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**Ethical decision-making of social work practitioners in
organizational settings**

Kugelman-Jaffee, Wendy Elyse, D.S.W.

City University of New York, 1990

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**Ethical Decision-Making of Social Work Practitioners in
Organizational Settings**

By

Wendy Elyse Kugelman-Jaffee

A dissertation submitted to the Graduate Faculty
in Social Welfare in partial fulfillment of the
requirements for the degree of
Doctor of Social Welfare, The City University of New York

1990

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This manuscript has been read and accepted for the Graduate Faculty in Social Welfare in satisfaction of the dissertation requirement for the degree of Doctor of Social Welfare.

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Abstract

Ethical Decision-Making Processes of Social Work
Practitioners in Organizational Settings

by Wendy Elyse Kugelman-Jaffee

Advisor: Professor Michael Smith

This work examined both the ethical and non-ethical (or extra-ethical) elements that come to bear upon the decision-making processes of social workers practicing in agency settings. It specifically focused upon the degree to which agency social workers were aware of, and able to use, the ethical principles of the profession, in resolving on-the-job ethical dilemmas; the impact of various extra-ethical elements on the decision-making of agency social workers confronted with ethical dilemmas; and whether awareness of ethical dilemmas and ethical principles would be effected by exposure to the research design.

In approaching this subject, the author reviewed literature from the fields of organizational theory, power and compliance, ethics, and social work ethics.

The research tool was qualitative, and was developed by the author. The research was conducted through two basically identical interviews, during which twenty participants were asked to reconstruct ethical dilemmas from their practice, and to respond to created case histories. One finding of this study was that there is an uneasy relationship between agency social workers and their employing organizations. Most

participants could not articulate or even perceive an obligation to their employing organizations. Instead, the organization was generally seen as a force which provoked resistance or submission. For many of the participants, the organization acted to constrict their cognitive abilities and undermine their other professional obligations.

Although many of the participants felt resigned and helpless when dealing with organizational constraints, several demonstrated that ethically informed positions taken in response to these constraints can support the agency social worker, and, consequently, can support the provision of quality social work services to clients.

This study found evidence of greater awareness of the ethical elements of practice through the process of attempting to reconstruct and to resolve ethical dilemmas. This heightened awareness however, was not accompanied by a greater ability to make decisions based on the ethical content of the dilemmas. Heightened awareness may be the beginning step in the educational process whose end is the application of this awareness in practice.

Acknowledgements

For the past three and a half years, I have had two burning passions in my life. One flame is about to dim, and the other is about to intensify.

As a brand new doctoral student, I was told I that if I didn't have a burning love for my dissertation topic, the completion of the work would be an unendurable agony. I was lucky enough to pick a topic that I have continued to love throughout the long hours and late nights.

As the passion needed to invest in this work fades, the flame that can now grow is for the man who has helped me think, work, and write. He has been my editor and my friend through the years that have passed, and will continue to be my partner in the years that will come. Our continued partnership is symbolized by the fact that he had the courage to marry me while I was still in the middle of my relationship with "ethics." Thank you, Roy, for your help and support. It is hard to picture either this dissertation or my life without you.

There were three other individuals instrumental in my work, the three members of my dissertation committee. As a group, they were supportive and available. Each one has professional integrity, and it was a pleasure working with them. I am pleased to say that I do not have even one horror story associated with my work with any of these professionals.

I had the privilege of working with Dean Harold Lewis, who I feel was a mentor to me during my tenure in the doctoral program. He nurtured me through the gestation and birth of this baby I call my dissertation. He never tried to change my ideas; instead, he cultivated them. His door was always open. I am grateful for his help and thankful I was in the program when he was the Dean.

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For Gary Anderson, my third committee member, I was his first doctoral candidate. I don't know first hand what it takes to do the work of a committee member, but I hope he can experience a small portion of the sense of accomplishment I feel at this time. I wish to thank him for the time and attention he gave to my work.

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INTRODUCTION

An analysis of all cases presented to the National Association of Social Workers from 1956 to 1977 alleging unethical behavior finds that "65 percent of all complaints involved practice that was related to administrative aspects within an organization."¹ Thus, although the mission of the social work profession is historically rooted in agency services, there is evidence that the relationship between the social work profession and employing agencies has become increasingly uneasy. In this context, Constable's question: "Do social workers have values and ethical standards to guide their activity, or should the decision on how social work shall be used go to the marketplace, the consumer, or the practitioner's judgment of what seems most workable in a particular situation?"² is an urgent one.

Prior to an exploration of social work ethics, a clear definition of social work should be offered.

¹ Charles W. McCann and Jane Park Cutler, "Ethics and the Alleged Unethical," Social Work (January 1979), p. 7.

² Robert Constable, "Values, Religion, and Social Work Practice," Social Thought (Fall 1983), p. 29.

Social work is defined as a social institutional method of helping people to prevent and resolve their social problems, to restore and enhance their social functioning... Social workers are professional helpers designated by society to aid people who are distressed, disadvantaged, disabled, deviant, defeated or dependent. They are also charged to help people lessen their chances of being poor, inept, neglected, abused, divorced, delinquent, criminal, alienated, or mad.³

As illustrated by Siporin, and codified in the National Association of Social Workers Code of Ethics,⁴ social workers maintain multiple commitments. This is a formidable task with many intricacies.

In Human Service Organizations, Hasenfeld and English state: "There are serious lacunae in the knowledge base of ... [social work] technologies which result in reduced effectiveness and inability to develop a coherent internal work system... Human service organizations cannot easily develop a routine and programmed set of procedures for staff to follow in order to obtain the desired output... One of the mechanisms ... to overcome lacunae in knowledge is to develop service ideology."⁵

³ Max Siporin, Introduction to Social Work (New York: Macmillan Publishing Co., Inc., 1975), pp. 3-4.

⁴ National Association of Social Work Policy Statement 1, Code of Ethics, Professional Standards.

⁵ Yesheskel Hasenfeld and Richard English, eds., Human Service Organizations (Ann Arbor: University of Michigan, 1974), p. 280.

The National Association of Social Workers has taken responsibility for defining ethical behavior for the social work profession by developing a Code of Ethics, most recently revised in 1980. The Code of Ethics may be viewed as the profession's policy for addressing the above-noted need for an ideology, but absent in the text are generally accepted procedures for implementation of the Code. Although "this code is intended to serve as a guide to the everyday conduct of members of the social work profession...",⁶ a gap appears to exist between the profession's stated policy and its implementation.

The gap in implementation, its definition and analysis, has significance for the profession, organizations that employ social workers, and social work educators. As stated, this gap is generated by the lack of a precise technology for service situations and manifests itself in the individual behavior of workers.

An examination of the social work practice arena is a reasonable first step in the pursuit of knowledge about how social workers behave when dealing with matters of ethics. This examination is the focus of the research at hand.

Two leading social work scholars have considered social work ethics in the context of the day-to-day practice of social workers.

⁶ Code of Ethics, op. cit., p. iii.

Levy states:

To understand the nature of ethical responsibility and to identify guides to ethical conduct, the social work service situation must be scrutinized... Although individual social workers make specific action choices when they confront and cope with ethical issues that arise during their dealings with clients, these choices should not be idiosyncratic.

In his book, The Intellectual Base of Social Work Practice, Lewis explores in detail the ingredients that generate the work in social work practice. Lewis states that all work is a combination of "the condition to be altered," "an investment of effort," and "the worker's necessary belief" that a condition can be improved."⁸ The question this author is most interested in is: "What informs an agency social worker of the condition to be altered when faced with conflicting multiple commitments and obligations?" Put another way, the question is: "How do agency social workers resolve ethical dilemmas?"

Webster's defines a dilemma as:

An argument which presents two or more alternatives;... A difficult or doubtful choice; a state of things in which evils or obstacles present themselves on every side, and it is difficult to determine what course to pursue.⁹

⁷ Charles Levy, Social Work Ethics (New York: Human Science Press, 1978), pp. 45 and 52.

⁸ Harold Lewis, The Intellectual Base of Social Work Practice (New York: Haworth Press, 1982), p. 10.

⁹ Webster's Universal Dictionary of the English Language, (New York: The World Syndicate Publishing Company 1937).

For the purpose of this research, the condition of multiple obligation, or the dilemma, will be composed of multiple ethical principles, two or more of which will be in conflict. Because this author agrees with Loewenberg and Dolgoff that "... there are ethical implications or ethical aspects to almost every professional decision,"¹⁰ it is assumed that dealing with ethical dilemmas is not an unfamiliar state for most practitioners.

Nevertheless, there are social workers who believe that "most situations that a practitioner encounters require only a high level of professional skill and insight, but do not involve ethical questions."¹¹ To what extent, therefore, are agency social workers aware of ethical dilemmas in their work? How aware are they of the codified ethical principles active in these dilemmas? To what extent are they influenced by this awareness, as compared to other influences not ethical in nature, i.e., organizational constraints, power relationships, clinical dynamics, and idiosyncratic forces of a personal nature?

This work will examine both the ethical and non-ethical (or extra-ethical) elements that come to bear upon the decision-making processes of social workers practicing in

¹⁰ Frank Loewenberg and Ralph Dolgoff, Ethical Decisions for Social Work Practice (Itasca, Illinois: Peacock Publishers, Inc., 1982), p. 5.

¹¹ Ibid., p. 5.

agency settings. In approaching this subject, the author has reviewed literature from the fields of social work and organizational theory, in order to clearly define ethics, social work ethics, organizational structure and constraints, and power and compliance.

Overview of Dissertation

Chapter One begins with a statement about the author's interest in the problem, and is followed by the literature review. Chapter Two, the methodology, begins with a description of how the problem is defined, and explains the purpose of the research. The research design and tool are introduced. The applications of the research, issues of validity and reliability, ethical implications, and cost will also be discussed in this chapter. The conclusion of the chapter will describe the research sample, including demographic information. Chapter Three presents and analyzes the first part of the research. Chapter Four presents and analyzes the second part of the research. Chapter Five summarizes the findings and presents some implications and recommendations derived from the study. Chapter Six presents the participants' feedback on their involvement in the research process.

CHAPTER ONE

Interest in the Problem

"The career of a social problem begins with its being privately recognized as a problem. Some individual or group comes to believe that a certain social problem exists because what their ideology designates as an ideal state of affairs diverges significantly from what they perceive the real situation to be."¹² Rein indicates that the recognition of a problem is directly related to the values of the analyst. "Their [the analysts'] most demanding task is identification of their own values, along with an understanding of how these values blatantly and subtly bias analysis."¹³ Similarly, Kahn has pointed out that a problem is always defined within the confines of a person's own values and experiences.¹⁴

The author became interested in learning more about the relationship between organizational constraints/mandates and professional ethics as a result of seven years of front line

¹² Robert Ross and Graham L. Staines, "The Politics of Analyzing Social Problems," Social Problems (Summer 1972), p. 19.

¹³ Martin Rein, "Social Policy Analysis as the Interpretation of Beliefs," Journal of the American Institute of Planners (September 1971), p. 309.

¹⁴ Alfred Kahn, "Definition of the Task: Facts, Projections and Inventories," in Planning For Social Welfare, eds. Gilbert and Specht (New Jersey: Prentice Hall, 1977).

practice in a major medical center where patient care steadily descended as an organizational priority. During this period, while working as an M.S.W. in the pediatric in-patient unit, providing direct service to hospitalized children and their families, the author's director insisted that the social work component be restricted to what is known in the field as concrete services, i.e., entitlement programs, applications for benefits, and discharge planning. Prior to this directive, the social worker's responsibilities had included individual and family counseling with the patients and families around their coping with the onset of acute, and often fatal, illness, as well as chronic illness and its ramifications.

The reason for this change was the aggressiveness of the nursing department, which hired clinicians and insisted these clinicians provide the counseling service. They were unconcerned about the fragmenting of the relationships between service providers and patients. Because of the power of the nursing department within the medical center's structure, the hospital administration supported this endeavor. The supervisory staff of the social work department, including the director, offered perfunctory resistance, but quickly capitulated to the demand to truncate the social work role. When the author refused to comply with this demand, she was taken to task by the director of the social work department,

and was forced to transfer to a different unit of service. A new social worker was hired with the understanding that she would perform this newly defined social work service, and she complied with this commitment.

At approximately the same time came the advent of Diagnostic Related Grouping of patients in the medical center, a Federal and local initiative aimed at reducing the cost of hospital care by classifying patients according to diagnosis, and paying a stipulated amount for treatment of the condition regardless of the number of days of hospitalization. Prior to this, hospitals were paid on a per diem cost basis.

In order to maximize payment, and/or minimize losses, it became advantageous for the medical center to discharge patients as quickly as possible. The director of the social work department, through his supervisory staff, advised the workers to inform patients and their families that their insurance coverages were lapsing, regardless of the veracity of this, in order to expedite the discharge of these patients.

The author was confused and alarmed by the behavior of the representatives of the social work profession in the medical center, who decided to abandon their commitment to their clients in order to comply with organizational goals and directives. If this study can assist the author in understanding how professional social workers in organizations

make decisions concerning ethical matters, whether her actions are "altruistic or egoistic,"¹⁵ she will feel well paid.

As a beginning step toward this understanding, the author conducted a review of the literature relevant to the interface between organizations and professional social work. As there is no discrete body of literature directed toward the factors involved in this interface, the following review is, of necessity, multifaceted. It will be divided into four sections: (1) Ethics, professional social work ethics, and the context of practice; (2) Organizational theory; (3) Power and compliance, and the socialization of the social worker; and (4) Constructs developed by social work scholars to view the practice of ethics.

Literature Review

Ethics

This section of the review intends to look at professional ethics as based on, but distinct from, general morality, reflecting the author's perception of the nature of social work ethics as the distillation of more or less

¹⁵ Ronald Winthrop, "It Pays to Do Good, But Not to Do More Good Than it Pays: A Note on the Survival of Altruism," Journal of Economic Behavior and Organization (September 1981), pp. 201-214.

"universal" values into the practices of the every day work situation. As stated in the National Association of Social Workers Code of Ethics, "specific applications of ethical principles must be judged within the context in which they are being considered."¹⁶ Ultimately, any understanding of social work ethics requires context and interaction to be meaningful. The author also intends to demonstrate the importance, and limitations, of the codification of professional ethics.

If, as Feldman states, "ethics is the philosophical study of morality,"¹⁷ then we must be clear about whose morality we are analyzing. Although it might normally be thought immoral for a transit policeman to insist on a subway passenger undressing for viewing, it is quite another matter for a physician to make the same request of the same person in an examining room. The physician doing a full evaluation could not ethically assert the degree of health of a patient without taking the time to perform such an examination. Gewirth explains that "professional ethics" should be distinguished from "ordinary ethics."¹⁸ He states that professional ethics gives license to act in a way that would not be accepted in any other situation. The license to step over appropriate

¹⁶ Code of Ethics, op. cit., p. iii.

¹⁷ Fred Feldman, Introductory Ethics (New Jersey: Prentice Hall, 1978), p. 1.

¹⁸ Alan Gewirth, "Professional Ethics: The Separatist Thesis," Ethics (January 1986), pp. 282-300.

social boundaries often blurs, for the professional, what is appropriate behavior in a practice situation.

In making the distinction between the ethics of strangers and the ethics of intimacy, Toulmin highlights what Tolstoy "rightly emphasized is the sharp difference that exists between our moral relations with our families, intimates, and immediate neighbors or associates, and our moral relations with complete strangers. In dealing with our children, friends and immediate colleagues, we both expect to and are expected to make allowances for their individual personalities and tastes, and we do our best to time our actions according to our perceptions of their current moods and plans... So, in the ethics of strangers, respect for rules is all and the opportunities for discretion are few. In the ethics of intimacy, discretion is all, and the relevance of strict rules is minimal." ¹⁹

Ethics, and the study of ethics, must stipulate how behavior is to be governed. Ethical decision-making might be viewed as "a pattern of moral reasoning [by which] one determines what one should do in a particular situation by reference to certain general principles or rules which one

¹⁹ Stephen Toulmin, "The Tyranny of Principles," The Hastings Center Report (December 1981), p. 35.

takes as premises from which to deduce a particular conclusion by a kind of practical syllogism...."²⁰

If professional behavior is unique, how can it be gauged? Levy begins his book Social Work Ethics by attempting to define professional ethics. He states: "One measure of ethical conduct in any occupation is the discrepancy between what its practitioner is supposed to do and what he actually does."²¹ Bayles states, "professional ethics may be viewed as a system of norms."²² There are general obligations that most professional groups accept as part of their social sanction: (1) the obligation to make services available to the public; (2) the primacy of the client being served; (3) an acknowledged obligation to the social institutions that sanction or fund professional practice; and (4) an obligation to the profession.²³

In response to such obligations, professional groups develop standards, principles, and rules. "Standards guide human conduct by presenting desirable traits (virtues) to be sought or undesirable one (vices) to be avoided."²⁴ Practicing

²⁰ William Frankena, Ethics (New Jersey: Prentice Hall, 1973), p. 2.

²¹ Levy, op. cit., p. 13.

²² Michael D Bayles, Professional Ethics (California: Wadsworth Publishing Company, 1981), p. 16.

²³ Ibid.

²⁴ Ibid., p. 22.

outside of the standards of one's profession would usually be considered unethical practice.

A beginning professional, or apprentice, relies on standards and rules because they supply the "do's" and "don'ts" of professional conduct. "Rules give direction and purpose to action."²⁵ They are specific. For example, when a client explains that he/she is battering the baby at home, the human service practitioner must contact the child protective agency.

Because the day-to-day practice of most social workers does not merely consist of situations wherein rules can be invoked readily, it becomes necessary to rely on principles.

As compared to standards and rules, which prescribe practice, principles guide practice. "Principles are clearly not intended to provide uniformity and control over practice, being formulated rather so as to allow maximum freedom of choice and innovation in their application."²⁶ Principles offer general guidelines for practice. By nature, principles are more complex than either rules or standards. A more detailed discussion seems suitable.

An operating definition of the word "principle" is:

²⁵ Lewis, op. cit., p. 42.

²⁶ Ibid., p. 55.

A beginning; A general truth; a fundamental truth or tenet; a law from which others are derived or on which others are founded; an elementary proposition.²⁷

Moral philosophy, societal structure, and individuals' interactions can be said to be based on principles. "The morality of a society, it seems, is the set of moral principles that are accepted in that society. The morality of a person, similarly, may be taken to be the set of moral principles he or she accepts. "Morality in general, if there is such a thing, may be thought of as the set of all the true or correct moral principles." ²⁸

By what means, then, do professions translate principles into practice? "It is possible to think of an adult person's mind or conscience as rather like a living telephone book, stocked with moral principles of the Ten Commandments type, but more numerous and more complex."²⁹ Different principles have the potential to conflict in the service setting, however, and no "superprinciple"³⁰ exists. For example, the application of Diagnostic Related Groupings noted above, sets up a conflict for the practicing social worker between the

²⁷ Webster's Universal Dictionary of the English Language, (New York: The World Syndicate Publishing Company 1937).

²⁸ Feldman, op. cit., p. 9.

²⁹ Richard Brandt, Ethical Theory (New Jersey: Prentice Hall, 1959), p. 247.

³⁰ Ibid., p. 247.

codified principles of the "primacy of clients' interests" and "commitment to employing organizations."³¹ If a health care organization must depend for its existence on the rapid discharge of patients, and if, for certain patients, such a rapid discharge does not serve their best interests, the social worker must make decisions regularly where no clear path toward the "right action" exists.

In such situations, the individual is forced to appeal to analogues.³² Furthermore, principles often do not contain formulations for the actions necessary to accomplish their goals. Contrast the social work principle "the social worker should under no circumstances engage in sexual activities with clients," with "the social worker should adhere to commitments made to the employing organization."³³ The former principle would be considered to be quite clear about its goal and the actions necessary to accomplish it. The latter, on the other hand, refers to a constellation of relationships that are often in flux, and whose concomitant behaviors are quite vague. The actions necessary to bring such a principle to fruition in practice must emerge from the professional self of the practitioner and must take place in the context of the service situation.

³¹ See Code of Ethics.

³² Ibid., see also Lewis, op. cit.

³³ Code of Ethics, op. cit., p. 5 and 7.

The critical document defining the standards for social work practice is the National Association of Social Workers Code of Ethics. The Code is based on principles, rather than prescribed behaviors.

This code is based on the fundamental values of the social work profession that include the worth, dignity and uniqueness of all persons as well as their rights and opportunities... The course of action that the social worker chooses is expected to be consistent with the spirit as well as the letter of this code... In itself, this code does not represent a set of rules that will prescribe all the behaviors of social workers in all the complexities of professional life. Rather, it offers general principles to guide conduct... The ethical behavior of social workers results...from a personal commitment of the individual. This code is offered to affirm the will and zeal of all social workers to be ethical and to act ethically in all that they do as social workers....³⁴

This section of the review attempted to define and discriminate general morality and professional ethics, to highlight the practice arena as the context in which ethical or unethical practice may take place, and to underscore the primacy of principles as the foundation of ethical practice in the professional group. It has already been noted that the ethical principles applicable to social work in organizations are among the most difficult to act upon, due to the complex nature of organizations and the multiple commitments of social workers. With this in mind, it would be helpful to engage in

³⁴ Ibid., pp. iii-iv.

an examination of literature on organizations, specifically, their structures and constraints, and their impact on employees, especially professional employees.

Organizational Theory

This part of the literature review is divided into five sections: components of organizations, organizational constraints, the worker in organizations, power and compliance, and the socialization of the social worker.

Components of Organizations

"Organizations are social units deliberately constructed to seek specific goals."³⁵ The unique characteristics of goals are often obscured in the modern organization. For example, although one goal of a medical center might be to offer high quality health care services to a community, another, and often overriding goal, might be financial prosperity. Goal displacement is an ongoing problem in organizations. Defined briefly, goal displacement is when one organizational goal (i.e., rehabilitation) is superseded by another (i.e., finances).

³⁵ Ralph E. Anderson & Irl Carter, Human Behavior in the Social Environment (New York: Aldine De Gruyter, 1984), p. 88.

Bureaucratic organizations can also be classified as having the following components: "(1) clear division of labor with specialized tasks, (2) a hierarchy of power and control, (3) rules and uniformity of behavior, (4) impartiality in the conduct of the office, (5) career employment within the organization, (6) machine like efficiency...."³⁶

An analysis of these ingredients illuminates the potential problems that professional workers have within organizations. For example: (1) Specialized tasks are difficult to define among professionals with overlapping skills; (2) A hierarchy of power subsumes expertise under organizational authority; (3) Rules, as compared to professional principles, can constrict professional responses to complex situations. In brief, concepts which ordinarily govern the behavior of professionals and concepts which govern the behavior of the organizational worker are often quite distinct.

³⁶ Ibid., p. 90.

Organizational Constraints

Organizational constraints can be defined as any inherent aspects of the setting in which professional practice takes place that have potential impact on the delivery of the professional service. Such constraints include resource scarcity, leadership style, patterns of communication, rules, accountabilities, etc.

Several authors explore how organizational constraints have the potential to effect the behavior of workers. Perrow suggests that there is a lack of adequate information about individual practice behavior within organizations. He states that studies of the influence of organizations on performance give "to the organizational variables (division of labor, communication system, etc.) the predominant control over individual behavior. This control is so extensive that we can neglect individual behavior (supposedly the real stuff of organizational life) in all its multiplicity and variability and deal with group or subunit behavior. It calls for simplifying models of individual behavior in order to capture the complexities of organizational behavior."³⁷ Both Simon and Perrow have demonstrated that strong organizational

³⁷ Charles Perrow, "The Analysis of Goals in Complex Organizations," in Readings on Modern Organizations, ed. Amitai Etzioni (New Jersey: Prentice Hall, 1969), p. 66.

constraints have significant power in determining the goals of the individual.³⁸ "The dominant organizations or institutions of our society have not experienced goal displacement and have been able to institutionalize on their own terms - to create the environments they desire, shape the existing ones and define which sections [they] will deal with... [In fact, organizations can be viewed as] ... tools in the hands of their leaders... We need not doubt that power [is] exercised from the top...."³⁹ This phenomenon is easily demonstrated by the Reagan administration's prioritizing funding for weaponry over funding for housing, creating vast, malfunctioning airborne fortresses, while causing thousands to forsake their dwellings for the streets.

The Worker in Organizations

In addition, Simon has indicated that motivations are often coincident with and directed by the goals of the organization, and that "by whatever means the individual was originally motivated to adopt the role in the first place, the goals and constraints appropriate to the role become a part

³⁸ Ibid., see also Charles Perrow, Complex Organizations: A Critical Essay: Third Edition (New York: Random House, 1979), pp. 157-177.

³⁹ Charles Perrow, op. cit., Complex Organizations: A Critical Essay, p. 175.

of the decision-making program, stored in his memory, that defines his role behavior...."⁴⁰

Perrow has also discussed the work of Michels, who "showed how people of good will with liberal values become transformed, through institutional processes that sociologists are adept at studying, into people who compromise their original goals and those of the organization they head in the interests of preserving their own position."⁴¹

In a review of studies devoted to the decision-making process in complex organizations, Black found that "judgments made under uncertainty [of outcome and time pressure] are not only emotionally demanding but are also open to cognitive strains and predictable biases [of the individual]."⁴²

Assuming these analyses are correct, it can be expected that individual practitioners often behave in their own or the organization's best interest, which has the potential to conflict with their professional ethical mandates. In order to further examine this process, an exploration of power seems warranted.

⁴⁰ Herbert Simon, "On the Concept of Organizational Goals," in A Sociological Reader on Complex Organizations (New York: Holt, Rinehart and Winston, 1969).

⁴¹ Perrow, op. cit., Complex Organizations, p. 170.

⁴² Rita Beck Black, "Risk Taking Behavior: Decision Making in the Face of Genetic Uncertainty," Social Work in Health Care (Fall 1981), pp. 11-25.

Power and Compliance

Power is an interactive process involving several actors;⁴³ as such it can best be described through an elaboration of various components. Obviously, these components are interwoven and not separable in any practical sense. However, it is the purpose of this section to analyze power heuristically.

A simple definition of power is offered by Robert Dahl. "A has power over B to the extent that he can get B to do something B would not otherwise do."⁴⁴ Max Weber states: "Power is the probability that one actor within a social relationship will be in a position to carry out his will despite resistance, regardless of the basis upon which the probability rests."⁴⁵ Within the same framework, Bertrand Russell states that "love of power in its widest sense, is the desire to be able to produce intended effects upon the outer world."⁴⁶ Power is viewed as causative; the intent of one

⁴³ William A. Gamson, Power and Discontent (Homewood, Illinois: Dorsey Press, 1968) p. 22.

⁴⁴ Gary L. Wamsley, "Power and the Crisis of the University," in Power in Organizations, ed. Mayer N. Zald (Nashville, Tennessee: Vanderbilt University Press, 1970), p. 54.

⁴⁵ Andrew S. McFarland, Power and Leadership in Pluralist Systems, (California: Stanford University Press, 1969), p. 13.

⁴⁶ Bertrand Russell, Power (New York: W.W. Norton & Company, Inc., 1938), p. 262.

behavior is to cause a change in another behavior. In addition, all influence is not power: power exists only if the influence causes change.⁴⁷ In a study of "Social Process and Power in a Medical Center," Bucher found that power is contextual. It can only function within a setting and with two or more actors.⁴⁸ By these definitions, we can accept that agencies utilize power over their workers to accomplish desired ends.

The elementary components of power are the setting and the actors. Power is complicated, however, by various actors (leaders and followers), the many types of power available for use, and several emotions effecting the uses of power. Table 1 represents the major components and subcategories of power.

Table 1
Components of Power

Setting	Leaders	Followers
Professional	Effected by feelings	Effected by feelings
Organizational	Utilizes different types of influence	Effected by tendencies towards conformity and compliancy

⁴⁷ McFarland, op. cit., pp. 3-14.

