 1987; Levy, 1993; Loewenberg & Dolgoff, 1996; Mattison, 2000; Reamer, 1990), support of a framework to be used for ethical decision-making can aid in understanding and defining the critical issues involved, those individuals affected by the decision-making, and

possible courses of action to take, the relevant state or federal guidelines that, taken together, can lead to improved ethical decision-making.

Social work as a profession needs to recognize that while there has been a recent emphasis on ethics education, more needs to be done to assess its effectiveness in practice. How ethics training is provided in professional education, what methods of instruction are utilized, and how this education is actually applied in practice will offer insight into how the CSWE mandates to integrate ethics into education is actually carried out.

Policy initiatives within the hospital setting can include development of informal discussions to highlight ethical quandaries to guide staff struggling with ethical dilemmas. Rotating staff participation on interdisciplinary ethics committees and forums through educational programs available to staff may foster development of skill in ethical analysis and decision-making. Those more experienced colleagues who demonstrated greater ethical reasoning in this study need to draw on both practice wisdom and experiences in the successful and unsuccessful resolution of ethical dilemmas with their less experienced colleagues. Policy development may include assignment of professional mentors to balance the obligations between ethical practice and the concerns with preventing negligence and malpractice.

Future research that measures social workers' tendencies to favor rules, policy and legalistic choices of action in identifying and resolving ethical dilemmas can offer insight into the ways these preferences factor into the ethical decision-making process. The tendency to fall back on external sources when attempting to resolve value conflicts suggests that additional research is needed as to the type of content and methods of instruction on ethics is presented in the social work curricula and in on going continuing education.

It would be useful to see whether the values of self-determination and confidentiality are as well defined and recognized as the study findings suggest and why social work values related to broader social issues and organizational policy such as cost containment and economic viability are less recognized and not so well understood.

Additional research may need to examine whether the primary dilemmas identified in this study are representative of the dilemmas faced by hospital social workers. Future study could

include comparisons of the perspectives of other health care professionals and social workers regarding their perceptions of what the major ethical dilemmas are in health care.

Limitations

Results of this study must be considered in relationship to the limitations of survey research.

How the study sample was similar to samples reported in the literature, consideration must include the issue of sampling techniques and the potential for selection bias. This study used a random sample of acute care hospitals affiliated with the American Hospital Association (AHA) which excluded any hospitals that do not maintain membership in the AHA, an exclusion restricting generalizability to all acute care hospitals. Furthermore, the low response rate (15%) and the self-selection of respondents to participate in the study must all be taken into consideration when examining the study findings', therefore, generalizability cannot be made beyond the parameters of the self-selected sample. The concern of selection bias does pose a threat to the internal and external validity of the study. One such threat is that as the subjects were drawn from the membership list of the AHA, it is possible that these subjects may have an unidentified characteristic (i.e., access to ethics training through AHA publications, seminars, or communications) that nonaffiliated hospitals may not have. Such a characteristic may impact upon the dependent variables of identification of an ethical dilemma, use of a rationale and the process used in ethical resolution. The study sample when compared to sample selection in the existing literature, previous studies have utilized a purposive non-probability sample (Beckerman, 1991; Kugelman-Jaffee, 1990; Landau, 2000). Sample size in the research has been reported as twenty, thirty-two and seventy-three subjects. This study included two hundred thirty-nine respondents; therefore, the sample size is larger.

Also, the instrument, despite being tested for content validity but not for reliability or for construct validity, and the cases reviewed by a panel of experts may not have been sensitive enough to capture some of the differences among the respondents. Future research might build on the findings of this study to refine a testing instrument designed to measure social workers' ability to identify and resolve ethical dilemmas.

An additional limitation recognizes these results reflect only what participants say they do in practice not what they actually do when confronted with an ethical dilemma.

Conclusions

The prevalence of ethical challenges in health care confront practitioners today at an accelerated rate. Ethical dilemmas resulting from improved health care technology and the economic pressures of managed care have led to changes in practice and to a need to understand ethical decision-making as part of a thoughtful, ongoing process. Therefore, understanding the process which influences the outcome is as important as the action taken. Knowing what tendencies and influences that factor into how a case is deemed as an ethical one and, ultimately, how it is resolved is an important part of social work practice and a first step in promoting ethical competence. Social workers, like other professionals in health care, are influenced by the medical-legal environment in which they practice. Understanding the role and relationship of the law and ethics related risk and malpractice is becoming more important for practice. Better identification and understanding of social workers' tendencies toward favoring rules, policy, or legalistic choices is a step toward recognizing how these factors impact on ethical decision-making. Similarly, recognizing these tendencies in practice can offer opportunities for enhanced efforts in considering courses of action that would balance both ethical and legal obligations and improve the decision-making process for all involved.

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