⁴⁸ Rue Bucher "Social Process and Power in a Medical School," in Power in Organizations, ed. Mayer N. Zald (Nashville, Tennessee: Vanderbilt University Press, 1970) pp. 3-48.

As seen in Table 1, power is contextual; it exists within a setting and is effected by actors. Russell indicates that different organizational settings are distinguishable by the kind of power that they exert. For example, the army and police exercise coercive power. Economic organizations use rewards and punishments as incentives and deterrents.⁴⁹

Bucher found that professional organizations have several unique characteristics. (1) An outside observer can not understand a professional organization by reading the organizational chart. (2) Power does not flow exclusively from the top down but has the potential to be directed from the bottom up. (3) Professionals are both dependent on the organization and in inherent conflict with some of the organization's goals.⁵⁰ (4) Professional identity impacts on the power structure as professionals feel allegiance to organizations outside of the employer.⁵¹ (5) Finally, in professional organizations, "power is a far more meaningful concept than authority...."⁵² Bucher defines authority as "obligations" and power as "control of necessities for the

⁴⁹ Russell, op. cit., p. 37.

⁵⁰ Bucher op. cit., p. 15. See also Paul Kurzman, "Ethical Issues in Industrial Social Work Practice," Social Casework (February 1983), p. 107.

⁵¹ Bucher, op. cit., p. 14.

⁵² Ibid., pp. 46-47.

advancement of a professional career-such as salary, space, and promotion...."⁵³ The literature is rich with descriptions of types of power. For the purposes of this work, the author has designated three basic forms of power: coercive, influential, and constructive (see Table 2).

Table 2
Types of Power

Coercive Power	Influential Power	Constructive Power
Naked Power	Suggestion	Requires Skill
Manipulative	Persuasion	Uses Sanctions
Destructive	Propaganda	Controls Resources
Physical Power Over Body	Cooption Tradition Education	Uses Rewards and Punishment

McFarland states: "Power as coercion ... is intended influence which although initially resisted, succeeds through the manipulation of sanctions."⁵⁴ William Gamson also uses the term manipulation in stating: "To be a threat, the [authority] must be the manipulator of the disadvantages, not merely a

⁵³ Ibid., p. 46.

⁵⁴ McFarland, op. cit., p. 14.

reporter of them."⁵⁵ In discussing coercion, Russell utilizes the phrase "naked power,"⁵⁶ and defines this as direct physical power over body. Russell notes that this destructive form of power requires little skill;⁵⁷ rather, it requires that those subjected to coercive power fear the authority figure. The "impulse of submission ...has its roots in fear."⁵⁸ He further notes that without a quality of "human sympathy,"⁵⁹ leaders tend to gravitate toward the use of coercive power.

McFarland uses the word "suggestion," which is defined as intended influence not resisted.⁶⁰ Gamson elaborates on influential power by highlighting pejorative and complimentary words associated with the term influence. The complimentary words include "persuasion, education, rehabilitation and socialization;" the pejorative words include "indoctrination, manipulation, propaganda, and brainwashing."⁶¹ Cooptation is another form of influence cited by Gamson, who also notes that

⁵⁵ Gamson, op. cit., p. 76.

⁵⁶ Russell, op. cit., p. 39.

⁵⁷ Ibid., p. 267.

⁵⁸ Ibid., p. 19.

⁵⁹ Ibid., p. 248.

⁶⁰ McFarland, op. cit., p. 14.

⁶¹ Gamson, op. cit., p. 125.

the more that followers trust the leader, the more power that leader has.⁶²

Traditional power falls under the category of influence. Russell calls traditional power that which does not have to be regularly justified; it is habitual power.⁶³ Traditional power has longstanding respect, i.e., monarchies. Several authors point out that man is a member of an organization from the time of birth to the time of death.⁶⁴ Individuals are born in hospitals, raised in a family, attend school, and work within organizations. From this point of view, we are all exposed to, and effected by, traditional power throughout our lives.

There are two distinctions Russell makes between coercive power and constructive power. (1) As previously noted, constructive power requires a great deal of skill⁶⁵ as compared to coercive power. Thus, rewards, punishments, and sanctions, to the extent that they demonstrate the mastering of the distribution of resources, would be considered manifestations of constructive power. (2) Additionally, Russell perceives a distinction "between power desired as a means and power

⁶² Ibid., pp. 39-58.

⁶³ Russell, op. cit., p. 38.

⁶⁴ Russell, op. cit., p. 275. See also Robert Linder, Must We Conform?, (New York: W. W. Norton & Company, 1954).

⁶⁵ Russell, op. cit., p. 267.

desired as an end in itself."⁶⁶ Coercive power becomes its own end, whereas constructive power is utilized for particular tasks within temporal limits, by leaders who have that quality of human sympathy.

Why would professionals obey authority when obedience would not necessarily be in the best interests of their clients? Russell indicates that individuals are viewed as good when they obey and bad when they don't.⁶⁷

The well-known, compelling, and controversial work of Stanley Milgram - "The Milgram Experiment"⁶⁸ - is worth citing in the context of a discussion of power and compliance.

Milgram states: "Obedience is the psychological mechanism that links individuals' action to political purpose. It is the dispositional cement that binds men to systems of authority. Facts of recent history and observation in daily life suggest that for many people obedience may be a deeply ingrained behavior tendency, indeed, a prepotent impulse overriding training in ethics, sympathy, and moral conduct." In order to test his hypothesis, Milgram designed the following experiment.

⁶⁶ Ibid., p. 263.

⁶⁷ Russell, op. cit., p. 275.

⁶⁸ Stanley Milgram, Obedience to Authority (New York: Harper and Row Publishers, 1974).

"The aim of the investigation was to find when and how people would defy authority in the face of a clear moral imperative." Simply described, the basic experiment included one subject and two actors: one in the role of an experimenter, and one in the role of a "learner." The experimenter would explain the experiment to the subject and actor by stating:

Psychologists have developed several theories to explain how people learn various types of material... One theory is that people learn things correctly whenever they get punishment for making a mistake. A common application of this theory would be when parents spank a child if he does something wrong... We know very little about the effects of punishment on learning, because almost no truly scientific studies have been made of it in human beings.

The experimenter would ask the subject and actor to draw from a hat to decide who would be the learner and who would be the teacher. The drawing was "rigged" so that the subject would always be the teacher, and the actor would be the learner. The subject/teacher would watch as the actor/learner was strapped into an electric shock chair. He would then be asked to sit behind a "panel consisting of 30 lever switches set in a horizontal line. Each switch was clearly labeled with a voltage designation that ranged from 15 to 450 volts" at 15 volt increments. "In addition, the following verbal designations were clearly indicated for groups of four

switches, going from left to right: Slight Shock, Moderate Shock, Strong Shock, Very Strong Shock, Intense Shock, Extreme Intensity Shock, Danger: Severe Shock...."

The subject was asked to administer a test which tested the actor's learning and memory. The subject was told to administer a shock to the learner each time he gave a wrong response. Moreover...the subject was instructed to move one level higher on the shock generator each time the learner gave a wrong answer.

Each vocal response of the victim was coordinated to a particular voltage level on the shock generator... The [actor] indicated no discomfort until the 75-volt shock was administered, at which time there was a little grunt. Similar reactions followed the 90- and 105-volt shock, and at 120 volts the [actor] shouted to the subject that the shocks were becoming painful. Painful groans were heard on administration of the 135-volt shock, and at 150 volts the [actor] cried out, 'Experimenter, get me out of here! I won't be in the experiment any more! I refuse to go on!' Cries of this type continued with generally rising intensity, so that at 180 volts the victim cried out, 'I can't stand the pain,' and by 270 volts his response to the shock was definitely an agonized scream. Throughout, from 150 volts on, he insisted that he be let out of the experiment. At 300 volts the [actor] shouted in desperation that he would no longer provide answers to the memory test.

At this juncture, it was found, subjects would usually turn to the experimenter for guidance. The experimenter would instruct the subject to treat the absence of a response as a wrong answer, and to shock the [actor] according to the usual schedule... At 315 volts, after a violent scream, the [actor] reaffirmed vehemently that he was no longer a participant. He provided no answer, but shrieked in agony whenever a shock was administered. After 330 volts he was not heard from, nor did his answers reappear....

In order to assure for validity and reliability, Milgram tested hundreds of subjects in a large variety of settings. Consistently, 26 of 40 subjects would shock the actor through the end of the scale (450-volts after the actor had appeared to pass out). The instances that this varied were (1) when the experimenter was not in the room; (2) when there were two experimenters who disagreed; (3) when the experimenter told the subjects to administer the amount of shock that they wanted to.

Milgram concluded: "This is, perhaps, the most fundamental lesson of our study: ordinary people, simply doing their jobs, and without any particular hostility on their part, can become agents in a terrible destructive process."

This harrowing look at the lengths to which compliance can stretch raises grave questions about the ability of professional practitioners to maintain ethical behaviors under organizational pressures. Milgram's experiment had subjects from all walks of life. Is there anything unique about the development of social workers that might influence their responses to authority?

The Socialization of the Social Worker

At the nexus of the forces that influence and inform ethical behavior is the individual practitioner. As stated

in the N.A.S.W. Code of Ethics: "The ethical behavior of social workers results ... from a personal commitment of the individual."⁶⁹ It would be reasonable to expect that individual practitioners would behave differently in addressing similar ethical dilemmas, based, in part, to the degree that their personal values are consistent with social work values. To what extent does social work education and practice experience influence personal values?

Varley conducted three studies which explored the socialization and educational processes of social workers. She questioned if values held by an individual could be changed during the educational process or during work experience.⁷⁰

Although her first study found no significant difference between the values of beginning and graduating social work students, both the second and third studies found evidence of value changes during the educational process and subsequent to work experience. Obviously, more research is necessary to determine the potential impact of social work education on students' values, but these studies offer potential evidence

⁶⁹ Code of Ethics, op. cit., p. iv.

⁷⁰ Barbara Varley, "Social Work Values: Changes in Values Commitments of Students from Admission to MSW Graduation, Education for Social Work, (Fall 1968), p. 71. Barbara K. Varley, "Socialization in Social Work Education," Social Work (July 1963), pp. 102-109. Dorothy D. Hayes and Barbara K. Varley, "Impact of Social Work Education on Students Values," Social Work (July 1965), pp. 40-46.

that the values of beginning social workers are accessible to change via the educational process.

The following review of constructs developed by social work scholars for the consideration of ethical issues suggests possible tools that are, and can be, passed along to apprentice social workers to assist them in dealing with the inevitable dilemmas they will encounter. Because of the complexity and strength of forces that come to bear on social workers in organizations, tools for maintaining the value base of social work practice in these settings can be invaluable in buttressing the integrity of the profession.

Constructs for the Consideration of Social Work Ethics

In order to address the need of the social work profession to integrate its Code of Ethics into its practices, social work scholars have developed ways of viewing the practice situation to discern necessary ethical considerations and to suggest methods for resolving ethical dilemmas. The author has termed these works "constructs," and has attempted to compare and contrast their forms and substance. These constructs are derived from studies of morality, ethics, and decision theory. They are, in reality, factors in the ability of practitioners to deal with the ethical issues of daily practice, in that they can, and do, inform the decisions that

practitioners make. The following review highlights some of these notable constructs.

The various constructs may be viewed in reference to one or more of the following six categories designed by the author to facilitate her comparison (see Table 3): deontologic and teleologic; values and knowledge; framework governed behavior; moral imperatives; distinction between professional and personal ethics; and situational approaches.

Table 3
Ethical Constructs

Type of Framework	Author and Year		
Deontologic	Lewis	Reamer	
Teleologic	(1982/84)	(1982)	
Values	Gordon	Lewis	
Knowledge	(1965)	(1982)	
Framework Governed	Levy	Reamer	Loewenberg and
	(1972)	(1982)	Dolgoff
			(1982)
Moral Imperative	Constable	Lewis	
	(1983)	(1972)	
Professional/ Personal	Levy	Gewirth	Toulmin
	(1976)	(1986)	(1981)
Situational	Levy		
	(1972)		

Deontologic/Teleologic

Lewis and Reamer have written about the use of deontological and teleological approaches in the analysis of ethics in general and social work ethics in particular.⁷¹ Deontological analysis attempts to locate overriding obligations present in the issue being viewed. An illustration would be a social worker who places the sustaining of life above all other considerations. Such a practitioner would tend to go to any lengths to prolong the life of a terminally ill person, regardless of the quality of that life, the wishes of the person or family, or the costs involved. This type of decision-making is considered deontological. The consideration of the other factors noted, with the intention of weighing them as part of the overall decision, is considered teleological.

The two approaches are not mutually exclusive. For example, Lewis advocates using both deontological and teleological approaches in making ethical decisions;⁷² that is to say, he discusses ethical behavior as deriving from

⁷¹ Lewis, op. cit. Also see: Harold Lewis, "Ethical Assessment," Social Casework, (April 1984), pp. 203-211. Frederic Reamer, Ethical Dilemmas in Social Service (New York: Columbia Press, 1982).

⁷² Lewis, op. cit., "Ethical Assessment," pp. 203-211.

foundations of duty and proper actions, and from an analysis of ends and means.

Values and Knowledge

Gordon has analyzed the relationship between values and knowledge in professional practice and advises that social workers must make a distinction between the two. This distinction should help to analyze ethical conflicts.⁷³

Almost twenty years later, Lewis took Gordon's analysis further by creating a model for ethical practice which operationalizes the behaviors of social workers. He proposes that ethical practice is derived from two sources - knowledge and values - and that these sources form principles, directives and rules.

Framework-Governed

Levy states: "What is required ... is a systematic framework for the decisions that practitioners make when they encounter ethical issues in their practice."⁷⁴

⁷³ William Gordon, "Knowledge and Values: Their Distinction and Relationship in Clarifying Social Work Practice," Social Work (July 1965), pp. 32-39.

⁷⁴ Levy, op.cit., p. 16.

Reamer might agree that ethical behavior has the potential to be framework governed. Reamer has advocated the use of lexical ordering,⁷⁵ the prioritization of possibilities, decisions, and/or options. For example, when faced with the knowledge that several clients could benefit from a scarce resource not available to all of them, a framework for determining how to allocate the resource can be developed. In the same view, Loewenberg and Dolgoff have employed the concept of a "decision tree" and offer a seven step model for making ethical decisions.⁷⁶

Moral Imperative

Issues of morality quite naturally enter into considerations of ethical practice. Lewis indicates that each practitioner has an individual development of morality which effects his ability to practice ethically. This moral maturity will be manifest, in part, by his ethical behavior in prioritizing his work.⁷⁷ A crass example of this would be a social worker who extends time limits for clients whom he

⁷⁵ Frederic Reamer, "Ethical Dilemmas in Social Work Practice," and Frederic Reamer, "Conflicts of Professional Duty in Social Work," Social Casework (December 1982), pp. 579-585.

⁷⁶ Loewenberg and Dolgoff, op. cit., pp. 63-90.

⁷⁷ Harold Lewis, "Morality and the Politics of Practice," Social Casework (July 1972), pp. 404-417.

finds physically attractive. Constable states that social workers need a specific language and method for dealing with ethical issues, and advocates the use of religious elements in developing ethical principles.⁷⁸

Professional/Personal Ethics

Levy states that "professional ethics must be distinguished ... from general ethics and other value-derived concepts that affect and guide human conduct, and serve as a basis for evaluation." He goes on to state that "what is expected of social workers is not expected of human beings in general because not all human beings are social workers."⁷⁹

Situational

"Applied ethics cannot get along on a diet of general principles alone. It requires a detailed taxonomy of particular, detailed types of cases and situations."⁸⁰ Levy has discussed this point, stating that ethics can only be

⁷⁸ Robert Constable, op. cit., p. 38.

⁷⁹ Levy, op. cit., Social Work Ethics, p. 25.

⁸⁰ Stephen Toulmin, op. cit., p. 38.

defined within the context of "real life situations."⁸¹ He has observed:

It is not good conduct in universal terms that makes for ethical conduct in professional practice; it is behavior that is consonant with the requisites of the professional service situation. To understand the nature of ethical responsibility and to identify guides to ethical conduct, the social work service situation must be scrutinized, especially to ascertain the obligations it implies for the social worker.⁸²

Summary

Kahn states that "the exploration of relevant realities is generally the most time-consuming phase of a planning endeavor."⁸³ Because there is a scarcity of material on the practice of social work ethics within organizations, this review attempted to explore those realities relevant to the author's understanding of the problem. The author's previous research (methodology available upon request) substantiates some of the implications of the literature review. Specifically, the author found that: (1) Social workers think there is a need for more education in social work ethics; (2) Social workers often tend to feel professionally compromised while working under agency auspices; (3) Social workers do not think that agencies adhere to professional standards; (4)

⁸¹ Levy, op. cit., "The Context of Social Work Ethics," pp. 45 - 55.

⁸² Levy, op. cit., Social Work Ethics, p. 45.

⁸³ Kahn, op. cit., p. 86.

Organizational constraints have substantial impact on the ethical behavior of social work practitioners; and (5) Social workers tend to perceive coercive power where influence or constructive power are present.

The literature reviewed also suggests that: (1) The social work profession has developed a body of knowledge on ethics that can serve practitioners; and (2) It is possible to share this knowledge through an educational process to enhance the ethical practices of social work practitioners.

Having reviewed the literature on the relevant areas, we can now refine the statement of the problem, define it, and analyze it.

CHAPTER TWO

Problem Definition

Mark Moore meticulously describes how problem definition leads to specific policy which, in turn, leads to specific programs.⁸⁴ In this case, the problem definition must lead to a specific methodology. Cartwright states that "problems are not objective things, inherent in the so-called real world, but 'images' of that world defined by people in a variety of more or less precise ways."⁸⁵

With these conditions in mind, I have attempted to "define the problem in detail, diagnose [some]...causes, seek relevant theories, [and] consider the interrelationship of component parts...."⁸⁶ Etzioni uses the analogy of a camera to illustrate how the search for a problem definition narrows. The wide angle lens is used to collect and analyze the data,

⁸⁴ Mark. H. Moore, "Anatomy of the Heroin Problem: An Exercise in Problem Definition," Policy Analysis (Fall 1976), pp. 638-662.

⁸⁵ T. J. Cartwright, "Problems, Solutions and Strategies: A Contribution to the Theory and Practice of Planning," in Planning for Social Welfare, eds. Gilbert and Specht (New Jersey: Prentice Hall, 1977), p. 119.

⁸⁶ Kahn, op. cit., p. 86.

and the narrow lens is used to decide on alternative approaches.⁸⁷

Should the problem of ethical social work practice within organizations be defined as one occurring in the agency or in the school? Rein observes that "the same facts can lead to different interpretations about the nature of the improvement of the circumstances...."⁸⁸ May notes "misconceptions about problem solving give rise to the myth that a solution to a given problem exists and that the analyst's task is to discover that solution."⁸⁹

Is the problem:

- (1) Improving the course content on ethics in schools of social work?
- (2) Sensitizing host organizations to social work values?
- (3) Modifying the admissions' processes of schools of social work to further emphasize the personal values of applicants?
- (4) Raising the awareness of ethics of agency practitioners?

How is such a choice made? "The planner's most serious decision and major contribution is what may be called the formulation or definition of the planning task."⁹⁰ May states: "The conceptualization of the kinds of actions that are

⁸⁷ Amitai Etzioni, "Mixed Scanning: A 'Third' Approach to Decision Making," in Planning For Social Welfare, eds. Gilbert and Specht, (New Jersey: Prentice Hall, 1977).

⁸⁸ Rein, op. cit., p. 303.

⁸⁹ Peter May, "Hints for Crafting Alternative Policies," Policy Analysis (Spring 1981), p. 229.

⁹⁰ Alfred Kahn, op. cit., p. 79.

possible to take - what I call 'feasible manipulation' - requires a sense of what can be done as well as a sense of what should be done."⁹¹

"For any given set of objectives there are likely to be a large number of conceivable alternatives (or variations) proposed."⁹² "While no one perception of a problem is more correct than another, some perceptions can be more useful...."⁹³

Gilbert and Specht's model will be utilized to explicate the research design. Although their tool speaks to policy analysis, it seems applicable to research. They indicate that "policies [research projects] are seen as choices ... to determine what benefits are to be offered, to whom they are offered, how these benefits are to be delivered and how they are to be financed."⁹⁴ The questions that must be addressed are: "Who gets what?"⁹⁵ Who is the target population? How is the research designed? And, how will the research be financed?

⁹¹ May, op. cit., p. 229.

⁹² Harry Hatry, Louis Blair, Donald Fisk and Wayne Kimmel, Program Analysis for State and Local Governments (Washington: The Urban Institute, 1976), p. 50.

⁹³ Cartwright, op. cit., p. 121.

⁹⁴ Neil Gilbert and Harry Specht, Dimensions of Social Welfare Policy (New Jersey: Prentice Hall) p. 37.

⁹⁵ Ibid., p. 37.

Who gets what?

Developing a research project that addresses practitioners' responses to ethical dilemmas would benefit:

- (1) Social work practitioners, who would develop improved skills in resolving ethical dilemmas;
- (2) Clients, who would receive a better quality of service;
- (3) Host agencies, whose compliance with social mandates would be improved;
- (4) Schools of social work, which would be graduating more qualified practitioners;
- (5) The profession's integrity, which requires limits to idiosyncratic professional behavior; and
- (6) Society, which gives the profession a mandate to practice.

"Choices in the design of delivery systems exert influence on who gets served and the type of benefits they receive...."⁹⁶ An examination of project alternatives reveals three possible foci: the agency practitioner, the schools' curricula, and the schools' admissions processes.

Friedman notes that "planners are often inspired by a wish to change existing reality. This almost compulsive desire stands in direct relationship to their inability to influence the requisite behavior to produce a change."⁹⁷ Additionally, "there seems to be no one effective decision-

⁹⁶ Ibid., p. 39.

⁹⁷ John Friedman, "The Transactive Approach" in Planning For Social Welfare, eds. Gilbert and Specht, (New Jersey: Prentice Hall, 1977) p. 115.

making strategy in the abstract, apart from the societal environment into which it is introduced."⁹⁸

It would seem a miscalculation to design a research project effecting admissions to social work schools. Such a design, if implemented, has the potential to lower admissions to already struggling schools. Why would they be interested? Schools, as with all other organisms, would invariably value survival over any other option. "Assuming that innovative changes in policy are a rarity, analysts need to turn their attention to the condition under which these changes are feasible."⁹⁹

Revamping a school of social work's curriculum, with the goal of heightening awareness of the ethical elements of social work practice, is another option. Curriculum change, from the author's experience, however, is an arduous endeavor, best undertaken once a specific need is brought to general awareness and is supported by a body of research. As such, curriculum change is only feasible as a long term goal.

Modifying host organizations to accept social work values is a task that, on its face, is rather more grandiose than this author imagines her resources are able to extend.

⁹⁸ Etzioni, op. cit., p. 95.

⁹⁹ Rein. op. cit., p. 308.

Although there is no antidote to a "wicked problem,"¹⁰⁰ a focus needs to be established. Having eliminated the possibilities of effecting the admission processes of the schools or their curricula, as well as having ruled out changing organizations that hire social workers, the focus of this project must be the agency practitioner's ethical awareness and practice. Warren states, "any change effort to be successful must somehow or other impact the system toward which change is directed."¹⁰¹

In its concern for the ethical practice of social workers, inclusive of direct services to clients, and its recognition of the integrity of the school and agency, the proposed research reflects Gil's thinking "that one's truth, in the sense of single-mindedly pursuing a particular ideal, needs to be tempered with love, in the sense of respecting the integrity of the other person and honoring that person's value, rather than using him or her for one's own purposes, however highly motivated they may appear to be."¹⁰²

¹⁰⁰ Horst Rittel and Melvin Webber, "Dilemmas in General Theory of Planning," in Planning for Social Welfare, eds. Gilbert and Specht (New Jersey: Prentice Hall, 1977) pp. 133-145.

¹⁰¹ Roland Warren, "Towards Social and Economic Justice," in Toward Social and Economic Justice, eds. Gil and Schenkman (1985) p. 261.

¹⁰² David Gil, "A Systematic Approach to Social Policy," Social Service Review (December 1970), p. 259.

Purpose of the Research

The overall purpose of this dissertation, and its concomitant research, is to examine the decision-making processes of social workers dealing with ethical dilemmas. The author believes the results may be helpful in adding to the knowledge base of social work educators and supervisors, one of whose tasks is to prepare new professionals to practice within the ethical boundaries of the profession, rather than, for example, in characterologically idiosyncratic patterns.

The author asserts a fundamental premise that practitioners' awareness of the profession's scholarship on social work ethics is necessary for social workers to practice ethically on a consistent basis. Because social work is a "doing" profession, and because ethical practice involves making practice decisions from among multiple alternatives, the author proposes that studying the processes by which practitioners arrive at decisions when posed with ethical dilemmas may yield valuable knowledge useful to educators and supervisors. Towards this end, the research tool first monitors participants awareness of ethical dilemmas, then examines the decision-making processes used to deal with designed ethical dilemmas, while deliberately attempting to heighten the participants' awareness of those elements in practice that are ethical in nature. The research hopes to

determine: (1) how aware the practitioners are of ethical dilemmas in their practice; (2) how social work practitioners in organizational settings make decisions when faced with an ethical dilemma; and (3) if heightened awareness does, in fact, enhance the participants' ability to recognize and analyze ethical dilemmas.

Some possible outcomes of this study might be as follows:

(1) Modification of the methodology for teaching ethics in schools of social work, based on new insight into the decision-making processes, and the impact of heightened awareness on those processes.

(2) New avenues for the supervision of practitioners to enhance their professional growth.

(3) The strengthening of professional practice, based on social work values rather than on idiosyncratic inclinations (see Chapters Three and Four for examples). The potential impact on performance and issues of burnout if practitioners can perceive their work in the context of a professional heritage and not in isolation.

(4) Implications for the selection of candidates for social work schools, if it appears that decision-making processes are not accessible to professional awareness, but are imprinted at a pre-professional stage of development.

The author views this research as a small step in a labyrinth.

Design

This was an exploratory study. As noted previously, the goal was three-fold: 1) To study social work agency practitioners' awareness of what constitutes an ethical dilemma; 2) To examine the decision-making processes of agency practitioners when they are faced with an ethical dilemma; and 3) To examine the impact of heightened awareness of the ethical elements of social work practice on the decision-making processes of social work practitioners.

As this is such a complex subject of study, the work at hand relied on qualitative data collection. Webster's Universal Unabridged Dictionary defines research as "diligent inquiry or examination in seeking facts or principles; laborious or continued search after truth...."¹⁰³

Social work research may be viewed on a continuum.¹⁰⁴ Tripodi would consider this work to be "level one," the "lowest level" (italics mine) of knowledge "seeking to describe social phenomena in a qualitative manner for the

¹⁰³ Webster's Universal Dictionary of the English Language, (New York: The World Syndicate Publishing Company 1937).

¹⁰⁴ Tony Tripodi, "Research Designs," in Social Work Research and Evaluation, R.M. Grinnel ed. (Itasca, Illinois: P.E. Peacock Publishers, 1985), p. 232.

purpose of developing general concepts into more specific measurable variables...."¹⁰⁵ The goal of qualitative research is to understand and describe participants' beliefs and ideas. Epstein states "the use of qualitative research methods in theory development has been called grounded theory and is more suited to the study of relatively uncharted social terrain."¹⁰⁶

The process by which social workers make decisions is both dynamic and individualized. This process would have been difficult, if not impossible, to study through a numerical objective test. As quantitative research utilizes deductive reasoning, and looks for cause and effect relationships, qualitative research seemed more suited to this area of study. Qualitative research relies on inductive logic, describes the phenomena, and makes inferences from the data.¹⁰⁷

In the research undertaken by this author, the process by which participants think was a crucial factor in the design. If the researcher could become familiar with the decision-making processes of the participants, insight into those processes could be gained. A thorough description of an occurrence would enable a social work researcher to develop

¹⁰⁵ Ibid.

¹⁰⁶ Irwin Epstein, "Quantitative and Qualitative Methods," in Social Work Research and Evaluation, R.M. Grinnell ed. (Itasca, Illinois: P.E. Peacock Publishers, 1985), p. 266.

¹⁰⁷ Michael Jacobsen, "Integration of Qualitative Methods into the Social Work Practice Curriculum," presented at New York State Social Work Education Association, Fall, 1988.

insight, ideas, and questions for further study. In qualitative research there is an assumption that a personally involved researcher, submerged in data, would be able to spawn new ideas.

The researcher must gain access to the "natural flow" of thoughts as they occur. In order to discern this flow of thoughts, two interview components were designed. In the first component, participants were asked to think of and report about an ethical dilemma from their practice experience. The second component relied on written case histories presenting ethical dilemmas that had to be resolved by the participants. These two components of the design were used to stimulate real-life thinking. Component one's goal was to obtain an understanding of participants' thoughts about their own practice. In the second component, the case histories were designed to be complex enough to create some difficulty for the participants. This difficulty assisted the researcher in understanding how the participants think in "normal" daily circumstances.

Upon completion of this research, the researcher and the readers of this dissertation, should have a better understanding of how social workers make decisions about ethical dilemmas. This is the first step towards helping social workers make more refined, less idiosyncratic decisions. Levy states:

There is - or there must be - a definable limit to idiosyncratic individual or group behavior in social work where social work values are concerned or else one must moan with the Prince of Wales in King Henry VI, Part III, 'If that be right which Warwick says is right, there is no wrong, but everything is right'.¹⁰⁸

The Tool

The research was conducted through a series of two interviews. Both interviews had three sections. Time two occurred one month after time one. Each section of the interview will be explicated. The device used to guide the researcher in the collection and analysis of the data, its explanation, and the case histories, are attached as Appendices C, B, and A respectively. With the permission of the participants, each interview was tape recorded to assure accurate data collection.

Interview One

Part One

Participants were asked to discuss an ethical dilemma derived from their own social work practice experience. An

¹⁰⁸ Charles Levy, "The Values Base of Social Work," Education for Social Work, (Winter 1973), pp. 38.

ethical dilemma was defined as a situation in which two or more professional ethical obligations came into conflict, as in the example posed in the introduction, discussing the impact of D.R.G.'s.

The goal of Part One, Interview One, was to determine participants' awareness of ethical dilemmas in their practice. Additionally, participants' awareness at time one could be compared with their awareness at time two.

Part Two

The goal of Part Two, Interview One was to determine how the participants arrived at their plan of action in response to Case History #1 (see Chapter Three and the Appendix for text of Case History #1).

The participants were asked to read Case History #1, then explain their considerations in arriving at a resolution to the case. The participants were informed that the primary goal of the interview was to understand the process of decision-making, rather than the decision itself.

As the participants articulated their considerations, the researcher attempted to isolate the elements in the case that influenced their thinking, what weight was given to each, how the elements related to each other and to the overall process of arriving at a decision.

The author proposed in the literature review that there are identifiable elements in practice experience that impact upon the decision-making process. Of interest to this work were organizational structure, issues of power and compliance, ethical principles and personal beliefs. During the course of the data analysis, it was necessary to create an additional category in order to accurately reflect the findings, that of clinical references. This category reflected responses that were informed by techniques of intervention. It is not uncommon in qualitative research, when analyzing data, to come upon material outside of the interest of the researcher, but which influenced the resulting findings.

Description of the Ethical and Extra-Ethical Categories

Ethical Principles

As stated in the National Association of Social Workers Code of Ethics: "The social worker is expected to take into consideration all the principles in this code that have a bearing upon any situation in which ethical judgement is to be exercised and professional intervention or conduct is planned."¹⁰⁹ The researcher designed each case history with

¹⁰⁹ Code of Ethics, op. cit. p. iii.

several ethical principles in mind. The applicable principles to each case history are noted in Chapters Three and Four.

Organizational Structure

As defined in Chapter One, the organizational elements in situations are those that refer to the structure and systems of the organization in which the situation is occurring. In addressing ethical dilemmas, some participants relied on negotiating the organization's bureaucracy, its communications systems, hierarchical structure, financing, and role definition, in order to resolve the presenting problem.

Power

Power has been defined in the literature review as the ability to influence the actions of another to do something the other might not necessarily do if this influence was not applied. Some participants noted power relationships as effecting their decision-making around the presented situations.

Personal

Personal elements are defined as those which are rooted in individual style or preference, i.e., idiosyncratic belief systems. For the purpose of this study, personal elements would be those responses evoked in the participants by the case histories which are unique to each participant based on his individual experiences, and which guided his actions.

Clinical

Clinical elements are those referring to the technical interventions in situations. Some of the participants resolved the presenting problems through a differential use of treatment techniques; they perceived the issues as manageable through treatment methodology.

In order to reach an understanding of the elements, ethical or extra-ethical, that influenced the decision-making processes of the participants, the author used a technique known in qualitative research as recursive questioning.¹¹⁰ Recursive questioning is quite similar to the social work interview as described by Kadushin. "... The social work

¹¹⁰ Recursive questioning was utilized in Interview One and Interview Two.

interview is apt to be diffuse, unstandardized, non-scheduled, interviewee-controlled ... and concerned with interpersonal interaction of participants ... Much of what [the interviewer] generally has to do in the interview cannot be determined in advance but must be advisable, under highly individualized circumstances, to achieve the purpose of the interview."¹¹¹ Recursive questioning, like the social work interview, is guided by the process of the exchange between researcher and participant, toward the goal of the research.¹¹²

For example, as the participants cited elements effecting their decision-making, the researcher would note and verbalize these elements, i.e., "Do you mean you believed the physician had a lot of power?" or, "Are you saying that there were not enough resources to offer the client?" or "What did you mean when you mentioned self-determination."

The assumption is that this type of discussion would raise the participants' awareness of the type of ethical and extra-ethical elements that influenced their decision-making processes, while assisting the researcher to reach an understanding of the decision-making process.

¹¹¹ Alfred Kadushin, The Social Work Interview (New York: Columbia University Press, 1972) p.14.

¹¹² Jacobsen, op. cit.

Part Three

Case History #2 was then presented to the participants to be read and responded to, following the same format as Case History #1. Case History #2 can be found in Chapter Three and the Appendix.

After having read Case History #2, the participant was asked to discuss the ethical and extra-ethical elements presented in the case that influenced the decision of what the appropriate action might be to resolve the situation.

At the end of Interview One, the researcher and participant set a date for a second interview, to take place about a month after the first interview.

Interview Two

The goal of this interview was to determine if the awareness of the ethical and extra-ethical elements evoked during the first interview would have any impact on the decision-making processes of the participants when discussing the new material of this interview.

Part One

The second interview began by duplicating Part One of the first interview. Specifically, the researcher asked each

participant to reconstruct another ethical dilemma from his social work practice.

Part Two

Part Two duplicated the second part of the first interview, but a new case history was presented for consideration. Case History #3 can be found in Chapter Four and the Appendix.

Each participant was again asked to discuss the ethical and extra-ethical elements in the situation that influenced the decision to be made by the participant. Again, recursive questioning was used to explicate the decision-making process.

Part Three

The researcher ended the interview process with the participants by requesting feedback regarding their experiences of the first and second interviews. The following questions were asked:

- (1) Did you think about the interview within the past month?
- (2) If yes, what did you specifically think about?
- (3) Do you believe there has been any impact from the interview?
- (4) If yes, how would you describe the impact?
- (5) How would you describe the interview process?
- (6) If you had the opportunity to change your responses in the first interview, would you?

Microcosm vs. Macrocosm

Gil has "noted that ... social problems existing in a society are considered to be consequences of existing social policies and therefore, that solutions to social problems seem to require appropriate modification of the social policy system."¹¹³ The dissertation at hand does not call for a total system or societal change; it addresses, instead, how professional social workers make ethical decisions. It addresses behavior, not necessarily values or attitudes, thus it deals with a symptom. Gil might agree with the goal of changing people's behavior within the limits of professional practice. "Every society must devise mechanisms for recruiting individuals to fill the various statuses within the total array of societal tasks and functions ... The role defines a normative range of possible behaviors, and different incumbents of a given status will tend to interpret the role in their individual ways within that range. This variability of role performance seems to be one important avenue of gradual social change."¹¹⁴

The ultimate goal of this research is to search for a more consistent and higher quality service for clients by

¹¹³ Gil, op. cit., p. 413.

¹¹⁴ Ibid., p. 417.

limiting those practices that disregard professional ethics. The author cannot conceive of social workers performing effectively with behavior that disregards the ethical obligations of the profession. "Do not aim at establishing happiness by political means. Rather aim at the elimination of concrete miseries." ¹¹⁵

The proposal itself is incremental, involving individual practitioners working within agency settings. In discussing the work of John Else, Warren states: "He maintains that incremental change is the only change really feasible for radical humanists, and he defines it as consisting of 'planned sequential steps toward a specified objective.'" ¹¹⁶ In a different context, but still relevant, is Rein's suggestion that "the dilemma of democracy is how to redistribute resources to politically weak and inarticulate groups in the interest of justice, without producing political and social instability, violence, and revolution ... Every policy analyst must come to terms with the philosophy of incrementalism [*italics mine*]." ¹¹⁷

If this research is successful at contributing to the understanding of the ethical decision-making processes of agency social workers, other research could ensue which might

¹¹⁵ Warren, op. cit., p. 256.

¹¹⁶ Ibid., p. 260.

¹¹⁷ Rein, op. cit., p. 306.

eventually lead to social work educators having more effect at helping beginning and experienced social workers to practice within the values of the profession.

Validity

The focus of this study is threefold: (1) to study social work agency practitioners' awareness of ethical dilemmas; (2) to examine the decision-making processes of agency practitioners when they are faced with an ethical dilemma; and (3) to examine the impact of heightened awareness of ethical and extra-ethical elements involved with practice choices on the decision-making processes of social work practitioners.

As the area of inquiry is enigmatic, content and face validity, and reliability, warrant clarification. The following questions will be addressed: Are accurate portrayals of participants' awareness of ethical dilemmas in their practice achieved by asking them to discuss ethical dilemmas? Do the concepts accurately represent the domain? Are the case histories accurate portrayals of the work in these areas? How accurately does this tool measure the concepts?

Content Validity

The first area the research intended to study was the degree of awareness agency social workers have of ethical dilemmas. To wit, participants were asked on two occasions to reconstruct and discuss ethical dilemmas from their practice experience. This format was composed with the assistance of a panel of two Masters prepared social work practitioners, and was pretested on another five practicing social workers. To avoid the possibility of participants misinterpreting the request to reconstruct a dilemma, thus creating inaccurate measurements, they were offered the operant definition of an ethical dilemma at the beginning of the first interview, and, by the second interview, they were familiar with the tool.

Do the concepts accurately represent the domain? The instrument was intended to measure the decision-making processes of the participants, as well as any change in awareness of the ethical and extra-ethical elements that influence decision-making between the first and second interviews. The tool directed its focus upon the following concepts: ethical principles, organizational structure, power and compliance, personal beliefs, and clinical technique. This form of inquiry was developed from three years of study of professional workers within organizational settings, and

of ethics. These concepts were cultivated from the literature on social work practice and social work ethics, and from the research process. All transcribed interviews were reviewed by a Masters prepared social worker.

Furthermore, the development of these concepts was facilitated by work with a panel of Masters prepared social workers. The panel consisted of one practitioner from a methadone maintenance program and two practitioners from a major medical center. Each phase in the development of this format was discussed with each practitioner. Their ongoing input was integrated into the work. The concepts were also reviewed, and approved, for content validity by a panel of social work educators at a Social Work Conference. The researcher believes that these ethical and extra-ethical elements of practice are critical in effecting the decision-making processes of practitioners.

Are the case histories accurate portrayals of the work? Each case history was developed in agreement with Masters level social workers practicing in the settings examined. The first case history was developed with the support of a social worker practicing in a medical center. The second case history was developed with a social worker practicing in a methadone maintenance clinic. The third case history was developed with a social worker in an outpatient mental health agency.

Face Validity

The methodology was reviewed for face validity by the panel of three Masters prepared social work practitioners and four social work practitioners who pre-tested the tool. Both groups believed that the instrument appeared to measure the intended concepts.

Reliability

How accurately does this tool measure the concepts? Although the concepts discussed demonstrate the ethical and extra-ethical elements social workers deal with in making ethical decision, there are inherent difficulties in this area of research, and the research tool. The limitations will be discussed in the order that the methodology was presented.

In Part One, Interview One, the participants were asked to reconstruct an ethical dilemma derived from their own experience, and explain how they decided to deal with it. The operant definition of ethical dilemma was offered to the participants. As the participants were unprepared for this interview, however, and under the pressure posed by a face-to-face interview, responding to this part of the interview was a demanding task. This difficulty was addressed by re-

testing the participants one month after the first interview, at which time they had been oriented to this process.

In Part Two, Interview One, there were subjective decisions that had to be made by the researcher. During the course of this part of the interview, the author used recursive questioning to clarify and understand the participants' decision-making. As such, the author had to make decisions about the interview while it was in process. For example, the author would often have to ask participants to explicate some of the elements they designated as effecting their decision-making, in order to achieve clarity in understanding the participants' points of view. Although the author attempted to minimize the impact of her questions of the participants, total objectivity was impossible under the interactive circumstances of the interview. It is possible that this format may have, therefore, caused oversight of elements that might have arisen in a non-interactive format.

This limitation in the design was addressed by the author's expertise in interviewing technique. The methodology used in this research is only reliable if executed by a trained clinician. Patti states that "recruitment and selection is basically a process of maximizing the fit between the jobs that must be done and the people who will do them."¹¹⁸

¹¹⁸ Rino Patti, Social Welfare Administration, (Englewood Cliffs: Prentice Hall, 1983), p. 138.

One of the foci in the education of social workers is the ability to conduct interviews that elicit data from clients in a non-judgmental and spontaneous fashion. The properly educated social work practitioner maintains an awareness and professional use of the self during the interview. The author's qualifications to perform the interviews in this research are a Masters Degree in Social Work (with a concentration on clinical practice), advanced education in family interviewing, doctoral education with a clinical concentration, and nine and one half years of clinical practice experience.

A further control of the possible loss of data through the interactive format was the use of a tape recorder, allowing the author to review the content of the interviews as often as necessary to accurately assess the responses of the participants.

The tool was pre-tested on four participants. This sampling demonstrated that the above hindrances were manageable. The researcher was able to execute the methodology without significant problems.

There is an interrater reliability component of the instrument which was utilized in the pre-test and in the actual administration of the methodology. The pre-test sample interviews were tape recorded and presented to a Masters prepared clinical social worker. The clinician agreed with

the interpretation of the elements presented, and coded the participants in the same categories as had the author. This colleague also reviewed the written transcripts of the participant interviews for interrater reliability. Category reliability was computed as a function of agreement using the following equation:

$$\frac{\# \text{ of agreement}}{\# \text{ of agreement} + \text{disagreement}}^{119}$$

The number of agreement as applied to Interview One was: ninety percent agreement in part one, ninety percent agreement in part two and ninety five percent agreement in part three. The number of agreement as applied to interview two was: ninety five percent in part one and ninety five percent in part two.

Cost

"How much [will] each alternative cost."¹²⁰ "The cost analysis should focus on those cost elements that are likely to be substantial...."¹²¹

The costs involved with this research were minimal, consisting of time and printing expenditures.

¹¹⁹ Polit, D. F. and Hungler, B. P., Nursing Research Principles and Methods, 3rd Edition (Philadelphia: Lippincott, 1987), p. 321.

¹²⁰ Gilbert and Specht, op. cit., p. 61.

¹²¹ Ibid., p. 62.

(1) Time: The researcher and the participants had to allocate time for this research. The researcher was teaching three days a week, and conducted the interviews on the days she was not teaching. The participants provided two and one half hours during their work days to engage in the research. As they were not asked for personal time, there was minimal resistance to this request.

(2) The questionnaires were printed. The researcher has a computer, and printed the original questions on computer paper. She was permitted to use her employer's copying machine for duplicating the questions.

Few other costs occurred.

Ethical Considerations

The Code of Ethics recognizes ethical concerns present in research and scholarship. The following four ethical principles apply to this research study:

The social worker engaged in research should ascertain that the consent of participant in research is voluntary and informed, without any implied deprivation or penalty for refusal to participate, and with due regard for participants' privacy and dignity.

The social worker engaged in research should protect participants from unwarranted physical or mental discomfort, distress, harm, danger, or deprivation.

Information obtained about participants in research should be treated as confidential.

The social worker engaged in research should consider carefully its possible consequences for human beings.¹²²

I. The social worker engaged in research should ascertain that the consent of participant in research is voluntary and informed, without any implied deprivation or penalty for refusal to participate, and with due regard for participants' privacy and dignity.

Participants were recruited from two organizations, a medical center and a family service agency. As the author was personally familiar with several employees from the medical center, she asked them for the names and telephone numbers of colleagues. The author then called the potential participants and told them how their names were obtained. They were also informed at that time about the nature of the research and that their participation was requested. Although several potential participants declined involvement, ten social workers agreed.

The author obtained the name and telephone number of a supervisor at the family service agency from a colleague at the school in which she was teaching. After a telephone conversation, and a subsequent letter confirming the nature of the research, the supervisor presented the author's request for participants to the social work staff. The social workers that wished to participant gave their names to this

¹²² Code of Ethics, op. cit., p. 4.

supervisor. He then contacted the author with the list of ten social workers who wanted to participate. At the beginning of each interview, the author again explained the purpose and nature of the research and why she wanted to tape record the interviews. Participants were informed that the tape would be transcribed and parts of their discussion would be taken from the interview and used in the text of the dissertation. They were informed that they could either refuse taping, or request the recorder be turned off at any point. Two participants requested the tape recorder be turned off for a few minutes as they discussed personal experiences. All twenty participants agreed to be tape recorded.

All participants were "... competent to [offer] consent ... provide[d] sufficient information to allow for a balanced decision ... and consent[ed] ... entirely voluntar[ily]." ¹²³

II. The social worker engaged in research should protect participants from unwarranted physical or mental discomfort, distress, harm, danger, or deprivation.

"Social workers must be vigilant in protecting participants' welfare, rights, and confidentiality throughout the research process." ¹²⁴

The author was concerned about the difficulty of the interviews themselves. Many of the participants found it

¹²³ Steven Paul Schinke, Ethics, in, Richard M. Grinnell, Social Work Research and Evaluation, (Itasca, Illinois: F.E. Peacock Publishers, 1985), p. 104.

¹²⁴ Ibid., p. 104.

awkward and arduous to communicate how they arrived at decisions; they were more comfortable simply expressing the decision itself. The author found it helpful to use supportive interviewing techniques, including the maintenance of a non-judgmental attitude, in order to help the participants through the rough spots of the process.

The author agrees with Schinke's view that "the emphasis on protecting research participants is quite appropriate...."¹²⁵ Most of the participants had never taken part in a research project prior to this one. If this were to have been a negative experience, the participants might have been left feeling reluctant to engage in any further research, their own or others'.

III. Information obtained about participants in research should be treated as confidential.

In compliance with the above principle, identifying information, reference to the employing organization, age and gender were all disguised or changed. As noted above, the participants were given the opportunity to stop the tape recording whenever they felt it might present a problem for them. All names were deleted from the written transcripts and random numbers were assigned to the participants. In addition, all participants were referred to in the male gender, to further disguise their identities. The male gender

¹²⁵ Ibid., p. 103.

was selected because there were less males than females in the sample, and it seemed to enhance further the obscuring of identities. In this way, the transcripts were handled in the same way as written case records used for social work research.

IV. The social worker engaged in research should consider carefully its possible consequences for human beings.

The author believes that, "sound ethical choices go beyond participant recruitment and informed consent. The actual implementation of social work research is risky in terms of ethics."¹²⁶ During the research, the author became privy to an ethical dilemma at the family service agency which involved a conflict between the administration and the workers. As the author was seen by the participants there as an expert in the area of ethics, and as they were undecided about how to deal with the conflict at the agency, the author had the opportunity to influence directly the way staff was handling the situation. During the research process, several of the family service participants discussed their thinking about this dilemma. It was somewhat surprising that others did not refer to it, and, during Interview Two, several stated they could not think of an ethical dilemma in their experience.

¹²⁶ Ibid., p. 106.

The author declined to give advice on the management of this dilemma because she felt that to do so would have violated the above principle. She was given access to the agency as a researcher, not a mediator, and would have blurred her role, and possibly prejudiced the research, by direct involvement in the conflict. Furthermore, the information she had at her disposal was incomplete, as it did not reflect the full range of perspectives at the agency. Another factor entering into the author's decision was that the agency had a long history of service, and the staff was quite competent, so to have attempted to effect the course of these events directly would have devalued the ability of those involved to resolve the dilemma confronting them.

As a researcher involved with the lives of individuals struggling with real-life problems, there is a great temptation, when the opportunity presents itself, to use professional skills to assist with the solution to those problems. As Levy has observed, however:

When [power] is intentionally used in the client's interest, the social worker is apt to proceed with a self-righteous lack of restraint. Whatever the resulting benefit, which might well satisfy the client, if it is at the involuntary expense of the client's personal control, it represents an abuse of power. In short, the operation can be regarded as a practice success but an ethical failure.¹²⁷

¹²⁷ Levy, op. cit. Social Work Ethics, p. 77.

Description of Sample

The author used a purposive non probability sample. Non probability samples are generally "used for generating hypotheses...."¹²⁸ They are "suited to exploratory studies with 'level one' knowledge objectives [see above] where investigators are merely interested in obtaining as much unique data on a research question as possible."¹²⁹

Purposive samples involve "hand selecting cases for inclusion in a study on the basis of some notion of what is typical or what is unique about the cases."¹³⁰ "Purposive sampling is predicated on the assumption that the social worker has sufficient knowledge related to the research problem to allow selection of 'typical' persons for inclusion in the sample."¹³¹

The sample this project studied was composed of twenty Masters level social workers employed by human service organizations. Because of the non probability nature of the

¹²⁸ Tony Tripodi and Irwin Epstein, Research Techniques for Clinical Social Workers, (New York: Columbia University Press, 1980), p. 170.

¹²⁹ James R. Seaberg, Sampling, Richard M. Grinnell, Social Work Research and Evaluation, (Itasca, Illinois: F.E. Peacock Publishers, 1985) p. 143.

¹³⁰ Tripodi and Epstein, op. cit., p. 171.

¹³¹ Seaberg, op. cit., p. 145.

sample, no assurances of generalizing to a larger population of social workers can be made.

Ten practitioners each from two organizations were enlisted as participants. A comprehensive medical center in urban New York City was chosen because it represents a large institution with a classical hierarchical structure in which social work is a "quest" discipline. The medical center employs approximately three thousand staff, among which approximately sixty are social workers. A smaller family service agency in suburban New York, employing approximately eighty staff, of which approximately forty are social workers, was chosen because it represents a traditional social work agency, wherein the service proffered is specifically within the purview and expertise of the social work profession.

The decision to choose for this research two distinctly different types of agencies employing social workers was made to determine if size or function of agency would have an impact on the data being collected.

The participants were asked for an initial hour and a half appointment and a subsequent hour appointment. They were told that they were taking part in research towards a doctoral dissertation that focuses on the decision-making processes used by social work practitioners, and that the device being used was fictitious case histories.

Demographics

The sample consisted of a total of twenty practitioners from two agencies. There were four males and sixteen females. There was no significant gender difference between the two agencies.

Religion

Seven of the participants were Catholic, twelve were Jewish, and one was Protestant. There was no significant difference in religious preference between agencies.

Age

There was a wide range in age. Ten participants were between ages twenty-eight and forty-five, and ten participants were between the ages of forty-six and sixty-five. The median age was forty five (see Tables 4 and 5).

Table 4

Age of Participants

Median	45
Mean	44
Mode	33

Table 5
Age of Participants

Age Range	Number of Participants
25-30	1
31-35	4
36-40	3
41-45	2
46-50	3
51-55	5
56-60	1
61-65	1

Years of Experience

The participants were, generally speaking, quite experienced. Their years of post-masters practice ranged from one to twenty. The median was ten years. Two participants had less than five years of experience, seven participants had between five and nine years experience, and eleven participants had between ten and twenty years of experience (see Tables 6 and 7).

Table 6
Experience of Participants

Median	10
Mean	9.950
Mode	10

Table 7
Experience of Participants

Years of Experience	Number of Participants
1-4	2
5	1
6	1
7	2
8	2
9	1
10	5
11	1
13	3
20	2

Years Worked in Agency

The length of time that the participants worked in their current agencies ranged between seven months and nineteen

years, with a median of four years.¹³² Eight participants were employed up to three years; three participants between four and five years; four participants between six and ten years; and five participants had been employed between eleven and twenty years (see Tables 8 and 9).

Table 8
Agency Experience

Median	4.25
Mean	6.2
Mode	1.5

Table 9
Agency Experience

Years in Agency	Number of Participants
1-2	7
3-5	4
6-8	4
11-12	3
16-19	2

¹³² The months have been rounded off to the nearest year.

Course in Ethics

Nineteen of the twenty participants had never taken a course in social work ethics (see Table 10).

Table 10

Course in Social Work Ethics

Ethics Course	Yes	No
Medical Center	1	9
Family Service	0	10
Total	1	19

The participant group was composed of a broad range of agency practitioners, with no significant difference between the two agencies represented. There was no evident clustering in the demographic data to indicate a skewing of the research findings. The following analysis of the data supports this interpretation.

CHAPTER THREE

Analysis of Interview One

Reconstructions

This chapter explores the responses to part one of the first interview. Participants were asked to reconstruct a professional ethical dilemma from their experience and to explicate the management of this dilemma. This part of the study moved the participants into the researcher's area of interest. It also initiated addressing the research questions: (1) What level of awareness of ethical material do social work practitioners have? (2) How do social work practitioners make decisions about ethical questions? and (3) What elements besides ethical principles influence social work practitioners' decision-making when dealing with ethical questions?

Ethical Dilemma or Non-Ethical Problem?

The operant definition of the phrase "ethical dilemma," as used in this work, is a service situation in which the social worker is aware of at least two ethical principles, as defined in the N.A.S.W. Code of Ethics, that are in conflict, and must choose one of those conflicting principles upon which

to act. A dilemma is defined in Webster's Universal Unabridged Dictionary as "a state of things in which ... obstacles present themselves on every side, and it is difficult to determine what course to pursue."

Let us create a situation that is compelling, but does not meet the requirements of the above definition. A colleague of ten years at the mental health agency, who has a wife with cancer and five young children, two of whom are mentally retarded, and who comes from a socioeconomically deprived family, is found by you to be having sexual intercourse with a client in his office. You confront him with this information, and he begs you to be discrete. He explains that his wife has become depressed and sexually indifferent, and that the client's case is about to be closed anyway. He promises to terminate his relationship with the client in the immediate future. He explains that this job is his only means of support for his family, and the loss of it would be devastating to his wife and children. Two months go by and you are convinced your colleague is continuing his sexual relationship with the client. You tell him you are obliged to report his unethical conduct. He leaves the office in a panic. You receive a call from his wife telling you she is aware of her husband's behavior, and that she is insisting he go for treatment to deal with his problems. She urges you to take no action.

Clearly this is a most disconcerting situation to find oneself in, but it is not an ethical dilemma by the definition being used, because it lacks a conflict of ethical principles. That the sexual relationship between the colleague and the client is unethical is clear. "The social worker should under no circumstances engage in sexual activities with clients."¹³³ There is no conflicting ethical principle in the situation, however, that would render it an ethical dilemma.

To further clarify the use of the definition of ethical dilemma, let us suppose that you are a social worker in an inpatient psychiatric unit. You have a compliant client who is currently on voluntary status, and who tells you that he wishes to be discharged, as his parents are in town for a week and he would like to spend time with them before they leave. The client appears well enough to be discharged. You tell the client that you do not foresee any difficulty with discharging him this afternoon. The director of the unit, however, asks you to convince the client to stay for two more days as the census on the unit is low, and the facility is in acute financial difficulty and could use the reimbursement for each patient day. Staying for two more days would not harm the client, and might even further consolidate his recovery. He would still have the rest of the week to be with his family. There is no question that the client would agree to stay if

¹³³ Code of Ethics., op. cit., p. 5.

it was recommended. The director offers to deal with the client around this issue. You consider what step to take next, and decide that you will ask the director to take over the care of the client.

The above creation qualifies as an ethical dilemma within the definition being used, as it places in conflict the principles of client self-determination and commitment to the employing organization, to wit: "The social worker should make every effort to foster maximum self-determination on the part of clients;"¹³⁴ and, "The social worker should work to improve the employing agency's ... efficiency and effectiveness...."¹³⁵ The action taken by the social worker, however, invalidates the situation as meeting the definition being used, as the choice made is not from one of the conflicting ethical principles, but is organizational in nature.

The author recognizes that the definition used for an "ethical dilemma" is both demanding and limiting. It required of the participants an analytic point of view probably unfamiliar to them, under the pressure to respond to an in-person interview. It is not surprising, therefore, that although nineteen of the twenty participants requested, and were given, the above definition of an ethical dilemma, twelve

¹³⁴ Ibid., p. 5.

¹³⁵ Ibid., p. 6.

of those nineteen reconstructed situations that did not meet the definition, as did the one participant who did not request a definition (see Table 11).

Table 11
Participants Citing Ethical Dilemmas

	Percent	Number
Cited an Ethical Dilemma	35%	7
Did Not Cite an Ethical Dilemma	65%	13

Five participants presented issues wherein one ethical principle was either cited or implied in their decision-making, but not in opposition to a second ethical principle. Eight participants described situations in which no ethical principles were cited or implied in their decision-making. This is not to say that these participants did not present dilemmas, but rather, they offered what the author terms "non-ethical problems."

Because of the frequency of this type of response, the author felt obliged to analyze these responses, and has coded them into the following categories: legal, personal, clinical, and organizational.

Legal

Legal problems are defined as issues in which the participants' decisions were considered by them to be preordained through prescribed societal mandates, i.e., reporting suspected child abuse in New York State.

Personal

Personal problems are defined as issues in which the conflict discussed was rooted in individual style or preference, i.e., idiosyncratic belief systems. An example of this might be extrapolated from the above-created problem of the social worker having sexual relations with a client. If the colleague were to view the situation primarily through his relationship with the worker and his family, the problem would be coded as personal.

Clinical

Clinical problems are defined as issues in which the participants' decisions were guided by practice methodology. An example of this would be if the colleague of our above-mentioned sexually involved worker would have predicated his actions on an understanding of the family dynamics of the worker rather than on the ethical principle being violated.

Organizational

Organizational problems are defined as issues in which participants' conflicts were related to specific organizational structure and systems, i.e., when the social worker in the above creation decided to remove himself from case responsibility for the hospitalized client.

There was no significant difference in the number of participants whose reconstructions met the definition of an ethical dilemma between the medical center and the family service agency. In the medical center, four participants discussed ethical dilemmas and six non-ethical problems. In the family service agency, three participants discussed ethical dilemmas and seven discussed non-ethical problems. A total of seven participants discussed ethical dilemmas and thirteen participants discussed non-ethical problems (see Table 12).

Table 12
Participants Citing Ethical Dilemmas by Agency

Agency	Ethical	Non-Ethical
Medical Center	3	7
Family Service	4	6
Total	7	13

Non-Ethical Responses

The thirteen non-ethical problems were of a clinical, personal, legal or organizational nature. Of the non-ethical responses, three medical center participants discussed clinical problems and three discussed personal conflicts. In the family service agency, one participant discussed a clinical problem, two participants discussed personal issues, one discussed a legal issue, and two discussed organizational problems (see Table 13).

Table 13
Non-Ethical Responses

Agency	Clinical	Personal	Legal	Organizational
Medical Center	3	3	1	0
Family Service	1	2	1	2
Total	4	5	2	2

Clinical

Three of the four problems coded as "clinical" involved the question of the limits of the principle of client confidentiality in the face of some degree of suicidal risk. Considerable thought was given to the question of whether these responses should be classified as ethical dilemmas or clinical problems. Reamer notes, "... an individual who chooses to engage in self-destructive behavior should be permitted to do so..." with provisions that such a decision is well informed by knowledge and consequences.¹³⁶ Thus, these three responses would reflect a conflict between the principles of client self-determination on the one hand, versus the principle of professional service in the client's

¹³⁶ Reamer, Ethical Dilemmas in Social Services, op. cit., p. 96.

best interests, if one assumes that the sustaining of the lives of these clients would be in their best interest.

This ethical dilemma, however, was not present in any of these three presentations. None of the participants cited the possibility that the client might have the right to commit suicide.

Another complication with the classification of these three responses, and perhaps a more pertinent one, is the implication that a conflict existed between the violation of confidentiality and loyalty to the client. In fact, Participants (A) and (C) noted this as a concern. This conflict, however, is not, strictly speaking, one between ethical principles, because the Code of Ethics notes that "the social worker should share with others confidences revealed by clients, without their consent, only for compelling professional reasons [italics mine]."¹³⁷ The question, then, was the degree to which the reasons were compelling, and all three participants decided the issues based on a clinical assessment of the situation. The responses were, therefore, classified as clinical problems, rather than ethical dilemmas.

¹³⁷ Code of Ethics, op. cit. pp 5-6.

Participant (A)

I was seeing [an adolescent]...who had a gun collection... At one point he talked about...killing himself... He didn't have a plan but he had all these weapons... I felt that I had an obligation to let his family know... He didn't want any part of [parental involvement]... So I called up his mother and I told her...and she was very protective of the confidentiality... I never told [client]... Making a clandestine contract with the parents is a big deal and we didn't do it other times. The confidentiality remained because the parents didn't do anything....

Participant (B)

[The client]...spoke of suicide a lot. Never...done it. The indications were when he spoke about it he wanted more medication. [The group therapist] called his apartment and the phone was busy for an inappropriate amount of time... He wanted to call the police to break down his door. He thought that he had...killed himself... He wanted me to call his mom... So I seeked [sic] out guidance...from the clinic directors... I ended up not doing anything...based on what the directors have said....

Participant (C)

I worked with an adolescent who...talked about...suicide and I had to decide whether or not to tell his parents... I felt like I was betraying his trust... I do a lot of family work now and I have a more of a systems perspective... I don't think that dilemma would feel the same to me... I think I was really an unsophisticated young social worker when this happened. I felt in much greater conflict then I would now... I did talk to his parents... There seemed to be an obligation to go beyond the limits of confidentiality because there was a real risk....

The fourth "clinical" problem was a judgment of the best foster care placement of a client.

Participant (D) explored a recent clinical decision in which he was dealing with an outside agency.

Participant (D)

I am working with [an adolescent]... He has been in...many foster families... He was caught stealing... [The client] described symptoms which...appeared to be...cleptomania... I feel this is real pathology. So I called his D.S.S. worker... I said I feel that this is...serious... I think he needs a more secure setting... He...said 'no, I think [a setting change] would be very bad for him...' He's the one who [represents the commissioner]...and he is in the care of the commissioner... Do I go along with what he says or do I do what I think is right...? [I] base [the decision] on the diagnosis and the prognosis and the alternative treatments.

There was no clear ethical principle cited by Participant (D); rather he presented a difference of clinical opinion, and questioned to what degree it is appropriate to be assertive.

Personal

Participants (E), (F), (G), (H), and (I) related personal struggles they experienced when faced with practice decisions. For Participants (E) and (F), the issue raised was discomfort over the need to "create and maintain conditions of practice that facilitate ethical and competent professional performance by colleagues."¹³⁸

¹³⁸ Ibid. p. 6.

Participant (E)

[A co-worker whom I supervised] had been there for...more than ten [years]... We were friends... She got pregnant and...would... spend the whole day talking to the staff about problems at home... So the other social workers started to resent this... I kept making...excuses... So there started to be this great inability of me to do supervision... She got pregnant and...lost the child...three times. Each time she came back she would do less...work... The [next] pregnancy took. She did nothing... I finally said to the director that it was clear to me that I was having no impact on her....

Participant (F)

I was called...to transfer [a pediatric patient]...for surgery... I figured I would read the chart first... There were no social work notes in the chart and I knew that the worker had followed up on this [case]... It took two and a half hours, this entire process... My dilemma was...notes should be in the chart...however there was improper documentation in the chart to allow the patient to go at this time... I could have done the [transfer] and blown the whistle too...[but] I'm not comfortable doing the whistle blowing....

Participants (E) and (F) were confronted with the problem of "blowing the whistle" on a colleague. Participant (E) experienced conflict due to his personal friendship with his colleague. He nevertheless addressed the issue in the end. Participant (F) expressed personal discomfort with the function of causing a colleague to be accountable for inadequate work, and, in fact, never addressed the issue in any form. Although an ethical principle was cited by both of these participants, the conflict was personal in nature, rather than between two principles.

For the following three participants, the issue cited was one of some personal discomfort with either agency or societal mandates. As in the clinical problems cited, these participants did not perceive the problems as among ethical principles, but, in these cases, as internal stresses.

Participant (G)

The little boy was placed... I felt that the child would have been better off with the foster mother... For me it was emotional... The child had his own lawyer...who told me...if B.C.W. in Boston found that they are adequate [grand]parents there was nothing that I could do. Basically he had the child's best interest in heart... I think my decision was to define myself as a professional and, as a professional, you are supposed to be clear-headed about what you do, and emotionally unattached as you can be.

Participant (H)

The agency...fee [for psychotherapeutic service] is seventy dollars... If you can't afford...that you pay on a sliding scale... We are supposed to get whatever [their insurance company] reimburses for up to seventy dollars... I have a real problem with this... My gut says, these folks are entitled to get something back on their insurance. There have been times where I...have not reported that [a] client has insurance... I haven't told [my agency].

When asked what informed his decision, Participant (H) responded:

I went to [family] therapy...and my [spouse] was very resistant to...paying... One of the directors asked me what my [spouse's] income was...and I said 'well, that is not important. We have to pay the top fee regardless...' They tried to make this a clinical issue for us... I remember how difficult it was for me to take that initial step to go.

Participant (I)

When...I have to now let a client know that I have to report to...an investigative agency...for me it's a personal conflict and it's a conflict of the trust that this person has put in me... I would rather...not report it but work with the family. I feel I have the expertise to do that... I don't think it is an ethical thing...because I am legally mandated to [call C.P.S.]... So what it does is it causes me a conflict....

Legal

Participants (J) and (K) raised issues which had a primary reference to legally mandated procedures, which they resolved through compliance with the law, rather than through a consideration of conflicting ethical principles.

Participant (J)

We had a...[client] who had a baby and...called [us] up. We went over there because [the client] said that the baby was burned. We got over there and the baby had burn marks that looked like the top of a lighter on his neck on his legs and one or two marks on his body... I've known this [client] for like five years. Now, I knew that I had to report it although that is not something that you do totally clean all the time although most of the time I'm pretty clean about it. It was my feeling right away that [the client] didn't do it. That has never been my experience with [this client]... I had to report it and what made it less conflictual to me is that [the client] knew that I am a mandated reporter and called me.

Participant (K)

A twenty-three year old woman who lives with mom...has three younger siblings, all of whom she feels are being abused by the mother... She comes to me concerned about her ten year old brother... Nothing life threatening at this point. My dilemmas is...do I immediately call C.P.S. regardless of the fact that I didn't discuss this with her?... If I went by the letter of the law, the minute she walked out my door, I should have been on the phone. But I waited a few days... [I did call] because the facts were the facts.

The above two participants' references for their actions were to social/legal mandates rather than to the potential ethical material that resided in the situations.

Organizational

Participants (L) and (M), both from the family service agency, discussed an issue that affected both of them. The focus for both participants was the organizational context in which the event occurred.

Participant (L)

The director of the...unit left... I agreed to be acting director... Then I devoted myself to teaching the new [director]. Problems began to appear... When I got to supervision with him ...he used the...time to really get at me... It's gotten worse and this Wednesday...he screamed and yelled and called me all kinds of names: a malinger, an eavesdropper. He said I didn't have the basic skills of a first years student, I was a liar, I didn't do any work, nobody here liked me, I was a cancer effecting the rest of the agency, I was an embarrassment... As I got up to leave he said 'what we have discussed here today doesn't go outside of this office...' Afterwards, [colleagues] said to me, 'Are you O.K.?' and I lost it. They...felt that he shouldn't get away with it... So we have a process in this agency whereby if we have a grievance, we go to our supervisor and it was clear I couldn't go back to him to discuss this. And if that doesn't work we go to our supervisor's supervisor. The supervisor's supervisor is very close to him, he hired him. He is devoted to him and they need each other... So we couldn't go to him, so we went to the director of the agency. And he [said] 'you must meet with [supervisor] and [supervisor's supervisor].' He was scandalized that I had said something about my supervision to other people... I...said that I was resigning and he said 'give me your reasons.' I gave him the history of what happened with a word for word account of what occurred in supervision... The only thing that he had to say is 'I'm glad you didn't let it drag on.'

Participant (L)'s response raises significant ethical questions about the practices in his agency, but the context in which he discussed the issue was organizational: office politics through which he was victimized. In fact, it might well be that his supervisor failed "... to act with consideration for the interest, character, and reputation..."¹³⁹ of Participant (L) whom he replaced, and clearly Participant (L) conformed with the Code of Ethics by attempting to "... seek arbitration or mediation when [his] conflict ... with [his] colleague ... required resolution for compelling professional reasons,"¹⁴⁰ yet there is an absence of conflicting principles from which Participant (L) felt obliged to choose.

Participant (M) referred to this same office situation in his response.

¹³⁹ Ibid., p. 6.

¹⁴⁰ Ibid., p. 7.

Participant (M)

There is a big issue in the adoption department involving [Participant (L)]... [My supervisor's] style and my style are so different... Initially I...wanted...to please [him] so I followed through [on his clinical directives]... Now I often miss supervision... That is a technical maneuver away from really confronting him about this... [The supervisor] listed all these things that [Participant (L)] had not done. And a lot of it was very insulting towards [Participant (L)]. I perceive it as a political problem...and I see [administration] as acting unethically and immorally... I feel that the only response has got to be a politically correct response... Over the two years since the new executive director took over, many long time social workers have left... I feel we have to define...the correct supervisory position....

Participant (M)'s response to Participant (L)'s situation, and his reactions, underscored the organizational context in which the situation was viewed. Participant (M) referred to the ethical principle requiring consideration by the supervisor toward Participant (L), but Participant (M)'s conflict is not between or among ethical principles, but grounded in political and organizational dynamics.

Summary of Non-Ethical Reconstructions

All of the above responses demonstrated some form of conflict in which the participants found themselves. Some cited ethical principles, but none of the responses met the definition of an ethical dilemma, and thus they were classified as non-ethical problems. The remaining seven responses were classified as ethical dilemmas because the

author feels they met the definition of citing a conflict between two ethical principles.

Ethical Dilemmas

All seven participants who reconstructed ethical dilemmas as defined by this study noted an organizational component involved in the dilemma. In five of those seven responses, the social worker's commitment to the employing organization came into conflict with the primacy of the clients' interests. One response cited a conflict between commitment to the employer and obligation to a colleague, and the remaining response cited a conflict between clients' right to privacy and commitment to the employing organization (see Table 14).

Table 14

The Obligations in Conflict in Reconstructed Ethical Dilemmas

Conflicting Obligations	Responses from Medical Center	Responses from Family Service Agency
Organization vs. Client	3	2
Organization vs. Colleague	0	1
Organization vs. Confidentiality	0	1

Organization vs. Client

Participants (N), (O), (P), (Q), and (R) presented dilemmas in which the demand for commitment to the employing organization came into conflict with the primacy of clients' interests.

Participant (N)

I speak Spanish and so I was...assigned an adolescent who...was a suicide watch... The parents were Spanish speaking... In the ...intake...the therapist asked about sexual abuse...and the kid...said yes, that her father had abused her...although it had not taken place in the last years. The father has become [religious]... We called [the child abuse administrator] and [the liaison to S.S.C.]...who said it didn't need to be reported right away; we needed to work with the family. The director of our unit made a decision that we had to call the family in that night and confront them and I had to do it since I spoke Spanish... I felt this was absolutely the wrong thing to do... I was a new staff member and I had no choice but to go along with this....

Participant (O)

My clinical services are closed...yet...I have to have statistics that show I'm doing something... [I was told to] see the people [once] and then make a [referral]...but...I know where I can send them [through our phone contact]... They are already stressed out and I'm delaying them getting what they really need... My director said that's what I should do... That made the balance of what to do....

Participant (P)

Part of the work that we do in this division is called the search. Searches for adoptees who...want to find...the birth parent... The laws in New York State have changed... [They] now say that an agency is not allowed to do a search for an adoptee unless the three parties involved have registered...in Albany: the adoptee...the birth parents...and the adoptive family... I was...about to begin one search... I decided not to do it... If one of the three parties involved resented any kind of communication and chose this point to make and issue of it, the agency would be at a loss... It's a sense of responsibility to the whole agency...a personal value... Wanting to do what is right...for the larger good....

Participants (N), (O), and (P) recognized they were in positions of conflict between countermanding ethical obligations. They appeared to be aware that by "adher[ing] to commitments made to their employing organizations,"¹⁴¹ they were not serving the best interests of their clients. Participants (N) and (O) did not perceive that they had a meaningful choice to make, perhaps feeling cowed by the authority of their supervisors. They indicated no awareness of the principle that "the social worker should be alert to and resist the influences and pressures that interfere with the exercise of professional discretion and impartial judgment required for the performance of professional functions."¹⁴² Participant (P), on the other hand, was clear that he was making a choice by adhering to agency policy and social

¹⁴¹ Ibid., p. 7.

¹⁴² Ibid., p. 3.

mandate. He reasoned in a utilitarian method that the social good in this case superceded the need of the individual.

Participants (Q) and (R) experienced similar dilemmas, but responded differently.

Participant (Q)

A patient...was undocumented and the agency didn't want to take the patient for services... Basically, my argument is that I don't think that you are illegal... He had rights as a patient in the hospital. So finally, after some meetings, they accepted the patient... I don't consider those people who flee from war and the situation [in Central America] illegal. They should be given the status of political asylum... This is primarily my position.

Participant (R)

The question is whether it is better to give a psychiatric diagnosis to a client in order to obtain reimbursement...as long as it's not harmful to the client or the therapeutic process... It has to be made for the benefit of the agency... Ultimately, it's the clients' interests that have to come first.

Have there been times that you thought it was harmful to the therapeutic process or client?

Marginally yes, but in those cases we decided against diagnosing them.

Can you think of one of your clients that you didn't give a diagnosis to?

It was a case that it was the absolutely only way to go that seemed to make any sense was to engage these people in conjoint marital therapy and we really couldn't have justified that...unless we gave them both a psychiatric diagnosis and structured everything differently. We would have had to see the clients individually because of the requirement of the clinic. And we decided not to do that.

So you decided to see them without getting clinic reimbursement?

Yes....

Participants (Q) and (R) were cognizant of their commitments to their agencies to "use with scrupulous regard ... the resources of the employing organization,"¹⁴³ as well as the need to "serve clients with devotion, loyalty, [and] determination."

Organization vs. Colleague

Participant (S) recalled a dilemma in which his commitment to his employing organization came into conflict with the principle of "treat[ing] colleagues with respect, courtesy, fairness, and good faith."¹⁴⁴

Participant (S)

We hired someone... He had an illness which later became defined as Crohn's Disease... He started in July and he started having severe symptoms in December and was hospitalized... We were... nearing the end of five months... At the point...I was saying to him 'my recommendation is that you extend your probation,' it had already been decided by the executive directors...to not make him permanent... I was the one who had to write the evaluation which was the tool by which they let him go. I felt none of that was necessary... This should be done in the least hurtful way possible... I didn't have a choice in the decision... In a sense, it was a...passive decision.

¹⁴³ Ibid., 8.

¹⁴⁴ Ibid., p. 6.

As with Participants (N) and (O), Participant (S) appeared to have been cowed by organizational pressure into making a distasteful choice.

Organization vs. Confidentiality

Participant (T)'s dilemma involved a conflict between organizational commitment and the principle of the privacy of clients' confidences. The outcome was markedly different from that of Participant (S).

Participant (T)

The host organization...was a school setting... People of authority...[did] not back up the confidentiality... I had to protect [it], but I also had to do it in a way that I could still work with the other people... I ended up quitting... [I] believe in confidentiality...as a person's right when they come [for help]...their right to privacy....

Summary and Implications: All Reconstructions

Why did two thirds of the participants fail to reconstruct an ethical dilemma as defined by this study? There are many possible explanations to account for this. Among them are: (1) They had not experienced an ethical dilemma; (2) They could not understand the definition provided by the author; (3) They confused work-related problems in

which an ethical principle is involved with an ethical dilemma.

As the author subscribes to Loewenberg and Dolgoff's position "... that there are ethical implications or ethical aspects to almost every professional decision...",¹⁴⁵ it strains common sense to think that experienced practitioners had not encountered ethical dilemmas in their work.

It is quite possible that the participants had not been in the practice of analyzing ethical dilemmas, or that they felt that "most situations that a practitioner encounters require only a high level of professional skill and insight, but do not involve ethical questions."¹⁴⁶ In that case, the participants were being asked to provide material with which they were not in the habit of recognizing as such.

The third speculation is that the participants, for the most part, seized upon work issues that involved ethical principles, but not within the dimensions of the definition provided.

The possibility that many of the participants practice in what they perceive as a "zone of moral indifference"¹⁴⁷ is supported by the fact that forty percent of the participants, when asked to present an ethical dilemma from their

¹⁴⁵ Loewenberg and Dolgoff, op. cit., p. 5.

¹⁴⁶ Ibid.

¹⁴⁷ Ibid.

experience, reconstructed situations that had occurred two or more years prior to the interview (see Table 15).

Table 15
When the Reconstructions Occurred

Time	Frequency of Response	Percent
One Month	12	60%
Two Years	1	5%
Three Years	2	10%
Four Years	1	5%
Five Years	1	5%
Seven Years	3	15%
Total	20	100%

A third finding from these responses that bears discussion at this point is the fact that seven of the seven ethical dilemmas presented involved an organizational component (see Table 16). This supports the findings of McCann and Park Cutler that sixty-five percent of complaints to N.A.S.W. alleging unethical behavior involved organizational practices.

Table 16
Ethical Dilemmas Involving Organization

Ethical Dilemma	Number of Responses
Organization vs. Client	5
Organization vs. Colleague	1
Organization vs. Confidentiality	1
Total	7

Case Histories #1 and #2

In this section, two fictional case histories were presented to the participants. The case histories were designed to present ethical dilemmas to the participants for them to discuss how they would think through to a resolution the questions raised. Built into the case histories, along with the ethical dilemma, were various other elements which might bear on the process of decision-making. The goal of this section, as compared to the former, was to determine what issues influenced the ethical decision making-processes of practicing agency social workers. In the former section, the goals were to orient the participants to the researcher's study, and to establish a comparative baseline for the participants.

Case History #1

You are an M.S.W. employed by the Social Work Department of Major Medical Center. You have recently been assigned by your Department to provide service to the Center's in-patient Gynecology/Oncology Unit. Dr. Marcus Casey, the notable Director of the Gyn/Oncology Division, requests your assistance with a Ms. Misfortune, age seventy-five, who is being transferred from Sticks Suburban Hospital for the purpose of undergoing a hysterectomy at Major Medical. Dr. Casey tells you that Ms. M. normally resides in a nursing home and liaison might be needed during her hospitalization. Upon calling Ms. M.'s residence, you discover that it is, in fact, a supervised Single Room Occupancy setting. The social worker there informs you that Ms. M. has resided at the S.R.O. for seventeen years, since being "deinstitutionalized" from the psychiatric hospital in which she spent twenty-five years from age thirty-three. Ms. M. is known to have been bleeding vaginally for at least six months, and was admitted to Sticks Suburban for a work-up where preliminary tests indicated the presence of ovarian cancer.

You meet Ms. M. the following morning in her room on the unit. She presents as a disheveled, frightened woman who speaks in broken sentences when she is at all audible. She cringes as you approach her. She has only two or three front teeth and no back teeth. She is overweight, yet it obvious that her abdomen is disproportionately distended. Ms. M. verbalizes that she is afraid of pain, does not want to stay in the hospital, and only wishes to return to her home at the S.R.O.

You accompany Dr. Casey and his Residents on their afternoon rounds. When the team enters Ms. M.'s room, she curls up into a fetal position and repeatedly cries "Don't hurt me!" Dr. Casey informs his Residents that Ms. M. has a psychiatric history and may be unable to make competent decisions for herself. He tells his staff to schedule tests preparatory to probable surgery the following week. As it turns out, all data indicates that Ms. M. has metastatic ovarian cancer, and her prognosis for cure is nil. Surgery would involve a large abdominal incision. The aim of the surgery would be to remove as much of the malignant tissue as possible, to control the vaginal bleeding and any bowel involvement. Beyond the usual risks involved with surgery, Ms. M. has already been weakened and her age also places her in a high-risk category. She will probably have a difficult recovery period, and it is anticipated she will be started on chemotherapy almost immediately to attempt to control the further spread of the cancer. This would, of course, entail side-effects such as loss of appetite, nausea, hair loss,

weakness, and the compromise of her immune system, rendering her vulnerable to infections. Hospitalization would probably be for three to four weeks, following which she might require care not available at the S.R.O.

Your contacts with Ms. M. during the week gradually reveal that she is capable of interaction and discussion. By your third visit to her room, she is able to sit up and speak in complete sentences. She tells you of her childhood, her psychiatric hospitalization, and her life at the S.R.O. She perceives that her family originally hospitalized her because she made them uncomfortable. She discusses her chronic loneliness, and her inability to feel comfortable with men. Her greatest pleasure in life had been eating, and even this has been limited due to her dental problems. She feels she has never been allowed to control what happens to her. She insists she does not wish to have surgery and the subsequent treatment, and she asks you to help her with this request.

You again contact Ms. M.'s social worker at the S.R.O. She agrees that Ms. M. is capable of making decisions, but is concerned about Ms. M.'s regressive behavior under stress. She does not feel she can advocate for Ms. M.'s position against surgery, but gives you the phone number of Ms. M.'s nephew, who accompanied her when she moved to the S.R.O.

When you call the nephew, he informs you that Dr. Casey has already spoken to him, explaining the importance of the surgery and Ms. M.'s inability to make a competent decision. The nephew, who hasn't seen Ms. M. for seven years, supports Dr. Casey's recommendation, and hurries off the phone to go to work.

When you next meet with Dr. Casey and his team, you report your findings. The team then visits Ms. M.'s room on Rounds. She goes into a fetal position and is incoherent. Dr. Casey requests a psychiatric evaluation. That evening Ms. M. is seen by a psychiatric resident whose report you read the following morning. It includes a description of Ms. M.'s regressive characteristics, a history of her psychiatric condition, and a diagnosis of chronic schizophrenia undifferentiated. You also see in Ms. M.'s chart signed consent forms for surgery. The Senior Resident tells you he met with Ms. M. this morning (Friday) and explained the surgery completely, and she signed consent. Although he understands what you have said about Ms. M., he schedules the surgery for Tuesday. He reminds you that since D.R.G.'s have been instituted in the medical center, the medical staff has been unable to allow for much pre or post operative time. You visit Ms. M.'s room and she tells you the Senior Resident spoke with her, but he appeared hurried, and she was unable to speak with him fearing he would be irritated, so she signed the papers he placed in front of her.

Question: What, if any, role does the social worker have in advocating for Ms. M.'s assertion that she does not wish to have surgery?

The substantive references in this case history that are relevant to the research can be categorized as ethical, organizational, power, clinical and personal. The investigator was interested in the decision-making process, not practice methodology. She explored the content that informed participants' actions. Attention was focused on the 'why' of action, not the 'how' of action.

Definitions Of Substantive References

Ethics

As stated in the National Association of Social Workers Code of Ethics: "The social worker is expected to take into consideration all the principles in this code that have a bearing upon any situation in which ethical judgment is to be exercised and professional intervention or conduct is planned."¹⁴⁸ The researcher designed case history #1 with the following ethical principles in mind:¹⁴⁹

¹⁴⁸ Code of Ethics, op. cit. p. iii.

¹⁴⁹ Ibid., pp. 3 - 8.

I. Primacy of Clients' Interest

(1) The social worker should provide clients with accurate and complete information regarding the extent and nature of the services available to them.

II. The social worker should make every effort to foster maximum self-determination on the part of clients.

(1) The social worker should not engage in any action that violates or diminishes the civil or legal rights of clients.

III. The social worker should adhere to commitments made to the employing organization.

(1) The social worker should work to improve the employing agency's policies and procedures...

IV. The social worker should regard as primary the service obligation of the social work profession.

(2) The social worker should act to prevent practices that are inhuman or discriminatory against any person or group of persons.

V. The social worker should act in accordance with the highest standards of professional integrity and impartiality.

(1) The social worker should be alert to and resist the influence and pressures that interfere with the exercise of professional discretion and impartial judgement required for the performance of professional functions.

The intention of the researcher was to establish a potential conflict of ethical principles from among those cited above, and to determine what informed the participants in their decisions of which principle or principles they would consider to be dominant.

Organizational

As defined in the previous chapter, organizational elements are related to the medical center's structure and systems. If an organization is an "effective means by which people can be organized into social units in order to achieve the goal of their companies..."¹⁵⁰ and one of the goals of a medical center is to assist clients in obtaining informed and appropriate health care, then the social worker's role is to facilitate this goal through "systematic preparation for action."¹⁵¹

Organizational references speak to both procedure and reasoning. The participant may view the ethical dilemma as a complex system to be adjusted, wherein the discussion centers on negotiating the structure and persons involved with the case.

Case history #1 offers the participants an opportunity to consider the medical center's hierarchy, its authority systems, and the role of the social worker in such a host setting. His references may be directed towards the various systems involved with the case, i.e., family, physician, psychiatrist, supervisor, outside advocacy groups, and the courts.

¹⁵⁰ Jay Shafritz, Steven Ott, Classics of Organization Theory (Chicago, Illinois: The Dorsey Press, 1987), p. 11.

¹⁵¹ Webster's Universal Dictionary of the English Language.

Power

"Power is an actor's ability to induce or influence another actor to carry out his directive or any other norms he supports...."¹⁵² Case history #1 contains the element of power wielded by Dr. Casey and the potential influence it has to direct the overall situation.

Clinical

Clinical elements are defined as those which deal with issues of practice methodology. Reamer contrasts ethical and nonethical aspects of social work by stating "the ethical aspects of the profession include questions about the obligations and duties of practitioners and about what is ethically right and wrong conduct. The nonethical aspects of the profession include questions about, for example, the effectiveness of particular intervention techniques...[and] methods for assessing the nature of a client's problems...."¹⁵³ In Case History #1, the clinical elements present are the assessment of Ms. M.'s medical and psychosocial situations,

¹⁵² Amitai Etzioni, A Comparative Analysis of Complex Organizations (New York: The Free Press, 1961), p. 4.

¹⁵³ Reamer, Ethical Dilemmas in Social Service p. 3.

and how the social worker used himself in his relationship with Ms. M. and her nephew. "The relationship between the client and the worker is the medium through which help is given and received."¹⁵⁴

Personal

Personal elements are defined as those which are rooted in individual style or preference, i.e., idiosyncratic belief systems. For the purpose of this study, personal elements would be those responses evoked in the participants by Case History #1 which are unique to each participant based on his individual experiences, and which guided their actions.

Findings

One striking, and universal, response to Case History #1 was that none of the participants perceived an ethical dilemma between their commitment to the organization and any other principle. In fact, all of the participants took an initial position of advocacy for Ms. M.'s right of self-determination, although they varied in their citations of the elements that informed this position. Many of the participants perceived

¹⁵⁴ Eda Goldstein, Ego Psychology and Social Work Practice (New York: The Free Press, 1984), p. 195.

that they had some obligation "... to resist ... pressures that interfere with the exercise of professional discretion and impartial judgement....,"¹⁵⁵ and there was a scattered reference to the other ethical principles potentially active in the case, but, again, none of the participants perceived an ethical dilemma as defined by the author.

There are several possible explanations for this phenomenon. To have perceived a dilemma between one's commitment to the organization and any other principle, the participants would have had to have taken seriously the issue of D.R.G.'s, and/or would have had to perceive a teleological rationale for not advocating for Ms. M.'s right of self-determination, such as: To have advocated for Ms. M. in opposition to the chief of service and the bureaucratic structure might have disabled the social worker from assisting other patients who might have benefited from her service.

Similarly, a participant could have asserted that, ultimately, the expense of keeping Ms. M. in the hospital to process this issue would be exorbitant and better used for other socially useful purposes.

That none of the participants cited the principle of commitment to the organization suggests that either they felt the principle of self-determination overwhelmingly outweighed other ethical obligations, or they did not perceive they had

¹⁵⁵ Code of Ethics, op. cit., p. 3.

an organizational commitment, or that the case history was written and presented in such a way that commitment to organization was not an evident dynamic in the case itself.

Another striking pattern in the responses was that although all of the participants did perceive a social work role in advocating for Ms. M.'s right of self-determination, fully half of the participants, upon further discussion of the case, abandoned this role, not due to an ethical dilemma, but due to other features of the case noted in the description of substantive references, specifically power, personal, or organizational elements.

The Initial Response

As stated, all twenty participants believed that they would advocate for Ms. M.'s wish to avoid surgery, thus supporting the ethical principle of the client's self-determination. Five participants mediated this position by further verifying Ms. M.'s competence, another three specifically stated opinions that she was competent, and the remaining twelve did not refer to competence as an issue (see Table 17).

Table 17

References to Ms. Misfortune's Competence

Reference to Competence	Number of Participants
Verify Competence	4
Specify Assumed Competence	4
Advocate Without Reference to Competence	12
Total	20

The five who verified Ms. M.'s competence offered the following remarks:

The social worker has...an obligation to make sure that everything is done... First of all, is she really competent? If she is, did she really get all the information necessary to give informed consent? And then, when her decision is voiced, is it understood correctly...? Because she has an absolute right to do what she wants with her life, to have it end, if that's what she wants... It is important to know what she will voice as a competent position...out of respect for her.

I'd speak with her again...and if she again...says that...I really don't want the surgery...then I would become an advocate....

I think you need to know what the patient was thinking...how the patient defines the problem... The first step before you come to a solution is to explore... It's her life and it will be her death....

I would want to talk with Ms. M....about what's going on and the signing of the papers, and in my attempts of...exploring that...if the client...would really want me to advocate and work with her, then I would take a very active role.

I would want to talk to her more. I don't think it is established that she is not competent.

The three who assumed Ms. M.'s competence, elaborated on this assumption.

If this woman does not want to have surgery...my position would be to advocate... I believe that she is entitled to make a decision for herself and there is enough in this record to suggest that she is competent to make that decision... When the social worker made an effort, she was very responsive....

I would certainly want to be an advocate for this woman. I feel...that she was competent to make a decision, [and] that I would want to support that decision. I understand enough about fear that it can make people do things that they don't mean to do.

I think she is capable of making a decision even if she has had a psychiatric history. She was able to do that when she was speaking to the social worker... The role is to try to, in any way you can...[actively support] her right to make the decision....

Here are some further examples of the participants' references to Ms. M.'s right of self-determination, and their intention to advocate for it.

I think that every person deserves, absolutely the right to have their wishes represented... A social worker has got a role because there is nobody else to do this for this patient.

I really feel that as the social worker, you have to advocate... Adults have the right to make their own decisions....

I think that you already have a role. You are there. Whether you like it or not. You're already involved....

Your role still has to be in supporting whatever her decisions are in whatever the conditions are... I think you do have a role....

Change Of Position

Of the twenty participants, ten maintained their advocacy of Ms. M.'s self-determination, and ten abandoned an advocacy position when confronted with obstacles, such as power and/or organizational constraints (see Table 18).

Table 18
Advocacy Position

Position	Number of Participants
Continued Advocating	10
Discontinued Advocating	10
Total	20

The Undeterred Advocates

Of the ten participants who maintained a position of advocacy, seven relied on an ethical analysis of the case, two on an organizational analysis, and one on a clinical analysis (see Table 19).

Table 19
Participants Continuing to Advocate

Analysis Type	Number of Participants
Ethical	7
Organizational	2
Clinical	1
Total	10

All seven advocates who were informed predominantly by ethical principles cited self-determination. Four additionally cited resistance to influence and pressure, one cited prevention of discriminatory practices, and one cited prevention of discriminatory practices, resistance to pressure, and clients' rights to complete information. These citations were either explicit or implied in the discussion (see Table 20).

Table 20
Ethical Principles Cited by Participants

Principle	Number of Participants
Self-Determination	7
Resist Pressure	5
Prevent Discrimination	2
Complete Information	1

Participant (A): Self-Determination and Resistance to Pressure and Influence

I do truly think that people have the right to die... I believe in peoples' rights to self-determination... I know that doctors have a lot of power in hospitals and they go their own way... I...would stay with the challenge. I would put my job on the line for something I believe in.

Participant (B): Self-Determination and Resistance to Pressure and Influence

I have strong feelings about this, you are there for the client... I will go back to self-determination and social work values... If employment goes along with the social work...values, then there is no conflict... I definitely came into this field with that... So I would fight, if it was a client's wish...and probably put myself at risk...of losing my job....

Participant (C): Self-Determination and Resistance to Pressure and Influence

You certainly don't have any great ethical conflict about what your role is... Support...what the client really wants... My main job is to allow her free will to be heard and plan for her... I don't know the hospital system, but I'm not going to be intimidated... This is my job.

Participant (D): Self-Determination and Resistance to Pressure and Influence

You have your ethics and you've done what you believe in and what you know is right, and you followed it through, but then you get 'God' speaking to you in the form of a doctor, and they seem to win... I think in a situation like this if people are forceful enough and make enough fuss, some period of time would be provided... I don't feel threatened... I feel that I am doing something I believe in...based on my past experience...and trust in the social work profession... I think I would do it [advocate]. Because otherwise, why bother.

The previous four participants' statements were informed by the same ethical principles. The next participant noted a different ethical area.

Participant (E): Self-Determination and the Prevention of Discrimination

I think she should be allowed to make the decision herself. The role [of the social worker] is to try to in any way you can [do] it...[support] her right to make the decision... She has the right to change her mind... [Her regressed response] is a typical response from someone what has been institutionalized for 20 years... It is just a result of the environment that she has been living in. Because she didn't have that response when she spoke to the social worker....

Participant (E) perceived Ms. M. as a member of a group that is typically unable to assert itself, due to its treatment by society. Participant (F) cited all of the

ethical principles noted above, plus Ms. M.'s right to be fully informed.

Participant (F): Self-Determination, Resistance to Pressure and Influence, Prevention of Discrimination, and the Right to Be Fully Informed

I would advocate for there to be a delay... I don't know that she fully understands what the choices are, and maybe doctors don't understand that there is a choice that people can make about not having surgery. That people have that right... There are hospice programs, and I think that somebody deserves to have a certain kind of respect and a choice in how and when they are going to die... This woman has been very easy to put into the closet or into the S.R.O., and for people to just forget about... And here is a stand that she is taking in which ever way she can, as strongly as she can, being disenfranchised for as long as she has been... And I believe that people have the right to make those decisions. That's it... Once somebody took a stand on this the doctor would...back off.

All six of the above participants, plus Participant (G), began with the position that they would advocate for Ms. M.'s right to self-determination. They maintained that position, and they justified it, through explicit or implicit citation of one or more ethical principles.

Participants (G) and (H) also maintained a position of advocacy for Ms. M.'s right to self-determination, but relied on organizational elements to persevere. Having decided to advocate for Ms. M., they did not return to ethical principles in their discussion of the case.

Organizational

Participant (G)

O.K., let's see if I can figure out a plan of attack here... It sounds like the worst person in this whole scenario is Dr. Casey, who is really out to chop her up. I guess one of the first things that I would asses is what kind of relationship I have with Dr. Casey. How much can I influence him on my own... [If I couldn't influence him] I would attempt to find some flaws in Dr. Casey's thinking. For example, is he afraid of law suits which is something that hospitals are terrified of? So I would try to weave my presentation with a little bit of fear...and depending on...how much I can weaken this individual, the nephew might be someone I might pull into this... I might also get this Resident... He is someone that I would really pressure... Because if I can get him or her to question it, then I have half the battle won....

Participant (H)

It appears that the consent was not informed consent... So...if she is to have the surgery she either needs informed consent or a court order... I think that I would make that clear to Dr. Casey and to hospital administrators. I think that I would do it in a way that would frighten them enough that the consent forms would be torn up... That's just as a start... I would feel strongly about this so that I would take this to the mat... I would attempt to disregard the nephew, not to not keep him informed... This is a nephew that brought her to the S.R.O., hasn't seen her in 7 years... The refusal for medical treatment [here] isn't acutely suicidal... I think that the decision of whether you are going to live or...die questions one's competency... That is why we have courts and guardians... The interest of the nephew, the doctor, the hospital and me as part of the hospital is not necessarily the same as the woman.

Participant (I) maintained a position of advocacy, but cited clinical components as the primary informing issue in continuing his support of Ms. M.'s self-determination.

Participant (I)

I think you need to know what the patient was thinking..., how the patient defines the problem. It's not my problem, it's their problem... So...the first step before you come to a solution is to explore... It's her life, and it will be her death. Yes, it is a more psychoanalytic approach... If it's going to get to the point [of bureaucratic difficulties] for this, it will get to that point for anything.

The Deterred Advocates

Of the ten participants who discontinued advocating for Ms. M.'s right to self-determination, three referred to power issues as dominant in their decisions, two referred to a combination of organizational and personal issues of fairly equal valence, and one each referred to the following issues or combinations: power and personal; power and organizational; organizational; organizational, power and personal; and clinical and organizational (See Table 21).

Table 21
Extra-Ethical Elements Cited by Deterred Advocates

Issue	Number of Participants
Power	3
Power Personal	1
Power Organizational	1
Organizational	2
Organizational Personal	3
Total	10

Power

Participants (J), (K), and (L) noted Dr. Casey's, and/or the hospital's power in deciding to limit the extent of their advocacy roles.

Participant (J)

What could I do... I didn't know what else I could do to make it absolutely clear in my mind that it was the best thing to do except to say to myself 'well this is a doctor that has a lot of experience and he had actually at least thought about it and wasn't sure and deliberated over it then maybe he was doing the right thing'... I'd have to back off. I have to keep my job too.

Participant (K) changed the focus of his work with Ms. M. in order to accommodate the will of Dr. Casey.

Participant (K)

What is comes down to is...the futility or the lack of futility of doing it [advocating]... The reality of the situation...is that [clients' rights are] not really respected... It is the doctor that really makes the decision... If ultimately I was unable to change the decision...I would...change the focus...with the patient...to make this really odious idea more palatable. I don't know what else I could do.

Participant (L) perceived that hospitals render social workers powerless.

Participant (L)

I think it's a question of who has the power... If you can't take...defeat, you shouldn't work in that...setting... I think at some point I might have to say that I'm powerless... If you feel like...the power structure is such that you will not be able to do what you consider quote unquote right, then you shouldn't be there... [In] hospitals, I don't think that you have a reasonable chance [to prevail].

Personal and Power

Participant (M) referred to the power of the organization to terminate his employment, and perceived of this as a threat in this situation. He noted his feelings about such a circumstance that recently arose.

Participant (M)

I would take it to the limit I could...according to how threatened I felt... I was just almost layed off and that was really scary. I'm not sure I would want to lose my job over it... I need this job. I might have to back down. That's the reality. I don't like telling you but that's the reality.

Power and Organizational

Participant (N) based his decision on Dr. Casey's power, and on his understanding of the structure of the organization.

Participant (N)

Maybe I would start with the doctors themselves and then go up to administration to...get my view known. I would look for support, but I would be very careful to look for support from different people... I've been in hospital settings... When Dr. Casey decides that this is what he is going to do, he is going to do it... It's one of those situation that you are not going to win.

Organizational

Participants (O) and (P) felt bound by the organization's structure and function, and did not perceive an advocacy role apart from that.

Participant (O)

Obviously if he [Dr. Casey] isn't going to listen to you alone maybe there is someone else that he will listen to... [If] you are the patient's advocate, then you try to find other people that can help... [However], you are there to the degree you can... [If I couldn't find other advocates] then I would still turn to the patient's needs...as I hear them and...help prepare her, and deal with some [pre-and post surgical] adjustment, if I couldn't prevent the surgery.

Participant (P)

I would exhaust all avenues that I knew about. And then, if there weren't anymore, I would give up... And I would share this with her, that I have exhausted all avenues and that there is nothing else I could do, unless she was willing or able to come up with an idea herself... I tend to think that in hospitals when you start increasing, upping the ante, you usually lose.

Organizational and Personal

Participants (Q), (R) and (S) saw the social work role of advocate as limited by the organizational structure. They referred, as well, to a personal sense of weariness or awkwardness as guiding their decisions.

Participant (Q)

I know in hospitals that the social worker is sort of the lowest rung on the ladder... Advocacy has to do with how long a person has worked... I think that burn out in this profession is a very strong component. And I think that perhaps one who is just beginning and who really still feels...that they can make a difference would perhaps try to be more of an advocate, and try to intervene... But I think what happens in the system is that people tends to say, this shouldn't be but I know it would be an exercise in futility... I think, I have less illusions [than] when I was younger... Today I see...the futility of doing things like this... I am very much dictated by my emotions at the time. And I can, for whatever reason, be unable to back down and have to prove that I am right. So I don't know [how far I would take this case].

Participant (R)

Well, knowing the structure of a hospital, it is very difficult for a social worker to supercede a medical professional's judgement. My first reaction would be...to speak to the doctor again...and then...go to my supervisor and discuss the matter with him or her... Then I would discuss it with my colleagues... There is always safety or power in numbers... I might get up a letter to my director of social service... I would...see if there's a policy about this... I may not be able to do anything for this woman... Beyond this, we would have to go to hospital administration on this.

Would anything cause you to discontinue your efforts?

Frustration...and I might be tired. Okay, what does it take to form an advocacy group? Am I that ambitious to do that?... It depends on how strongly I felt. Right now I'm not [strong]... I have relinquished that role [of leader]. I don't want to be in that position.

Participant (S)

I know that a social worker in a...hospital is low man on the totem poll... I have to understand what my own feelings are... Do I feel comfortable with the [advocate] role... Advocacy is so difficult because you really have to believe in what you are doing... I wouldn't want to be ostracized. I don't know... I've never been in this role...because that would be provocative...and wouldn't serve anything.

Summary and Implications

That Case History #1 was set in a medical center, it might have been expected that there would be a major difference in the advocacy positions from among the medical center participants as compared to the family service

participants. Instead, there was a minimal distinction between the two groups (See Tables 22 and 23).

Table 22

Ethical and Extra-Ethicals Element Cited by
Participants Who Continued Advocating

Analysis Type	Medical Center	Family Service
Ethics	3	4
Organizational	2	0
Clinical	1	0
Total	6	4

Table 23

Extra-Ethical Elements Cited by Participants
Who Discontinued Advocating

Analysis Type	Medical Center	Family Service
Organizational	1	1
Power	2	1
Personal Power	1	0
Power Organizational	0	1
Organizational Personal	0	3
Total	4	6

Of the ten participants who maintained an advocacy position in behalf of Ms. M., seven were informed by ethical principles in making this decision. The remaining three were informed by extra-ethical elements in the case.

Of the ten participants who discontinued an advocacy position, none were influenced by ethical considerations to do so. Rather, they were informed by issues of organizational structure or power. The cessation of advocacy was invariably accompanied by a sense of resignation. The impact on ethical decision-making by extra-ethical considerations was cited in the literature review. The impact on practitioners who find themselves in these situations was cited by Participant (R): "I think what happens in the system is that people tend to say, this shouldn't be, but I know it would be an exercise in futility...."

Case History #2

You are an M.S.W. working in the Tambourine Methadone Maintenance Clinic for the past five years. The Clinic's philosophy is that the dispensing of methadone must be combined with psychotherapy in order assist clients to reach a drug-free status. All clients in the program are seen weekly and/or bi-weekly for psychotherapy. The goal of the program is to wean clients off both street drugs and methadone. The program is considered a "model program" with a good success rate. Although the social worker is responsible for psychotherapy with clients, the physicians prescribe the medication and supervise the treatment. The physicians consider themselves the "case managers."

You have a caseload of thirty clients. One of your clients is Mr. Clean, a twenty-nine year old student. You

have been seeing Mr. C. in individual psychotherapy for three years. He discontinued his substance abuse at the time of entry into the program, and has been methadone-free for three months. He is generally consistent with his therapy appointments, and your assessment is that he is working hard to maintain a drug-free existence. He is about to terminate treatment.

Another client recently added to your caseload is Ms. Ivy, a very attractive twenty-three year old woman referred for treatment by her father, a New York State Assemblyman who chairs the committee that deals with funding of drug treatment facilities. During the first several weeks of therapy, Ms. Ivy needed regular reassurance that her discussions with you are confidential. She was very concerned that her father would have access to information she shared with you. Initially quite guarded, she began to be more candid after about one month into treatment. She sees herself as somewhat reckless and has trouble controlling her impulses. She agreed to follow her father's wishes and begin treatment because she recently found out that she is H.I.V. positive. She currently has no symptoms of A.I.D.S. She believes she can postpone getting A.I.D.S. if she takes better care of her body. She has been living with her drug-dealing boyfriend for the past four years. She hasn't told him that she wants to stop taking drugs and she hasn't told him that she is H.I.V. positive. She believes that if she finds another place to live she can stop taking drugs. She will not return to live with her family and, as she doesn't work, she cannot afford an apartment.

You have been seeing Ms. Ivy for four months. The immediate goal of your work is to have her admitted to a detoxification unit. She has not been compliant with this treatment plan. She is inconsistent with therapy, and is continuing to use street drugs. Her motivation in therapy is weak.

Mr. Clean and Ms. Ivy meet at the Clinic's annual Thanksgiving party. They spend the afternoon talking. At Mr. C.'s next session, he reports feeling very healthy and determined, and is looking forward to ending treatment at the Clinic. He feels very grateful for the Clinic's help in general, and your help in particular. He feels a sense of debt and responsibility to help others who suffer from drug addiction. He is considering changing his major at school to social work, to pursue a career in substance abuse counseling. He also tells you of his meeting Ms. Ivy, and his desire to help her. He is aware of her current living situation and is considering offering to share his apartment with her. He admits that he finds her quite attractive, and this might have something to do with his desire to help. They have plans to go out on a date this week.

The next day Ms. Ivy comes for her scheduled appointment, but does not volunteer any information about her contact with Mr. C. When you mention that you noticed them together at the party, she acknowledges their contact but does not continue the discussion. She becomes withdrawn and fidgety. You drop the subject, thinking that this might be more your own curiosity than sound clinical judgment.

The following week, during your session with Mr. C., he speaks of his growing infatuation with Ms. Ivy. He believes he can help her clean herself up. He tells you of his plans to continue to date her and he discusses his sexual desire for her. He plans to have her move in with him this weekend. As in the past, you raise the issue of safe sex. He states he always has condoms available, but, being human, he occasionally succumbs to the passion of the moment and disregards his better judgment. He assures you that he is not endangering anyone, as a recent test found him to be H.I.V. negative. In any event, he feels confident because the recent literature reports that it is less likely for a man to contract A.I.D.S. from a woman than vice versa.

Later that week you have your next appointment with Ms. Ivy. She tells you that she has found other living arrangements. She still believes this will help her stop taking drugs, and agrees to go into a detoxification unit if she is not "clean" after three weeks. When you ask her about the new apartment, she tells you that Mr. C. has invited her to live with him, and she will be moving in this weekend. She is aware that he is attracted to her and she says she really needs a friend and he is very nice to her. She expects their relationship will become sexual, and that is all right with her. When you ask her if she has told him about her H.I.V. status, she says she hasn't because she is afraid he may withdraw his offer, and that she will tell him to use condoms.

When she leaves your office you wonder what responsibility you have to Mr. C., in terms of the risk of his contracting A.I.D.S. You contact your supervising physician and explain the situation. He speaks to the clinic's attorney who says there are no laws governing this area, although there has been discussion regarding various legislative proposals. In the absence of legislation, however, decisions must be ruled by ethical considerations, which are the realm of the professional practitioners.

You meet with the supervising physician. He validates your concern about the situation, but feels that the clinic must be governed by the principle of confidentiality until such time as legislation is written to govern these decisions. He notes that the clinic serves a small community of clients and feels that if the principle of confidentiality was violated, there could be devastating consequences to the program, as this would get around to all of the patients and

to the professional community-at-large. This issue would not be as pressing in a more anonymous program, but that, unfortunately, is not the case here. He also points out that Ms. Ivy comes from an influential family, and says he doesn't need to draw a picture of what this means to the clinic. He states that he is sure you have discussed with both clients the issue of safe sex, and that the clinic cannot control the lives of the clients if they choose to disregard the precautions provided through the program. Finally, he asks you to consider whether your concern might have some basis in your counter-transference for Mr. C. with whom you have worked for so long.

You leave this meeting feeling quite uneasy. What action, if any, do you take?

As in Case History #1, there are five substantive references in this case: ethical, organizational, personal, clinical and power.

Definitions of Substantive References

Ethics

Case History #2 was designed with the following ethical principles in mind:

I. The primacy of the clients' interests.

(1) The social worker should serve clients with devotion, loyalty, determination, and the maximum application of professional skill and competence.

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

III. The social worker should adhere to commitments made to the employing organization.

(1) The social worker should work to improve the employing agency's policies and procedures...

IV. The social worker should act in accordance with the highest standards of professional integrity and impartiality.

(1) The social worker should be alert to and resist the influence and pressures that interfere with the exercise of professional discretion and impartial judgement required for the performance of professional functions.

The principle of service to clients could be applied to either Mr. Clean or Ms. Ivy. The second principle is applicable to the knowledge the social worker has about Ms. Ivy's H.I.V. status. The third principle relates to the possible threat to the clinic's functioning by divulging the information about Ms. Ivy, in opposition to the clinic's policy. The fourth principle refers to the power wielded by Ms. Ivy's family and the supervising physician, and its impact on the social worker's decision. The potential dilemmas from among these principles would involve a conflict between service to Mr. Clean and any or all of the other operant principles.

Clinical

The clinical issues in this case include the therapeutic relationship with both clients and the interpretation of their behaviors. Is countertransference an issue? Of what significance is Mr. Clean's reaction to Ms. Ivy?

Organizational

The organizational references include the agency structure and hierarchy, the financial situation, and the forms of collegial communication. Of what significance is the structure of the treatment team? How does the financing of the clinic come to bear on practitioners' decisions?

Power

Power references include the influence of the supervising physician and Ms. Ivy's family. To what extent are the participants' decisions effected by the potential impact of the exertion of the power of the family or the administration?

Personal

Personal elements are defined, as in Case History #1, as those which are rooted in individual style or preference, i.e., idiosyncratic belief systems. For the purpose of this study, personal elements would be those responses evoked in the participants by Case History #2 which are unique to each participant based on his individual experiences, and which guide their actions.

Findings

Responses Informed by Ethics

Unlike the responses to Case History #1, eight of the twenty participants recognized an ethical dilemma in the second case, and predicated their actions based on an ethical analysis of the dilemma. The principles they relied upon invariably consisted of an obligation of service to Mr. C. and a conflicting obligation to Ms. Ivy's right to privacy. Three participants noted an obligation to the Clinic as the employing organization, and one participant referred to the above three principles plus that of the obligation to resist pressures on his professional discretion (see Table 24). Seven of these participants decided to inform Mr. C. of his risk; one was unable to resolve the dilemma.

Table 24
Ethical Principles Cited by Participants in
Case History #2

Principles	Number of Participants
Confidentiality	8
Primacy of Clients' Interests	8
Commitment to Employing Organization	4
Resist Pressure	1

Primacy of Clients' Interests vs. Confidentiality

Four participants perceived a dilemma between their professional obligation to Mr. C.'s interests, and an obligation to Ms. Ivy's right to privacy. They did not refer to pressures brought upon them; nor did they mention an organizational commitment. Examples of their responses follow.

Participant (A)

So the issue here is confidentiality as opposed to this guy's health... It seems to me...that Mr. C.'s health has to have stronger weight because we are basically talking about his life... I go through a step by step thing in my own head... First, I said to myself, which of these two values, confidentiality, or the question of the life of the patient, which carries more weight for me? I decided that life...carries more weight for me. So then, if the confidentiality is second, then my choice is to tell him... Whether or not he has a death wish...really doesn't take away from the responsibility that I have, that I know something very dangerous might happen and I am keeping quiet about it.

Participant (B) came to the same conclusion as Participant (A), also by ordering the principles involved.

Participant (B)

I feel somewhat comforted then that there is no law... I don't know if I would feel free to break the law... I could tell him...for his own life...to prevent him from getting this illness... I guess I think this is really an exception to confidentiality, that a person's life is at risk. So that's how I would explain it to him, and if I had to explain it to the supervising physician that is what I would have to say to him too... If it was something less serious that would not threaten his life then I guess I would live with it. But I couldn't live with this.

Participant (C)

I would tell [Mr. C.]... Like when there is confidentiality with a psychotic and they tell you they are going to murder somebody. I think you have to not keep that confidential... I think when it threatens someone else's life, then you have to act on it... This is a young man; he has worked very hard at getting his life together... I'm taking that responsibility... I don't know if I could hold it back... There is a different sense of [obligation]... This is a lie... You are withholding information... It's really in your control to allow this person to know and make a decision.

Primacy of Clients' Interests vs. Confidentiality & Commitment
to Employing Agency

Participants (D), (E), and (F) all cited the above three principles as informing their actions. Participants (D) and (E) decided to inform Mr. C. Participant (F) could not resolve the dilemma of his conflicting obligations.

Participant (D)

[I feel] some sort of allegiance to the therapeutic process... I really don't feel good about someone who I am seeing, who is H.I.V. positive, having sex with someone else that it's not discussed... Ethically, I don't agree with it, and I don't think ethically I could sit there and allow them to make a lot of money and kept the A.I.D.S. virus alive and well in the clinic... Because the virus will spread within the clinic. You want to bring more people in and make more money... It sounds like...[they] want to maintain confidentiality because [they] want to see more people...and make more money.

Participant (E)

My first feelings are responsibility to inform Mr. Clean... This is a life-threatening thing... I guess that in certain areas confidentiality has to be breached... This young doctor in Downstate who was infected, it became known in the hospital. [Then] he couldn't get work... Yes, it was a breach of confidentiality...but I think it didn't have the purpose of protecting anybody... I do believe that we have responsibilities that when we are given knowledge...to deal with it in a correct way... So that if a father who is donating money to the clinic and is supporting it, withdraws his money because of this, then other support has to be found... It's sort of like people in the government knowing that there was a threat against that [Pan Am] flight... People have the right to decide... I would want to be informed of the danger, but I wouldn't want anyone to telling me what I have to do.

Participant (F)

I would be conflicted about it but I don't think that I would tell the client that the young woman was H.I.V. positive... It's really hard because this is a really cold example of how this stuff can happen, but basically we see it all over our practice and we will more and more; two people with H.I.V. positive and I don't think you can go around telling people... It's the confidentiality... I am torn about it. I think that it is a life-threatening thing and one could say that they could easily tell him because there is a threat on his life. On the other hand, I don't know what that means in terms of a value that one would place on all H.I.V. positive... There are tremendous repercussions and tremendous stigmas... I think it would be a real touchy situation at the drug facility. People wouldn't come to get treatment for something that you can help them with because they would be afraid. I'm not really sure... It has to do with the confidentiality on one hand and, on the other, a life-threatening situation... I could tell somebody, it's not that I couldn't, and I could feel fine about doing that. I don't know.

Primacy of Clients' Interests & Resistance to Pressure vs.
Confidentiality & Commitment to Employing Agency

Participant (G) referred to all four ethical principles in his decision-making process.

Participant (G)

You die from A.I.D.S.... The A.I.D.S. issue and the confidentiality in and around A.I.D.S. is such a big issue it even overrides other treatment considerations... I agree, in order to run a clinic, there are real issues of confidentiality, and they are ethical issues...and I would encourage her to tell him... But, at the same time, I would encourage him to ask... But then the other part is that you are talking about life and death and the other person is irresponsible and you know it. But, I know that I would lose my job if I would break confidentiality... Basically, this would be the same as she saying, 'I'm going to kill him'... I would inform him...[if] it was clear to me that this relationship was becoming out of control... And the basis would be it is like she is holding a gun to his head... I would tell him, even though in terms of quote unquote therapeutic treatment, he should know and what part of him is not allowing him to see the handwriting on the wall... I still would feel as a human being, as one human being to another [responsible].

Responses Not Informed by Ethics

Of the twelve participants whose actions were not based on the resolution of an ethical dilemma, four decided that the risk to Mr. C. lacked the imminence of a "gun to his head" scenario they felt was required to overstep the principle of confidentiality, and, having made that decision, they moved on to extra-ethical considerations of the case. In fact, aside from whether or not Mr. C.'s risk qualifies as having a gun to his head, the principle of confidentiality is not limited that specifically. "The social worker should share with others confidences revealed by clients, without their

consent, only for compelling professional reasons [*italics mine*]."¹⁵⁶

In Case History #2, the participants had an opportunity to view their obligation to "serve [Mr. C.]...with devotion, loyalty, [and] determination..."¹⁵⁷ as a compelling reason to overstep confidentiality. Because these participants perceived the principle of confidentiality as the governing principle in the case, and/or because they defined confidentiality within narrow parameters, decision-making referred to the non-ethical components of the case. Examples of this process are:

I've sort of taken this oath to uphold confidentiality whether I like it or not. If somebody is in danger of harming themselves or harming others, suicide or homicide that is the only time you are supposed to breach [it]... Legally, it's not the same [as homicide]...;

And,

I think...I would not break confidentiality and really...[concentrate on] safe sex education... The...likelihood of [Mr. C.]...getting that disease...is not known... That would flavor my decision to maintain the confidentiality. They are two adults ...and I would have to leave that decision up to them... I think it comes down to the danger and the risk. Just like when I am trying to assess [homicide]... I have to assess...the real severity....

Eight of the twelve participants based their actions on clinical references, two on organizational and power

¹⁵⁶ Code of Ethics, op. cit. pp 5-6.

¹⁵⁷ Ibid., p 4.

references, one on power and clinical, and one on power and personal references (see Table 25).

Table 25
Extra-Ethical Elements Cited by Participants in
Case History #2

Element	Number
Clinical	8
Power & Clinical	1
Personal & Power	1
Power & Organizational	2
Total	12

Clinical

Seven Participants relied on clinical expertise to inform their actions. For these participants, there was a unanimous sentiment that Mr. C. should, or did, know his risks in the situation. This interpretation mitigated against any feeling of compulsion to inform him further. It was considered his responsibility to use the assumed knowledge in whatever way he chose. Examples of clinical references follow.

Participant (H)

I would...just discuss safe sex with them. I don't feel that you can do more than that. You can't get into [their] bed. You can't insist that they use condoms... They already have all the facts. They know what...A.I.D.S. means, and who will potentially get it... I would feel like I would be controlling their lives and that's my need to control... If they want to sleep together and get A.I.D.S., as horrible as I think that is...my clinical training tells me that I don't make the ultimate decisions....

Participant (I)

The issues involved could be raised in groups... But I would tell Mr. Clean 'You know that Ivy comes here and you know that she has a drug problem... Moving in with someone who has a drug problem, there are consequences...' I would tell Ivy a similar kind of thing... And I would push to have a meeting with the two of them... That's where you start so you don't have to face this ethical dilemma until you do all that work.

Participant (J)

You have brought the issue up with the client who has the A.I.D.S. And you are responsible to do that, to at least encourage them to act responsibly... They're both in a drug program, and the world knows people who are using I.V. drugs are likely to have A.I.D.S.... If they were concerned about themselves, they should have a sense about that.

Participant (K)

First...the line of questioning I would ask would be clinical... It's a process... The end part of that would be to try to get her in a position for her to tell him... I would talk to him...in a clinical way... He knows her drug background... Without saying she's got it, [I] would come damn close, but...would never say it... He is an adult, he's been impulsive in the past, he may be impulsive in the future. I can't follow him around twenty-four hours a day... He now has the information and it's up to him what he does with it.

Clinical and Power

Participant (L) was informed by clinical knowledge, and by his concern over Ms. Ivy's family's influence. These two elements persuaded him to not inform Mr. C. of Ms. Ivy's condition.

Participant (L)

I would go back to Ms. Ivy and tell her how uneasy I feel and really work with her to see if she can tell him... It is her disease, and it is her relationship... It is the simplest route to take... The other thing to consider, which makes it really tough, and I hate to think this, but if she were impoverished and had no resources, I wouldn't be so worried about it. But the fact that she's got a lot of support and money, makes me think that I'm in a more vulnerable position....

Power and Organizational

Participants (M) and (N) were primarily guided by organizational and power issues in their actions. Participant

(3) never resolved whether or not to inform Mr. C.;

Participant (6) decided not to inform Mr. C.

Participant (M)

I would want to find out more about...the consequences if I do tell. It might mean a loss of a job... I think I would speak to other workers... This is a really overwhelming situation to handle... I would probably go to [supervising director] and [administrative director], and the legal person... If I was getting conflicting advice...I think I would bring it up at a staff meeting... I guess what I'm looking for is some sort of policy to guide my decision....

Participant (N)

I would...be in some sort of support group... I would...need education on this issue...before I'm going to make my little decision about what way I think I would handle it. So, in the meantime, I'm not going to take on the clinic...policy when I'm not ready to make an argument for something else... I don't see any way that around breaking policy without leaving the agency or going public in some other way... I...would have to be part of some larger entity in the clinic...so that I am not just one lone voice raising issues... I don't think you are effective. And I think my ethical dilemmas would be resolved... So what peace I would make is I guess I would feel like I'm not ready to leave the agency. Then I would take a wait and see around the confidentiality and work with Ms. Ivy.

Power and Personal

Participant (0) perceived that he would be attacked if he considered informing Mr. C. of his risks. He responded by discussing possible defenses, and his anticipated action.

Participant (O)

I'd try to get a balance, call N.A.S.W.... I'd look for other people who would advocate for me. I believe there is someone that would fight for me... If everyone says 'no, we can do nothing,' and they all refer me back to my agency, I might have to terminate working with these patients...

Would you feel comfortable with that decision?

I would feel somewhat in that I would seek my own personal comfort and an ability to be a better professional person... I am not responsible for all of them.

Summary and Implications

As in the two previous sections, there was little if any difference between the participants from the medical center and the family service agency, either in their perception of the ethical principles in the case, or in their choice of whether or not to inform Mr. C. of Ms. Ivy's condition (see Tables 26, 27 and 28).

Of some note is that seven of the eight participants who were categorized as having perceived an ethical dilemma chose to inform Mr. C. The one exception was uncertain. Eleven of the twelve participants who were categorized as having been guided by extra-ethical references chose not to inform Mr. C. The other one was uncertain.

Table 26

Type of Analysis of Participants Who Would
Inform Mr. C. of Ms. Ivy's H.I.V. Status
By Agency

Analysis Type	Medical Center	Family Service
Ethics	3	4
Total	3	4

Table 27

Type of Analysis of Participants Who Would Not
Inform Mr. C. of Ms. Ivy's H.I.V. Status, by Agency

Analysis Type	Medical Center	Family Service
Clinical	3	5
Personal Power	1	0
Power Organizational	1	0
Power Clinical	0	1
Total	5	5

Table 28

Type of Analysis of Participants Who Were Uncertain
About Informing Mr. C. of Ms. Ivy's H.I.V.'s Status
by Agency

Analysis Type	Medical Center	Family Service
Ethics	1	0
Power Organizational	1	0
Total	2	0

There were several factors in Case History #2 that were designed to discourage participants from informing Mr. C.: the principle of confidentiality, the organizational structure of the clinic, the power of the psychiatrist and of the family of Ms. Ivy. The only factor in the case suggesting Mr. C. be informed was the principle of serving him, as a client, with loyalty and devotion. And, as this principle could equally apply to Ms. Ivy, its use was far from ambiguous.

With all of the above factors in mind, it is not unreasonable to conclude that the majority of the participants were moved to rely on their more specific understanding of the principle of confidentiality, on their clinical expertise, or on common organizational and power elements found in most agencies, than on the less specific and less easily defined

principle of client service, especially when this principle is placed in opposition to all of the other factors.

Comparative Analysis of Interview One

Decisions Informed by Ethics: Parts I, II, and III

There was no significant difference in the number of participants whose decisions were informed by ethics when the three parts of Interview I were compared (see Table 29).

Table 29
Number of Participants Informed by Ethics
During Interview One

Section of Interview	Percentage
Dilemma	35%
Case #1	35%
Case #2	40%

Of the seven participants who presented an ethical dilemma within the definition of this study in the first part of Interview I, three proceeded to make ethically informed decisions on Case History #1 and Case History #2. Only two of the original seven were considered ethically informed through all three parts (see Table 30).

Table 30

**The Utilization of Ethical Analysis by Participants
Who Reconstructed an Ethical Dilemma**

The Utilization of Ethical Analysis	# of Part.
Did Not Utilized Ethical Analysis Either Case History	3
Utilized Ethical Analysis in Case History #1 Only	1
Utilized Ethical Analysis in Case History #2 Only	1
Utilized Ethical Analyses in Both Case Histories	2
Total	7

Decisions Not Informed by Ethics: Parts I, II, and III

Of the thirteen participants who did not present an ethical dilemma in the first part of Interview I, four made ethically informed decisions in Case History #1, and five made ethically informed decisions in Case History #2. Of the four who moved to an ethically informed decision in Case History #1, three went on to make an ethically informed decision in Case History #2. Seven participants were consistently not informed by ethics in all three parts of Interview I (see Table 31).

Table 31

The Utilization of Ethical Analysis by Participants
Who Did Not Reconstruct an Ethical Dilemma

The Utilization of Ethical Analysis	# of Participants
Did Not Utilized Ethical Analysis Either Case History	7
Utilized Ethical Analysis in Case History #1 Only	1
Utilized Ethical Analysis in Case History #2 Only	2
Utilized Ethical Analysis in Both Case Histories	3
Total	13

Of the thirteen participants who were not informed by ethics in Case History #1, five cited power elements as influential, eight cited organizational elements, four cited personal elements, and one cited clinical elements. Of the twelve participants who were not informed by ethics in Case History #2, four cited power elements, two cited organizational elements, one cited personal elements, and nine cited clinical elements as having informed them (see Table 32). The variation in the frequency of citation of these elements was probably due to the nature of the case being presented, rather than to any change in the decision-making processes of the participants.

Table 32
Extra-Ethical Elements Cited in Case Histories #1 and #2

Extra-Ethical Elements	Case #1	Case #2
Power	5	4
Organizational	8	2
Personal	4	1
Clinical	1	9
Total	18	16

Family Service Agency and Medical Center

There was no significant difference in the frequency of ethically informed responses to any of the three parts of Interview I between the participants from the family service agency and the participants from the medical center (see Table 33).

Table 33
Participants Informed by Ethics in
Interview One by Agency

Informed by Ethics	Medical Center	Family Service
Dilemma	3	4
Case 1	3	4
Case 2	4	4
Total	10	12

This absence of difference is evident in the number of participants from each agency who were informed by ethics (see above Table 33), and the number of participants from each agency who were not informed by ethics (see below table 34).

Table 34
Participants Not Informed by Ethics in
Interview One by Agency

Not Informed By Ethics	Medical Center	Family Service
Dilemma	7	6
Case 1	7	6
Case 2	6	6
Total	20	18

There were some variations in the frequency with which participants from the two organizations cited specific elements other than ethical principles in response to both cases. Medical center participants cited power elements twice as often as family service participants (see Tables 35 and 37). Family service participants were more likely to cite clinical elements than were medical center participants (see Tables 36 and 37). It may be inferred that medical center social workers are more likely to find themselves confronted by issues of power, and that family service social workers are more accustomed to rely on clinical interventions to resolve problems.

Table 35
References to Power by Agency

Reference to Power	Medical Center	Family Service
Informed by Power	6	3
Not Informed by Power	4	6
Total	10	10

Table 36
Clinical References by Agency

	Medical Center	Family Service
Informed Clinically	4	6
Not Informed Clinically	6	4
Total	10	10

Table 37
Combined Case #1 and Case #2, References to all
Elements by Agency

Case #1 and Case #2 Combined	Frequency of Citation	
	Medical Center	Family Service
Power	6	3
Organizational	5	5
Personal	2	3
Clinical	4	6

The only apparent variation between the responses from the participant groups citing ethical principles is that family service participants were five times as likely to act to resist pressures on their professional discretion than medical center social workers would be (see Tables 38 and 39). This phenomenon may be linked to the finding that the medical center participants were more likely to be influenced by power elements.

Table 38
Citation to Resist Pressure by Agency

	Medical Center	Family Service
Resist Pressure	1	5
Not Resist Pressure	9	5
Total	10	10

Combined Table 39
Ethical Principles Cited in Both Case
Histories by Agency

Case #1 and Case #2 Combined	Frequency of Citation	
	Medical Center	Family Service
Self-Determination	3	4
Prevent Discrimination	2	0
Resist Pressure	1	5
Complete Information	1	0
Confidentiality	4	4
Primacy of Clients' Interests	4	4
Commitment to Employing Organization	2	2

Outcomes In Case Histories #1 and #2

There was a statistically significant relationship (at the $p < .0005$ level) on a Fisher Exact Test, between the decision whether or not to continue to advocate for Ms. M. in Case History #1, and the decision whether or not to inform Mr. C. in Case History #2, with participants' reference to ethical principles or extra-ethical elements.

In Case History #1, all seven participants who were informed by ethical principles in arriving at a decision, persevered in advocating for Ms. M. Of the thirteen participants who were not primarily informed by ethics, ten relented in advocating and only three persevered (see Table 40).

Table 40

Relationship between Reference to Ethics and Advocacy
for Ms. Misfortune's Right to Choose

Advocacy Position	Undeterred Advocate	Deterred
Informed by Ethics	7	0
Not Informed by Ethics	3	10

In Case History #2, using the Fisher Exact Test, there was a statically significant relationship at the $<.00003$ ($p=<.00003$) between participants who relied on ethical principles and informed Mr. C., and participants who did not rely on ethical principles and did not inform Mr. C.. Of the eight participants who relied on ethical principles, seven informed Mr. C. of Ms. Ivy's condition, and one was undecided. Of the twelve who did not rely on ethical principles to come to a decision, eleven did not inform Mr. C., and one was undecided (see Table 41).

Table 41
Relationship between References to Ethics and
Informing Mr. C. of Ms. Ivy's H.I.V. Status

	Informed Mr. C. Of Ms. Ivy's H.I.V. Status	Did Not Inform Mr.C. Of Ms. Ivy's H.I.V. Status
Informed by Ethics	0	7
Not Informed by Ethics	11	0

In Case History #1, the number of elements in opposition to maintaining an advocacy position for Ms. M. was greater than the number supporting that position. In Case History #2, the number of elements supporting informing Mr. C. was less than the number opposing that position.

A reasonable explanation for these findings is that those participants who felt they could rely on ethical principles to decide their actions were better able to withstand the extra-ethical elements that opposed their positions, while those participants who were informed by those extra-ethical elements were less likely to maintain an ethically informed position. This explanation is not meant to imply that, in either case, one action was more ethical than another. In fact, any action taken by a participant could have been principally informed by ethics. What may be manifest in these

findings is that, as social work becomes more technical, practitioners may feel more comfortable making difficult decisions by relying on "the tools of the trade," instead of on the historic values of the profession.

CHAPTER FOUR

Interview Two

The second interview with the participants was arranged to take place approximately one month following the first. The objective of this delay, and of the interview itself, was to ascertain if the first interview created any change in the way the participants analyzed ethical dilemmas.

Second Reconstruction

At the beginning of the second interview, participants were again asked to reconstruct an ethical dilemma from their experience, and to explicate the management of this dilemma. In contrast to the first interview, the operant definition of an ethical dilemma was neither asked for by the participants, nor volunteered by the author.

Of the twenty participants, three from the medical center and one from the family service agency, a total of four participants (twenty percent), could not think of an ethical dilemma to reconstruct, and moved to the second part of the interview. Of the remaining seven participants from the

medical center, four reconstructed ethical dilemmas and three reconstructed non-ethical problems. Of the remaining nine participants from the family service agency, one reconstructed an ethical dilemma and eight reconstructed non-ethical problems. A total of five participants, or twenty-five percent of the total, reconstructed ethical dilemmas, and eleven participants, fifty five percent of the total, reconstructed non-ethical problems (see Tables 42 and 43).

Table 42
Reconstructions in Interview Two

	Ethical	Non-Ethical	No Dilemma
Medical Center	4	3	3
Family Service	1	8	1
Total	5	11	4

Table 43
Percentages of Reconstructions in Interview Two

	Ethical	Non-Ethical	No Dilemma
Percent	25%	55%	20%

Non-Ethical Responses

The non-ethical problems were once again coded into the following categories: legal, personal, clinical, and organizational. As in the first chapter of the data analysis, legal problems are defined as issues in which the participants' decisions were considered by them to be preordained through prescribed societal mandates; personal problems are defined as issues in which the conflict discussed was rooted in individual style or preference; clinical problems are defined as issues in which the participants' decisions were guided by practice methodology; and organizational problems are defined as issues in which participants' conflicts were related to specific organizational structure and systems.

Of the non-ethical responses from the medical center, one each reconstructed a clinical problem, a personal problem and a legal problem. In the family service agency, two participants reconstructed organizational problems, four reconstructed clinical problems, and one each reconstructed a personal problem and a power problem (see Table 44).

Table 44
Types of Extra-Ethical Reconstructions

	Clinical	Personal	Legal	Organization
Medical Center	1	1	1	0
Family Service	4	1	0	3
Total	5	2	1	3

Organizational

Participants (A) and (B) discussed what appears to have been a violation of personnel standards by the administration of the family service agency.

Both participants perceived an obligation to "improve the employing agency's policies and procedures..."¹⁵⁸ The problem raised is the intransigence of the agency and the expectation that a significant portion of the social work staff will lack the determination to see this issue through to a satisfactory conclusion, due to the structure and function of the organization. As such, the issues raised by Participants (A)

¹⁵⁸ Code of Ethics, op. cit., p. 7.

and (B) do not meet the definition of an ethical dilemma, because they lack conflicting ethical principles. They are, nevertheless, quite compelling, and they underline the problem of pursuing ethical practice within agency settings.

Participant (A)

A colleague resigned from our agency because...he feels he has been maligned... [The question is] what position to take and how strong to be. I realize that some [colleagues]...have more fear of the consequences... [The social workers] decided to write a strong letter about what we would like and how we feel... I...[thought] we should do something stronger... [like] take a sick day... But you need everybody to do that... What I can see happening is that they will ask for some kind of meeting...to give their side of the story... No matter what they [the administrators] say, they can't be excused for the way this...happened... It...was not ethical... I want a satisfactory reason or something done...even an apology...anything... I feel that everyone is entitled to fair treatment... I value that people who have given a lot and have done a good job are entitled to be treated with respect as professionals....

Participant (B)

One of our colleagues has been asked to resign... Some social workers on staff...may be able to say 'we don't care about our job.' But other of our colleagues...need the money... All our ideas of how we were going to picket and strike and have a sick out...that is all history... One of the dilemmas is, since we are not allowed to communicate with the board of the directors, how do we let them know what a mess this all is...without...jeopardizing somebody else's position?... I think we should send a letter to the executive director... Perhaps it will lay the ground work for something to come... We are wondering if this is some systematic way of restaffing the social workers; some change in philosophy that will effect the whole agency... We shouldn't take it like namby pambies, which nine times out of ten everyone decides to do....

Participant (C) was confronted with a problem about offering service to a potential client who had requested help through an intermediary, or to deny this service due to recent changes in his agency's practices, and fear of administrative retaliation. This was categorized as an organizational response because Participant (C)'s thinking was guided by the structure of his agency, and his speculation about the possibility of organizational reprisal, rather than by a set of conflicting principles. Had he taken into account the rationale, if any, for an agency policy preventing his involvement with the client, this might have qualified as meeting the definition of an ethical dilemma. Participant (C) had not resolved the dilemma at the time of the interview, but stated he did not perceive the problem as an ethical one.

Participant (C)

Someone...had [met]...with a young woman who is a resident in one of our group homes...[and] is pregnant...and asked if I could see her. My first thought was that I could see her once, and in the course of the interview I would tell her that she had to talk to the social worker in the group home... Thinking about the problems in this agency, I don't know what to do... I guess I feel partially immobilized now. To me it's not a matter of ethics, it's a matter of something else... I don't know what they would say. They might be of the opinion that I...shouldn't have seen her... Given what is going on, who knows how that might be used...against me... It effects your work... I never felt this way before. I have felt pretty free to do what I had to do... But now, when she asked me that...it just colored the whole situation, and I didn't feel as free to do what I just described that I would do [see the client]....

Personal

Participant (D) reported his stress at working under conditions he felt were professionally unacceptable but which he felt unable to change. The tension in this situation is internalized into a somatic response.

Participant (D)

[An issue at the agency] is over and it's really left me feeling very upset... That leads...back to me. What do I want to do?... The actual work I do, I like... When do my values come in where it becomes intolerable?... I feel like I am being self serving by staying here... Part of my job is public relations. I have to go out and sell the service... It is very upsetting to me to tell someone to come here when I know about the service... I feel terrible by the end of the week... I am squeezing my schedule so tight that I have no time. I know that I am doing it to keep myself busy so I don't have to deal with the problems here... My response to stress is to get sick and eventually I'll just get sick and I'll have to leave... The scenario that I imagine...is a personal scenario, not a professional one.

Participant (E) found himself in financial difficulty due to being layed off by his employer. He considered contacting his agency clients, but decided that to do so would have violated the principle that "the social worker should not exploit relationships with clients for personal advantage, or solicit the clients of one's agency for private practice."¹⁵⁹ As such, the dilemma was between personal need and an ethical principle, rather than between conflicting ethical principles.

¹⁵⁹ Ibid., p. 4.

Participant (E)

When I got layed off...cause they only gave me a f---in' week, I was most concerned about myself... I wrote a letter [to my clients] that basically said, 'I've been layed off. It's been wonderful working with you, and I'm sorry I didn't contact you.' Then...I felt horrible not talking with these people...and...if I speak with them, they might become private patients... Then I thought it really is unethical for me to contact them now because...it would be because I wanted them for my private practice... If I had done it while I was still there...I could have said something to them that would have had more justification, and then if they wanted to call...they did it on their own... But after the fact, it's [using] my role as a social worker...for private financial gain. And I felt that was really unethical, that I couldn't do that in any kind of conscience....

Legal

Participant (F) cited a situation wherein there was a conflict between his obligation to a client, and his obligation to society, as represented by a law enforcement agency. He resolved the conflict by adhering to legal and agency mandates. Had the resolution been based on a decision to choose one obligation over another, the response would have been coded as an ethical dilemma.

Participant (F)

I was seeing the mother of a child who had been murdered by the father... She had been the only witness to the murder... She went to the court...and...recanted her testimony. The district attorney...wanted to arrest her for perjury so they contacted me to find out when the next meeting would be so they could arrest her at the clinic... My supervisor...and [I]...met with...the director of the clinic who was also an attorney. He said 'you can refuse it, then they might bring proceedings against you... They could [subpena her records]... So you have to give her up.' I did.

Clinical

Participant (G) recalled a situation in which he made a decision to step outside what he considered to be the boundaries of inter-agency decorum, in order to create a more satisfactory outcome for a client. There was no evident ethical principle in this situation. The issue presented was a choice from among possible strategies of intervention.

Participant (G)

I worked for the Bureau of Child Welfare... A seven year old girl...had lead poisoning... I had to get [the family] housing... City Housing said that...there was a two years waiting list...so I...said that it was okay to get a smaller apartment because three of the [six] children would be dead and their names would be on the front of the New York Times. Fifteen minutes later they had her in an apartment... [Was] threatening to expose them...an appropriate way for a clinician to behave?... My options were to wait or to force their hand... I felt it was okay... The obligation to the family came before the decorum and the protocol....

Participant (H) noted a situation in which the onerous task of reporting a client to a child protective service fell to him. The difficulty was in determining whether the mother had acted in a neglectful manner which had endangered her child. As above, there was no evident ethical principle or principles in conflict in this situation; rather, the issue was a clinical judgment of a mother's ability to function. This response was coded as clinical, rather than legal, because the resolution was based on a treatment consideration, rather than on an understanding of the requirement of law.

Participant (H)

This is a [client]...who...feels incapable of mothering... My role...has been to help her firm up her role as a mother... She has a thirteen year old boy... She was approached by a stranger... [who] said to her that he is a big brother and he would come over to the house and take care of the child. She took this man up on his services and it turns out, of course, that he was an abuser... So when she tells me this...I tell her if she doesn't get rid of him, Child Protective Services must be called and she must call the police if he doesn't [leave]... She doesn't share with me [that he never left]... Months go by and...the boy tell[s] the school psychologist...[that he] has been abused sexually... There hasn't been a...report to C.P.S. because this man was a stranger and they don't take stranger reports... But...the mother allowed this to happen... I have to make the decision soon about the neglect that happened... Someone has to make this report. The dilemma is sort of over because I know that this mother is real low functioning and it is just blatant neglect....

Participant (I) presented a case wherein he and a colleague were seeing a married couple in individual treatment. Participant (I) and his colleague arrived at the

opinion that the couple should be seen together, and the question became how to inform the couple simultaneously, so that question could not be raised by one spouse that would compromise the confidentiality of the other, and thus damage the treatment. This problem alludes to confidentiality, but the central consideration is the treatment, rather than a conflict between ethical principles. Should a situation have existed wherein one of the spouses would not have been aware of the other being in treatment, and with an assessment that marital counseling was necessary, a dilemma could have been posed conflicting confidentiality with the interests of the clients. Such was not the case in this situation, however, and it best fit the clinical category.

The solution to the problem at hand, however, was imaginative.

Participant (I)

[A colleague and I] were seeing a couple... I [was] seeing the husband and [the colleague was] seeing the wife in individual treatment... It became clear...[that we] could see the couple together... How could we let them both know...and not break confidentiality?... That became [the]...dilemma... We came up with writing individual letters...saying the same thing [and] putting them in one envelope... The letters stated please call us...for a joint session... [Trust] was a major issue for this couple... The ethical dilemma [was] serving...[two] clients'...best interest...with...honest[y] and truthful[ness]... It was...your obligation to...both clients, so it was...split....

Participant (J) offered a situation in which a client known to be episodically suicidal notified the social worker

that he was not well, but was refusing hospitalization. There is a suggestion of a conflict between the client's self-determination and what might be considered the social worker's responsibility to the client, if hospitalization was considered to be beneficial to the client. The worker clarified, however, that his clinical judgment was that hospitalization would probably be harmful to the client, therefore resolving the dilemma through a clinical, rather than an ethical, resolution.

Participant (J)

There is a change in my perception regarding a case that I have. The woman is suicidal and I think that no matter what we do the outcome is going to be...suicide... Up until now I thought I had to be a hero in dealing with this...but you really can't save everybody... When she calls and is concerned herself about how bad she sounds, that is the time that she wouldn't want to talk to our psychiatrist... She has said that if she is hospitalized, 'I promise you I will be more at risk...' She doesn't have the receptivity to have her needs met...no matter who you are and no matter what you do... You have to take some risks... [Not hospitalizing her] allows her to maintain some autonomy and freedom... It's a clinical judgment....

Participant (K) found himself precipitously terminated by his agency. He was given insufficient time to close with his clients, and had to make a decision whether to honor his obligation to the agency, which chose to discontinue his service, or to honor his obligation to his clients. Participants (K) reconstructed an event that met the operant

definition of an ethical dilemma, but denied the situation was ethical in nature. When questions arose about what, if any, viable role he could have following his termination, and of the potential difficulties for his clients due to his continued involvement in their lives, they were resolved through a clinical analysis of the individual cases. This is evident by his decision to withdraw from a boy's case, in which he reckoned that his continued involvement would have created problems in the client's current situation.

Participant (K)

I haven't experienced an ethical dilemma while terminating with my clients... Clients...responded to...my news about leaving...in ways that were very personal to them... Three couples...going through the finalization of their adoption...[want] me with them at the finalization hearing... I said 'of course I will...' My little boy that I have been seeing for two years...was very upset... I told him...that I would stay in touch with him on his birthday and that I am still his friend... [His residential treatment facility]... has considered me kind of a thorn in their side because I am a strong advocate for him... So I am afraid that if I do anything that is out of line that they will cut him off. I would have gone on seeing him but I didn't want that to happen and...I didn't want to interfere with the relationship that should begin to develop between him and the new social worker... I thought for a while that I should keep in touch with [clients] but...I really do have to close with them....

Ethical Dilemmas

All five participants who reconstructed ethical dilemmas as defined by this study noted a primary obligation to clients as one of the principles in conflict. In two of those five responses, the primacy of the clients' interests came into conflict with the social worker's commitment to the employing organization. One response cited a conflict between the careful consideration of withdrawing services to clients, and the principle which mitigates against soliciting clients into one's private practice. One response noted a conflict between the interests of two different clients, and one response described a situation in which the social worker's obligation to a client was in conflict with an obligation to a colleague. (see Table 45).

Table 45

The Obligations in Conflict in Reconstructed Ethical Dilemmas

Type of Dilemma	Medical Center	Family Service
Consideration of Service Withdrawal vs. No Solicitation	1	0
Organization vs. Client	2	0
Client vs. Client	0	1
Client vs. Colleague	0	1

Ethical

Precipitous Withdrawal of Service vs. Soliciting Clients

Participant (L) found himself in a situation in which he was confronted with a conflict between two ethical principles: (1) "The social worker should withdraw services precipitously only under unusual circumstances, giving careful consideration to all factors in the situation and taking care to minimize possible adverse effects;" and (2) "The social worker should not exploit relationships with clients for personal advantage,

or solicit the clients of one's agency for private practice."¹⁶⁰

Having offered service to a client, Participant (K) was advised by his agency to discontinue, in conformance with agency policy. He felt that the withdrawal of his service would damage his client, but was concerned about violating the proscription against soliciting the client for his private practice. One might question clinically the circumstances and dynamics under which the client bonded with the social worker, but the dilemma was the manifestation for the social worker.

Participant (L)

The case of an undocumented [family] that wants service but doesn't live in the catchment area [of the center]... The hospital said...I should refer this couple to another facility... I could see them privately...but, because they came to the hospital, I am not so sure I can offer [this]... They threatened...to just quit... I am going to see them next week... I could offer to see them privately without charging, because they are unable to pay for treatment [and] tell them what their options are, [and] what my position is, that I could see them privately but I am facing some ethical problems...and that they should make the decision themselves... In some way, I may be running away from taking responsibility for...the decision... I don't...feel like this is unethical, since the hospital has refused to see them here... Once we discussed the idea of getting patients from the hospital into private practice, which is unethical... If they ask me...then it would be a different issue, because...I didn't solicit them... The issue here is trust. She is very afraid that...someplace...will report her [to immigration]... They need help. The [family] is at risk...and it is my responsibility not to just drop them and tell them 'I am sorry; go someplace else.'

¹⁶⁰ Ibid., p. 4 and 5.

Organization vs. Client

Participant (M) presented a situation wherein he found himself having to resolve a conflict from among two ethical principles: (1) "The social worker should use with scrupulous regard, and only for the purpose for which they are intended, the resources of the employing organization;" and (2) "The social worker should serve clients with devotion, loyalty, [and] determination...."¹⁶¹

Participant (M) was confronted with the now fairly common situation of a client in a hospital no longer needing acute medical care, but unable to return home. By remaining in the hospital, the client was taking up a bed that could have been better utilized by an acutely ill person. Furthermore, the hospital was not getting reimbursed fully for this client's stay, due to his medical status. The hospital wanted the client discharged as soon as possible.

On the other hand, because of the background of the client, he would have been poorly served by placement in a setting in which he would neither understand nor be understood by the staff or other clients.

¹⁶¹ Ibid., p. 9.

Participant (M)

I was working with a Chinese-only speaking patient, who was elderly and needed a nursing home. The hospital was waiting desperately for this patient to get into a nursing home. He is on alternate level of care and has been for at least three or four weeks now. And there are no beds available. They [the family] turned down one bed...[because] that nursing home did not have Chinese-speaking staff. So it really would have been unfair to send him there. However, the policy of the hospital is to send him to the next bed available... He has the right to be able to voice his needs, issues and concerns with staff when he gets there. And he would be totally incommunicado-like and alien if he couldn't do that... I think I'll go to bat for the family...because...that is very inhumane...and dangerous... If [the hospital] decides to override me and send him anyway, I will still maintain my perspective... For the record I will.

Participant (N) also cited a conflict between the service obligation to his clients and his commitment to the agency.

Participant (N)

I run a...group [of teenagers]... We...get money for performances... There is no way to filter this money down to these kids... The conflict is between the rights of the kids and the rights of the agency... As the budget crisis continues in health care...they really cut prevention... It is something that I fight with the administrators about. As the last grant came up, because of money pressures, they were really wanting not to put in any stipends [for the teenagers]... I know the [kids] are angry about it... I have to squash it, even though I think they earned it... I feel that the administration...is very condescending [and] provocative... These are people that these kids should be protected from... They are not going to get [the money], so why should they have to be battered in the process....

Client vs. Client

Participant (O) reconstructed a dilemma which pitted the needs of one client against the needs of another, specifically, service to a neglectful mother as opposed to protection of her son. This situation was referred to earlier by Participant (H), who approached it from a diagnostic point of view. For Participant (H), the question was whether or not the mother could be considered neglectful. The determination that she could, created the resolution. For Participant (O) the dilemma was whether the potential damage to the mother from making a report to the Child Protective Service was outweighed by the potential benefit to the child.

Participant (O)

The ethical dilemma really was...should this be reported as child neglect... The conflict is really whether one does more damage by reporting this because...diagnostically, this woman is beyond borderline and this might totally destroy her, and we don't know what will happen to the child. On the other hand, there is greater harm if it is not reported... I don't think there is a mandatory reporting...because...the truth was...kept from us... The other consideration...is to what extent is the Child Protective Service system really effective... When it is not clearly a mandatory situation, that enters into the decision as well... We came to the conclusion that we had to report it.

Client vs. Colleague

Participant (P) experienced a dilemma in which his view of the needs of a client came into conflict with the views of a colleague. Because "the social worker should treat with respect...the ... views...of colleagues...",¹⁶² Participant (P) attempted to resolve the dilemma by "seek[ing] arbitration or mediation when conflicts with colleagues require resolution for compelling professional reasons."¹⁶³

Participant (P)

I am the liaison to the Teen Clinic... There is a...referral...from that...clinic... I gave the information to [the secretary]... [The client's previous] therapist happened to be standing...there and...said 'I don't want to see him. He never comes...' So they said...'let him be seen somewhere else...' The question is, how much do you extend yourself to give someone the benefit of the doubt?... [The client] seems...motivated... Maybe this is the time that he might be more receptive... The ethical dilemma is: What is my responsibility?... It seems like [it] is...to the teen clinic [staff]...and to the kid. And yet I am a full time employee here and they said no... Why should we refer him? We do take cases back... I will have to go to [the director]... It might cause some conflict...[but] if they're assigning me to do that work over there, then they have to back me up. There are not going to sacrifice me...and pull their resources away....

¹⁶² Ibid., p. 6.

¹⁶³ Ibid., p. 7.

Summary and Implications

All twenty of the participants interviewed ventured some form of reconstruction of a situation in the first interview (one hundred percent), while sixteen of the twenty (eighty percent) offered reconstructed situations in the second interview. Of the four who could not provide a reconstructed situation of any kind, three were from the medical center and one was from the family service agency. A possible explanation is that this was a rather rigorous exercise, and four of the participants did not wish to engage in this exercise the second time around.

Of the twenty participants who reconstructed a situation in the first interview, seven responses (thirty-five percent) met the operant definition of an ethical dilemma. Of the sixteen participants who reconstructed a situation in the second interview, five responses (thirty-one and a quarter percent) met the definition of an ethical dilemma (see Table 5). This finding was unexpected, as it was assumed that once the participants became familiar with the researcher's area of interest, the frequency with which they would have responded with ethical dilemmas would have increased.

Table 46
Percentage of Participants Reconstructing Ethical Dilemmas

Interview	Percentage
Interview One	35%
Interview Two	31.25%

A possible contributory factor for this finding is that the operant definition for an ethical dilemma was not discussed in the second interview as it was in the first, although this did not appear to effect the responses from the medical center participants. As a matter of fact, four medical center participants reconstructed ethical dilemmas in the second interview, compared to three in the first interview. In contrast, four family service participants reconstructed ethical dilemmas in the first interview, but only one did in the second interview (see Table 47).

Table 47

Frequency of Participants Reconstructing Ethical Dilemmas:
Interviews One and Two

	Interview One	Interview Two
Medical Center	3	4
Family Service	4	1

The decrease in the frequency of family service agency responses meeting the operant definition of an ethical dilemma from the first to the second interview might be attributed to an organizational upheaval occurring at the family service agency which four family service participants alluded to during this stage of the second interview, but refused to discuss. It might be, as suggested by Beck-Black, that the stress caused by organizational difficulties might have impaired the decision-making of the family service participants, rendering them less cognitively able to reconstruct ethical dilemmas. Whatever the reason for this finding, it was quite marked, and dovetailed with a subsequent finding involving organizational references.

In the first interview, seven of the seven ethical dilemmas presented (one hundred percent) involved an organizational component. In the second interview, two of the five dilemmas involved an organizational component, and one involved a problem of precipitous withdrawal of service due to an organizational action (see Table 48). Thus, in three of the five dilemmas (sixty percent), the organization was central to the dilemma.

Table 48

Types of Ethical Dilemmas Reconstructed by
Participants: Interviews One and Two

Ethical Dilemma	Interview	
	One	Two
Organization vs. Client	5	2
Organization vs. Colleague	1	0
Organization vs. Confidentiality	1	0
Withdrawal of Service vs. No Solic.	0	1
Client vs. Client	0	1
Client vs. Colleague	0	1
Total	7	5

In the first interview, nine of the twenty participants (forty-five percent) referred to organizational elements, regardless of whether their responses were based on ethical analyses or extra-ethical issues. In the second interview,

six of the sixteen participants (thirty-seven and one half percent) referred to organizational elements in their responses regardless of the type of analysis (see Table 49).

Table 49

Percentage of Participants Referring to
Organizational Elements in Reconstructions:
Interviews One and Two

Interview	Percentage
Interview One	45%
Interview Two	37.5%

When viewed from the perspective of a comparison between agencies, six of the ten family service participants (sixty percent) referred to organizational elements in their reconstructions in the first interview, while only three of the nine participants from the family service agency (thirty-three percent) referred to organizational elements in their reconstructions in the second interview (see Tables 50 and 51).

Table 50

Percentage of Family Service Participants'
References to Organizational Elements In All
Reconstructions: Interviews One and Two

Interview	Percentage
Interview One	60%
Interview Two	33%

Table 51

Frequency of Family Service Participants'
References to Organizational Elements In
All Reconstructions: Interviews One and Two

Interview	Frequency
Interview One	6
Interview Two	3

The medical center participants also showed a diminished frequency of references to organizational elements in their reconstructions from the first to the second interviews, but the degree of diminution was minimal. Three medical center participants out of ten (thirty percent) referred to organizational elements in the first interview as compared to two participants out of seven (twenty-eight percent) in the second interview. (see Tables 52 and 53).

Table 52

Frequency of Medical Center Participants' References to
Organizational Elements In All Reconstructions:
Interviews One and Two

Interview	Frequency
Interview One	3
Interview Two	2

Table 53

Percentage of Medical Center Participants'
References to Organizational Elements In
All Reconstructions: Interviews One and Two

Interview	Percentage
Interview One	30%
Interview Two	28%

It is reasonable to assume that the family service participants felt constricted, for some reason, from discussing organizational issues. The only plausible explanation available to the author is the above-noted agency upheaval occurring at the family service agency, which may have effected both the ability of the participants to reconstruct ethical dilemmas, as well as to engage in discussion of the organization in any context.

Finally, in the first interview, eight of the twenty participants (forty percent) reconstructed situations that had occurred more than one month prior to the interview. In the second interview, only two of the participants (ten percent) reconstructed situations that had occurred more than one month previous (see Table 54). Although a causal relationship cannot be proven, there appears to have been a sensitization to issues understood to have ethical content from the first interview that was reflected in the second interview. This finding, however, is subject to an interpretation of the phenomenon of the four participants who could offer no reconstruction whatsoever during the second interview.

Table 54

Time Lapse Difference Between
Interview One and Interview Two

	Interview One	Interview Two
Time	Percent	Percent
One Month	60%	70%
Two to Seven Yrs	40%	10%
No Dilemma	0%	20%
Total	100%	100%

After completing the first part of Interview Two, the participants were asked to read the third and final case history.

Case History #3

Due to recent financial difficulties in the institution resulting in layoffs, the social work staff was advised by administration they must increase their caseloads by thirty percent. A series of meetings ensued, in which the social work staff advised administration that they were already working to their limit and that the proposed increase in caseloads would result in deteriorated service for clients. The administration countered by suggesting individual sessions with clients be curtailed, and that more groups be initiated, so that staff would be serving more clients in the same time period. The social work staff expressed the opinion that most of the clients in question needed individual work, and that groups would not meet their needs. The administration pointed out that without an increase in productivity, the organization might have to cut back or cease operation, in which case the clients would receive little or no service at all, and many of the staff would, of course, be unemployed. The administration advised the social work staff to reconsider its resistance to the suggestions for greater productivity, or face the consequences. The decision would have to be made by the end of the week. What is your thinking about this situation?

As in Case Histories #1 and #2, there are five substantive references in this case: ethical, organizational, personal, clinical and power.

Definitions of Substantive References

Ethical

Case History #3 was designed with the following ethical principles in mind:

I. The social worker should regard as primary the service obligation of the social work profession.

(1) The social worker should retain ultimate responsibility for the quality and extent of the service that individual assumes, assigns, or performs.

(2) The social worker should act to prevent practices that are inhumane or discriminatory against any person or group of persons.

II. The social worker should act in accordance with the highest standards of professional integrity and impartiality.

(1) The social worker should be alert to and resist the influences and pressures that interfere with the exercise of professional discretion and impartial judgement required for the performance of professional functions.

III. Primacy of Clients' Interests.

(1) The social worker should serve clients with devotion, loyalty, determination, and the maximum application of professional skill and competence.

(2) The social worker should withdraw services precipitously only under unusual circumstance, giving careful consideration to all factors in the situation and taking care to minimize possible adverse effects.

(3) The social worker who anticipates the termination or interruption of service to clients should notify clients promptly and seek the transfer, referral, or continuation of service in relation to the clients' needs and preferences.

IV. The social worker should treat colleagues with respect, courtesy, fairness, and good faith.

(1) The social worker should create and maintain conditions of practice that facilitate ethical and competent professional performance by colleagues.

V. The social worker should adhere to commitments made to the employing organization.

(1) The social worker should work to improved the employing agency's policies and procedures, and the efficiency and effectiveness of its service.

(2) The social worker should use with scrupulous regard, and only for the purposes for which they were intended, the resources of the employing organization.

VI. The social worker should promote the general welfare of society.

(1) The social worker should act to ensure that all persons have access to the resources, services and opportunities which they require.

(2) The social worker should encourage informed participant by the public in shaping social policies and institutions.¹⁶⁴

Explanation of Ethical Principles

I. The social worker should regard as primary the service obligation of the social work profession.

(1) The social worker should retain ultimate responsibility for the quality and extent of the service that individual assumes, assigns, or performs.

(2) The social worker should act to prevent practices that are inhumane or discriminatory against any person or group of persons.

Principle I gives to the social worker the ultimate responsibility for his professional interactions with clients. In Case History #3, this means that the social worker cannot ethically yield responsibility to the administration. Furthermore, this principle acts in opposition to discrimination against the client group, as identified by the participants.

¹⁶⁴ Ibid., pp. 3 - 9.

II. The social worker should act in accordance with the highest standards of professional integrity and impartiality.

(1) The social worker should be alert to and resist the influences and pressures that interfere with the exercise of professional discretion and impartial judgement required for the performance of professional functions.

In the context of Case History #3, this principle refers to the obligation of the social worker to resist the implicit or explicit threats or rewards posed by the administration in judging the situation at the agency.

III. Primacy of Clients' Interests.

(1) The social worker should serve clients with devotion, loyalty, determination, and the maximum application of professional skill and competence.

(2) The social worker should withdraw services precipitously only under unusual circumstance, giving careful consideration to all factors in the situation and taking care to minimize possible adverse effects.

(3) The social worker who anticipates the termination or interruption of service to clients should notify clients promptly and seek the transfer, referral, or continuation of service in relation to the clients' needs and preferences.

Principle III focuses on the primacy of the clients' needs, and the requirement to see those needs in the foreground of any proposed changes in how the agency functions.

IV. The social worker should treat colleagues with respect, courtesy, fairness, and good faith.

(1) The social worker should create and maintain conditions of practice that facilitate ethical and competent professional performance by colleagues.

Principle IV refers to the potential interaction among the colleagues at the agency dealing with the situation, and the potential impact of changes on the staff's ability to function competently.

V. The social worker should adhere to commitments made to the employing organization.

(1) The social worker should work to improved the employing agency's policies and procedures, and the efficiency and effectiveness of its service.

(2) The social worker should use with scrupulous regard, and only for the purposes for which they were intended, the resources of the employing organization.

Principle V refers to the obligation of the agency social workers to nurture and protect the agency's functions in a situation where those functions are threatened.

VI. The social worker should promote the general welfare of society.

(1) The social worker should act to ensure that all persons have access to the resources, services and opportunities which they require.

(2) The social worker should encourage informed participation by the public in shaping social policies and institutions.

Principle VI, as well as addressing the availability of services, suggests the advisability of involving the client population in discussion of the possible re-organization of the agency.

Organizational

In Case History #3, the agency is a major component. Should participants predicate their thinking on structural or policy analysis to address the predicament of the agency, instead of on the inherent ethical principles stated above, those responses would be categorized as organizational.

Power

The power reference in Case History #3 is the threat of layoffs if the social workers don't come around to the administration's point of view. Those participants who indicate their actions would be based on this threat would be categorized as having responded to the power component.

Clinical

The clinical component in Case History #3 is the individual and group treatment modalities. Should a participant offer an analysis on the relative merits of either treatment apart from reference to ethical principles, that response would be categorized as a clinical one.

Personal

Once again, personal elements would be those responses evoked in the participants by Case History #3 which are unique to each participant based on his individual experiences, and which guided his actions.

Findings

The situation posed by Case History #3 was perceived by fifteen of the twenty participants to have been experienced at their agencies (see Table 55).

Table 55

Participants Reporting The Situation in Case History #3
Occurring at Their Agency

Participants' Perceptions	# of Part.
Reported Case #3 as Occurring in Agency	15
Reported Case #3 as Hypothetical	5
Total	20

Rather than being able to view this case as they had the first two, as hypothetical situations, Case History #3 was designed to enable participants to view the event as occurring within their employing organization. In contrast to Case Histories #1 and #2, Case History #3 did not specify unique characteristics of the clients or staff. This ambiguity allowed the participants to refer to their own professional experiences. A total of fifteen participants, eight from the medical center and seven from the family service agency, explicitly noted a similarity to events at their employing organization. For example:

My thinking about the situation is that it is much too close to here;

What happened in this case is what happened at [my agency];

This is not a good case for all of us here because we are going through something [similar], as you know, and it is definitely going to be flavored by the staff [participating in this study].

Very often the participants would leave the structure of Case History #3 and recreate the events at their agencies without even a segue. Rather than responding how they might have dealt with such a situation, they reported how they dealt or were dealing with it in their agencies. One consequence of this phenomenon was that the participants did not necessarily respond to the substantive references in the case

history, but, rather, in their agencies. For example, one participant said:

It is clear that...there is not a budget deficit. They are taking money they could use for staffing, and they are using it for something else, building buildings....

Many participants felt that administration was behaving in an arrogant manner towards the staff, and was unconcerned about the welfare of the agency's clients, based more on their own experiences than on the data in Case History #3. For example, one participant stated:

The [agency] is in a financial mess... There is an answer to the major mess. They could open up a drug program or an alcohol program or something, they don't want those types of people in the hospital... Residential treatment and partial hospitalization is the way to go but we don't want those kind of people.

Explicit references to the principle of commitment to the employing organization were infrequent. There are two possible explanations for this phenomenon: (1) The general sense of mistrust and anger many of the participants expressed toward the administrations of their agencies; (2) That the principle, "the social worker should adhere to commitments made to the employing organization," is vague in terms of its practical use.

This major principle is distinctive for its vagueness. Other major principles are more easily applicable to the practice of social work in agencies. For example: "The social

worker should treat colleagues with respect, courtesy, fairness, and good faith," defines a reasonably specific area of behaviors being addressed. Similarly, "the social worker's primary responsibility is to clients" points to a definable area and obligation.

The content of what might be seen as the social worker's commitment to the employing organization is neither specified in the Code of Ethics nor in the organization. This principle can connote anything from taking a one hour lunch break, to working with the organization towards improving the mental health of a community.

With these qualifiers in mind, it was still necessary to categorize the responses of the participants into those citing ethical dilemmas and those not citing ethical dilemma. This was done in the following manner. Implicit in several responses was the recognition of the importance of the agency structure and the role of the social worker within it, and it was this recognition that most often generated the conflict experienced as a dilemma.

This recognition was demonstrated in two ways. The first involved the nature of the relationship between the participant and the organization, from adversarial to identified.

For example, one participant noted:

I think that this situation calls for the staff to resist those kinds of moves... That doesn't mean that you're not working in the context of the agency....

Contrasted to this, another participant responded:

Here's an institution that doesn't have money and they're in financial difficulty...; an organization like this is trying to get more [funds] to service more [clients]... I would give it [the reorganization] a try.

For the former participant, the commitment to the organization was a much more contentious experience than it was for latter participant, who saw the organization in a more benign light.

The second means by which participants were noted to perceive an ethical dilemma recalls the discussion in the literature review of professional/personal ethics. This discussion addressed the distinction between professional and personal behavior. More specifically, one of the frameworks created by social work scholars indicated that social workers must deal with ethics in their roles as social workers, not as "the man on the street." For example:

One of the roles of the social worker is...representing a client who has less access to the system... The social workers represent the patient....

If you look at the goal and purpose of the agency, it is to serve the people who are in need... I can understand that the agency needs money, but I am not administration... If I were, I would be taking a different tactic....

The two responses noted above explicate the perceived role of the social worker in the organization, and what that role entails.

It is worth noting that although the ten participants who addressed an ethical dilemma in Case History #3 viewed the point of conflict as between the employing organization and one or more other principles, it was possible to have perceived conflict between or among other ethical principles besides commitment to the organization. For example, participants could have found a conflict between improving agency practices and service delivery; or, while in the process of "trying to make services and resources available" through a social action process, a worker might have had less time to "deliver high quality service" to current clients. A third possible conflict existed between "making services available to the public" and "improving the employing agency's policies" and/or "taking care to minimize possible adverse effects of withdrawal of service."

The above principles could have conflicted in the following manner. The social worker could have made a determination that in order to maintain his employment in the agency, and to attempt to change the agency's policies, he would have to comply with the agency reorganization. As such, he might have followed the directives of administration and terminated existing individual service to his clients by

placing them in groups. He might have decided not to process this transition with his clients, thus generating upset in the client group. As a result, the clients might have been provoked to voice their reaction to the administration and relevant reviewing agencies, causing community involvement and possible policy change.

Responses Informed by Ethics

Ten of the twenty participants (fifty percent) responded to Case History #3 by referring to the ethical elements in the situation. Of those ten, four were from the medical center and six were from the family service agency (see Table 56).

Table 56

Participants who Utilized an Ethical Analysis
in Case #3

Agency	Number of Participants
Medical	4
Family Service	6
Total	10

All ten participants perceived a conflict between their commitment to the employing agency and their responsibility for the quality of service they provide. Three participants referred as well to the primacy of service to clients. Two added a combination of the primacy of service to clients and the prevention of discrimination against client groups. Two more added a combination of the obligation to resist pressure on their professional judgment and the obligation to maintain conditions of competence for the professional group. One participant each added a combination of the primacy of service to clients and the obligation to resist pressure; the ensuring of access to services, resistance to pressure and the encouragement of participation by the public in the planning of policy and program; and the obligation to maintain competence in the professional group (see Table 57).

Table 57
Ethical Principles Cited by Participants in
Case History #3

Principles	Number of Participants
Ultimate Responsibility for Quality of Service	10
Prevent Discrimination	2
Primacy of Clients' Interests	6
Resist Pressure	4
Ensure Access to Resources	1
Maintain Conditions of Competence	3
Commitment to Employing Organization	10
Encourage Participation by Public	1

Responsibility for the Quality of Service, Resistance to Pressure, and Maintain Conditions of Competence vs. Commitment to Employing Organization

Participant (A) recognized the dilemma posed by the threat to the agency on the one hand, and the threat to the quality of service on the other hand. He felt strongly that there needed to be resistance to a precipitous reorganization, and sought a role for the social workers in defining any changes in the services offered by the agency. He also questioned whether staff was competent to serve clients in the manner proposed by the administration.

Participant (A)

What happened in this case is what happened [here];...the implicit threat that you will be layed off if you don't follow what we say, irrespective of what you consider is good social work practice... I think that often a lot of work can be done with groups. I don't think that this is the only solution... The solution...is to get people together and come up with ideas that would be helpful... Social workers have to be aware of the fact that institutions have financial problems. It shouldn't be taken lightly, but I think they can participate in the change... Maybe you see patients for ten weeks instead of fifteen weeks... But there have been other techniques developed of which they are clearly not ready to discuss. So there's just a lot of animosity... There's a point where you have to save...the program, and it may mean that people [suffer]... I don't think putting people on a waiting list...is theoretically or technically wrong, but I think it's not good service to force people to do work they can't possibly do... I'd rather wait and give them the service they deserve than give them half-assed s--t... Administration thinks in dollars and cents, which is in direct opposition to...good treatment... They're very rarely on the side of the patient [or] the employee... It's a constant battle. And you have to know...how far you're gonna go... Either I can do this job or I can't... And if you can't, you make a moral judgement....

Participant (B) alluded to the same principles as Participant (A). Unlike Participant (A), however, he was not prepared to say "there comes a point where you have to save the program." Instead, he questioned whether the agency, as redefined by the administration, ought to continue to function. He mediated this question based on the competence of the staff, the type of clients being served, and his experience that inferior service inevitably displaces superior service.

Participant (17)

I believe that just to justify the continued existence of an organization does not permit doing something that is...professionally inexcusable... A lot of organizations lose sight of what they set out to do, and function to maintain themselves... To the extent that you have control over it...[you] can and should act... If what we do...lead[s] to the cessation of the operation, so be it... If the agency can't survive, then it shouldn't... If it can be shown that [groups] are an appropriate way to deliver services, that's another story...but if all they are going to do is to have higher census, and justify their existence, and collect fees so that they can continue to do what they are not doing properly, then no, absolutely not... Very often...it is not a black and white case; maybe the services are going to be watered down... That makes it more difficult. I think one needs to take a stand...to deliver the best possible service... If you deliver a service that is not helpful, but pretend that it is, nobody then will come and deliver the appropriate service... Bad service always drives out good service... If you have a staff that has been trained...to do...individual and...family therapy...and then you say to them you have to do groups only, that certainly makes the difference. If you have some [trained] group people that are enthusiastic about group work and you have...a population that would benefit from group work, you can have a different mix....

Primacy of Clients' Interests and Responsibility for the
Quality of Service vs. Commitment to Employing Organization

Participants (C), (D), and (E) recognized a clear dilemma between the needs of the clients and the needs of the agency. All three also articulated a strong sense of responsibility for the quality of the service they provide. Participant (C) began by attempting to mediate the plan for reorganization, but, failing that, felt that a decision had to be made between the needs of the organization, as enunciated by administration, and the obligation to serve his clients with integrity. The premise for his analysis is that the social worker's primary role is to meet the needs of the clients.

Participant (D)

I would want to come together as a group in order to open a dialogue where other options could be considered in terms of the financial situation... If I felt that administration was still not open to that and was very firm about their decision...it would eventually come down to...a...decision... Would I be willing to work in a place where I felt they were not providing quality service for financial reasons?... Would it be productive for [my caseload] to go into groups?... There is a basic value I have... The reason I am here, or in any role that I take, is in the best interest of the client, not for my needs, but their needs. And if I felt that their needs were not being met...I would rather go someplace else where an agency is...in line with my values....

Participant (E), as Participant (D), began by attempting to establish a dialogue with the administration regarding the reorganization, and raised similar questions about its impact. He also questioned the effect such a reorganization might have

on his ability to function with his clients, and on his integrity.

Participant (E)

First there comes the reality of the situation. You know, there's an institution that doesn't have money and they're in financial difficulty. If you told me this was a corporation...I would be more suspicious...[but] an organization like this is trying to get more [funds] to service more [clients]... The workers should get some explanation about...what efforts were made by the institution to generate income... Open up a dialogue... Will this thirty percent increase in productivity really be so taxing?... How are the clients going to be affected?... It would be a terrible conflict...for me... I think about the people I work with here... I would give it a try... So I couldn't get back to my clients today...and...a client...couldn't be seen today, but had to wait for days...and it wasn't an emergency... That would be okay... But if it really came to that I was so stressed that my thinking became impaired, or I was missing important things...then I would have to rethink staying...because of the way I need to be with my clients, because of my professional integrity....

Participant (E) arrived at the same conclusion as Participants (C) and (D), without the step of mediation they undertook. His analysis focused upon the role of the social worker within the structure of the organization.

Participant (E)

There is reality on both sides here. The reality is that they don't have the money, and also the reality is that the optimum should be that the groups shouldn't be. This happens here all the time. They want to raise the fee... I feel that my work is to help the client... If you look at the goal and purpose of the agency, it is to serve the people who are in need. If the people in need, need individual [help], well that is what I have to do. And, if the agency is willing to prostitute itself, that doesn't mean that I have to... I can understand that the agency needs money but I am not administration... If I were, I would be taking a different tactic....

Primacy of Clients' Interests, Responsibility for the Quality of Service, and Resistance to Pressure vs. Commitment to Employing Organization

Participant (F)'s analysis of Case #3 referred to the four ethical principles noted above. Although cognizant of his commitment to the agency, and the need to work within the agency context, he believed that clients' needs come before agency demands. As such, he felt responsible for the quality of the service the organizational changes would bring, and he strongly resisted pressure on his professional discretion.

Participant (F)

I think that as a social worker, there are situations that you need to be willing to get fired for, or quit your job for... There is room for compromise... There should be room for groups and other kind of things...but they have to make the bottom line clinical decisions for clients...and the staff should push for that...and refuse to put someone in the group who is not an appropriate candidate... I think the staff has to stick to its guns... I think that this situation calls for the staff to resist those kinds of moves... It comes from a basic ethical value that, as helping professionals, the needs of the clients come first... That doesn't mean that you're not working in the context of the agency... You should do it in concert with other workers, but ultimately you might have to stand alone about this...even though being fired won't help the patients... Once it chips away at your standards, you have to take those kinds of stands....

Primacy of Clients' Interests, Responsibility for the Quality of Service, and Prevent Discrimination vs. Commitment to Employing Organization

Participant (G) viewed his obligation to the organization within the context of the delivery of the professional

service. To the extent that his social work values and those of administration are synchronized, there is no ethical dilemma. Once he perceived this synchronization to be lost, due to the plan for reorganization, the ethical dilemma arose. When the administration is seen as not caring about his work, it is translated into not caring about his clients' needs. Participant (G) saw this situation as a form of discrimination against the client group as well. He felt he would be unable to remain in an agency which would compromise service to clients due to economic pressures.

Participant (G)

This is...hard because it is easily applied to [this center]; this is what is happening, and I have a lot of biases. A lot of the people that work here see patients for ten minutes...but if I was seeing these people for forty-five minutes, and I had a caseload of thirty, I don't feel like I could take another thirty percent... The only way I would be able to do it would be to stick them all into a group that I saw once a week... I would want to work for an organization that cares about what I am doing... There is...a paradox, [or] dichotomy. We are supposed to be working to help people, or help people to help themselves, that are having some difficult problems...and that it is hard work... The other part is the financial part. So it doesn't matter if you help them to do better, we just want you to try to help as many as you can... But there are only a certain amount that we can effectively work with to help them do better, so then you are kind of perpetuating the mental health system... It is like the poor. Only the students work with the poor. All the good ones then do private practice, so the poor don't get help....

Prevent Discrimination, Resistance to Pressure, Primacy of Clients' Interests, and Ensure Access to Resources vs. Commitment to Employing Organization

As with Participant (G), Participant (H) saw an element of discrimination against the client group in the plans of the administration. Although he did not rule out the possibility of compromise, he saw an obligation to resist any plan that would deprive clients of access to necessary services. He based this responsibility on his understanding of the function of the social worker within the organizational setting.

Participant (H)

My thinking about this is it is very real, and I think that some of it is true. Some of what the administration says about cut backs is true, and some of it is exaggeration... I think that a lot of clients can be serviced in groups...but...it has to be done by a case by case review... Basically, what the administration says is what you have to do... However, the social worker's responsibility is to fight for patient care... I think that a lot of the patients we have are disenfranchised, so they don't feel very powerful... So there is a political aspect to mental illness... One of the roles of the social worker is...representing a client who has less access to the system... The social workers represent the patient as well as the agency. Administration represents the business part... Patient care is an issue worth pursuing... I have a problem with ignoring the people who...couldn't be in the group....

Resistance to Pressure, Responsibility for the Quality of Service, Ensure Access to Services, and Encourage Participation by the Public vs. Commitment to Organization

Participant (I) also recognized the obligation to ensure access to the services of the agency. He was the only one who also noted the advisability of involving the client group in

advocating for its own services. He felt that a commitment to the organization was contingent upon the organization recognizing the professional role of the social worker, and was prepared to resist administrative changes that precluded input by the staff.

Participant (I)

I'd resist because you are being strong armed and administration isn't hearing you... It is a two way street between administration and staff in order for an agency to function... That's what I would try to get across... There has to be a dialogue, and I would try to open up a dialogue... Being forced into a position to give poor service is totally unethical... The other thing I was thinking of is that I might want to contact N.A.S.W. as...an advocate for social workers... Maybe even the Department of Mental Health, in terms of rights for clients...and have the clients do some of this work too... From the hospital, there were patients that would call the Department of Mental Health, or they would call the hospital administrator....

Maintain Conditions of Competence and Responsibility for the Quality Of Service vs. Commitment to Organization

Participant (J) recognized a commitment to the organization to the extent that the organization maintained its commitment to the delivery of the necessary professional service. He felt that the loss of this commitment would compromise his professional role as well as the existence of the organization. He also recognized a need to maintain competent service in the face of possible changes in the helping modality.

Participant (J)

Group is not my expertise... It doesn't seem to me that this would even make sense... We have had maybe six requests [from administration] for donation in the last month... I don't know what to do. It is not hopeful... There has to be some looking at the skills of the staff... Maybe there are times that there shouldn't be any more services... If there are no more people that need the services that I have to offer, then we should be out of business... I don't think that the agency should be in business for the employees. We are here to deliver a service, and that is the commitment of a social work agency....

Extra-Ethical Responses

Ten of the twenty participants responded to Case History #3 by referring primarily to substantive elements that were not ethical principles. Although some of them noted ethical principles in their discussions, their resolutions of the situation posed by Case History #3 were informed by references to elements other than the ethical principles involved. For example, one participant stated: "I think the client's needs should be considered first in the best possible world," which is an allusion to the ethical principle of the primacy of service to clients. Nevertheless, his resolution of the situation was based on his view that "I don't see what the staff would do other than go along. The staff is not powerful." He was, therefore, categorized as being primarily informed by power elements, rather than by ethical elements.

Of the ten participants who were categorized as having been informed by extra-ethical elements, six were from the medical center and four were from the family service agency (see Table 58).

Table 58
Extra-Ethical Responses to Case History #3 by Agency

Agency	Number of Participant
Medical Center	6
Family Service	4
Total	10

Seven of the ten participants viewed Case History #3 as an organizational problem, either completely, or combined with personal or power issues. One participant viewed Case History #3 as a clinical problem, one combined power and personal issues, and one viewed the problem as exclusively related to power issues (see Table 59).

Table 59
Extra-Ethical Elements Cited by Participants in
Case History #3

Category	Number of Participants
Organizational	3
Organizational and Personal	3
Organizational and Power	1
Power and Personal	1
Power	1
Clinical	1
Total	10

Organizational

Participants (K), (L), and (M) saw Case History #3 as predicated on structural or functional features of the organization, and dealt with it through organizational analyses. Participant (K) noted the principle of ensuring access to services, but saw the situation as a microcosm of society and reckoned there was no solution to the problem as he envisioned it.

Participant (K)

What I think about the situation? I think it stinks. This is a total betrayal of the [agency mission]... [The agency] is built to serve the community... This is just one more example of what is happening, not just at [this agency], but throughout the city and throughout the country as well. To me, it's...not...an isolated case. That comes to the political issue again. I think this is just the tip of the iceberg... It's profits first and people second. And this is a result of government policies and health care in terms of profit... People don't count: neither patients nor workers. We are just numbers; we are not individuals... But I don't think there is a solution... The solution is in the entire system....

Participant (L) specifically denied seeing an ethical dilemma in Case History #3. For him, the situation was bothersome, but easy enough to get around by using his knowledge of how the organization functions.

Participant (L)

I know enough about the system that I can get out of doing what they want me to do... This is happening here... [But] the patients are so unconnected to therapy that whether they go into a group or stay individually is probably not going to affect their treatment... There are enough loopholes in this place that I can...form groups from the batch they give me and patients who come in every second or third week... It's not really a dilemma. For me, it's a nuisance... I don't see that as a dilemma...because I don't see an immediate danger... I don't care if they lay me off. What I do is try to carve out my piece of work....

Participant (M) also denied seeing an ethical dilemma in Case History #3. Although he recognized the issues of client need, quality of service, and commitment to organization, he negated the ethical implications of the situation, and saw it

instead as an organizational phenomenon requiring organizational responses.

Participant (M)

It is the reality... There are financial difficulties... It's frustrating [but] not surprising... There could be some negotiations around what's the best we can do given the circumstance. If it goes to group services, I think that there's little choice for workers... Our director has made some more flexibility that on certain cases, we can maintain individual service, but that in [general] we have to transfer...or terminate... I don't think we are the only ones that could give service, but it's a disruption to clients... I don't know how you're defining ethical. There are professional issues, quality of service issues....program priorities [and] agency mandates... I see it more as quality of service rather than ethical... Ethical just seems much more abstract to me... In one's day to day work, one doesn't sort out 'Oh, this is an ethical problem.' So I'm just not used to thinking in those terms. I see a real person, I got to give them service, and it brings up a lot of stuff, but it's not like there's this consciousness about I'm in an ethical dilemma... I feel bad I can't give someone individual service when I think they may need it...but given those circumstances, I see what's the best I can do given the realities and options available to me....

Organizational and Personal

Participants (N), (O), and (P) framed their analyses of Case History #3 within organizational parameters, referring to workloads, remuneration, and forms of communication. They also cited personal issues related to stress factors and lifestyles in determining their responses.

Participant (N)

This is like this organization...the veiled threat... This is the issue that I am struggling with... I am setting myself up for some physical [problems]... I am doing more hours and not getting paid, so I have even more anger... They don't realize how helpful staff can be if they approached them in the right manner... They don't use their resources....

Participant (O) began by exploring the legitimacy of the current caseloads of practitioners. As such, his examination of Case History #3 initially dealt with organizational issues, and concluded with a personal response.

Participant (O)

Well, I think the social workers would have to be pretty honest about what their caseloads are. We can all say that we are over-worked, but when you come right down to it, the numbers of people we see may not be that much. However, there are other...things...like dictation...[and] how many minutes in a session... I would love to run groups, but I know that we charge less for a group...so [it] wouldn't even meet the cost...and not everybody wants to be in a group... The social workers could make an effort to do more... We are also not getting paid more for seeing more clients, so there is a risk of burn-out.... You have a choice, you try to ...adapt or you leave... [I base my decision on] how stressed I am feeling at work or personally or what my other goals are in life....

Participant (P) felt he would comply with administration's recommendations, although he would want to explore financial alternatives. He referred to his lifestyle as enabling him to see more clients. He denied perceiving any ethical dilemma in the situation.

Participant (P)

This is the situation that was happening at our agency... Everyone was trying hard to think of groups to have... As far as handling more clients, I think I would probably try. I think the problems are real. The alternatives to the problems are for administrative people to...write grant proposals and try to find other ways to get money, but I know how hard that is... I would carry more cases. I wouldn't fight it... I worked extra time...and never took the amount of time off I was supposed to get. I was at a time in my life that I could do that. My kids were grown. They didn't need me. My spouse comes home late... My own personal solution is not a general solution... I wouldn't have considered that an ethical dilemma. I would have seen the workers as each of us, in our own ability, to respond to the problem as much as we could. For me, the easiest way would have been to take on the cases....

Organizational and Power

Participant (Q) recognized organizational issues in Case History #3, but was primarily informed by administration's threat to lay off workers, and his need to remain employed.

Participant (Q)

The bottom line is that people want to keep their jobs...and I don't want to lose my job... It is very real... We have had two layoffs and we are over-worked... It is clear that...there is not a budget deficit. They are taking money they could use for staffing, and they are using it for something else, building buildings... In the short run, I would go along with it. I don't want to lose my job...but I wouldn't just go along with it. I would work with other staff to come up with a plan, because this is just symptomatic....
Power and Personal

Participant (R) perceived the ethical dilemma of the commitment to organization in conflict with the responsibility for the quality of the service. What informed his thinking,

however, was a personal need to work and the threat of the loss of employment.

Participant (R)

I would probably do what they want... I am doing it in reality...because I have to work. But what is really suffering is the quality of the work... It is quality of service or the survival of the agency... I have...a personal need [to work] so now I have to do groups. I'm not the world's greatest group leader, so in order to be better at it I would work on [my skills]... That is what I would do... It's all too real....

Power

As with Participant (R), Participant (S) recognized central ethical elements in Case History #3, yet resigned himself to the administration's demands, because he considered the professional group to be powerless in the situation.

Participant (S)

It is much too close to here... They're asking people to take over caseloads for people who've been...laid off... [But] no service...is worse...than groups, which may be less beneficial, ...but...still a useful professional service. Most [clients]... couldn't afford to go privately... I don't see...what the staff would do other than go along [with it]... The staff is not powerful... I think the clients' needs should be considered first in the best possible world... They just don't care about the clients. That's the reality of working in an agency... To go somewhere else is just to change the location, not to change the problems.

Clinical

Participant (T) was informed in his thinking by clinical concerns for the viability of the groups being proposed.

Participant (T)

It is possible to have groups centered around emotional concerns... It is possible that people would benefit from it. But if everyone has to enter a group, then a lot of people will lose out, because it is not a choice...and you will have a lot of clients who are very unhappy and probably apathetic to your cause. It could be fine if you were doing some concrete services... Some people who are having difficulty dealing with their [issue]...don't want to talk about it...with everyone else... I am usually the kind of person who tries to see if things can work out. I don't generally make hasty decisions....

Summary and Implications

As with Case Histories #1 and #2, Case History #3 found little difference between the responses of the participants from the medical center and the family service agency, either in the numbers of participant who perceived an ethical dilemma, or their perception of the ethical principles in the case (see Tables 60 and 61).

Table 60
 Participants Who Perceived an Ethical Dilemma in
 Case History #3 by Agency

Analysis Type	Medical Center	Family Service
Ethical	4	6
Percent	20%	30%

The only differences of any note between the two groups was that two medical center participants referred to the principle "preventing discrimination," and one family participant each referred to "ensure access to service" and "encourage participation by the public" (see Table 61). This is not deemed to be a significant finding, as the three principles are closely related to each other. It is reasonable to conclude that two participants from each agency drew upon the same ethical area.

Table 61
Ethical Principles Cited by Participants by Agency

	Medical Center Family Service	
Responsibility for the Quality of Service	4	6
Resistance to Pressure	2	2
Maintain Conditions of Competence	1	2
Primacy of Clients' Interests	3	3
Prevent Discrimination	2	0
Ensure Access to Services	0	1
Encourage Participation by the Public	1	1

There was, however, a difference in the extra-ethical elements cited by the participants. More family service participants drew upon personal experience during their decision-making than did medical center participants (see Tables 62).

Table 62
Extra-Ethical Elements Cited by Participants by Agency

Analysis Type	Medical Center	Family Service
Personal	0	4
Organizational	4	3
Power	2	1
Clinical	1	0

The most reasonable explanation for this finding is that the family service agency was still experiencing the effects of the forced resignation of a worker. Three of the four family service participants who referred to personal issues in Case History #3 were intensely involved in the ramifications of this event. The fourth participant who cited personal issues was the resigning worker.

There was no significant difference between the medical center and the family service agency participants in their responses to the possibility of contesting the reorganization directives of the administration in Case History #3 (see Table 63).

Table 63
Participants' Responses to Directive by Agency

Response	Medical Center	Family Service
Followed Directive	2	2
Contested Directive	6	5
Unclear	2	3

Of note, however, is that nine of the ten participants citing conflicting ethical principles in their responses to Case History #3 stated they would have contested the administrative directive. In contrast, of the ten participants who were primarily informed by extra-ethical issues during their analyses of the case, four would have followed the administrative directive, two would have contested the directive, and four were uncertain of whether or not they would have followed the directive (see Table 64).

Table 64

Responses to Directive by Ethical and Extra-Ethical
References

	Extra-Ethical	Ethical
Follow Directive	4	0
Contest Directive	2	9
Uncertain	4	1
Total	10	10

Generally speaking, participants who contested the administrative directive for reorganization were more likely to predicate their actions on an ethical analysis of the dilemma. Those participants who either complied with, or were uncertain about their responses to the administrative directive, were more likely to refer to extra-ethical elements in their analyses of the situation presented by Case History #3.

This finding suggests that social workers who are aware of ethical principles are more likely to resist organizational directives that create conflicts with professional values than are social workers who are not aware of ethical principles.

CHAPTER FIVE

Overview of the Research Findings

Comparison of Family Service Agency and Medical Center

The one substantial area of difference in the frequency of ethically informed responses between the medical center and the family service agency occurred during the second interview, in response to the request to reconstruct an ethical dilemma. The responses to all other areas of the interviews revealed no differences between the participants from the two agencies (see Table 65).

Table 65

Number of Ethically Informed Responses by Agency

Section of Interview	Number of Participants Informed by Ethics	
	Medical Center	Family Service
Dilemma 1	3	4
Case 1	3	4
Case 2	4	4
Dilemma 2	4	1
Case 3	4	6
Total	18	19

This relationship between the two groups of participants is evident, as well, in the frequencies of non-ethical responses (see below Table 66).

Table 66

Number of Non-Ethically Informed Responses by Agency

Number of Non-Ethical Responses		
	Not Informed by Ethics	Medical Center Family Service
Dilemma	7	6
Case 1	7	6
Case 2	6	6
Dilemma 2	3	8
Case 3	6	4
Total	29	30

Because the responses of the two groups of participants were so similar, the one area in which there was substantial difference, the second reconstruction found in Interview Two, warrants close examination.

Comparison of Reconstructions

In Interview One, seven participants (thirty five percent) reconstructed an ethical dilemma: three from the medical center and four from the family service agency. During interview two, five participants (twenty five percent) reconstructed ethical dilemmas: four medical center participants and one family service agency participant (see Tables 67, 68, and 68). Thus, although during Interview One there was no substantial difference in the response from the two cohorts, during Interview Two participants from the medical center presented ethical dilemmas four times as often as participants from the family service agency (see Table 68).

Table 67

Number of Participants Reconstructing
Ethical Dilemmas by Agency: Interview One

Agency	Number of Participants
Medical Center	3
Family Service	4
Total	7

Table 68

Number of Participants Reconstructing
Ethical Dilemmas by Agency: Interview Two

Agency	Number of Participants
Medical Center	4
Family Service	1
Total	5

Table 69

Percentages of Participants
Reconstructing Ethical Dilemmas

Dilemma Number	Percentage
Dilemma #1	35%
Dilemma #2	25%

Examining this phenomenon further reveals that of the seven participants who reconstructed an ethical dilemma during Interview One, three reconstructed an ethical dilemma during Interview Two (see Table 70). Stated another way, three of the five participants who reconstructed an ethical dilemma in Interview Two had also reconstructed an ethical dilemma in Interview One. Of these three participants, two were employed

by the medical center and one was employed by the family service agency.

Of the participants from the medical center, only one reconstructed an ethical dilemma exclusively in Interview One. In the family service agency, however, three participants reconstructed an ethical dilemma exclusively in Interview One (see Tables 71, 72 and 73).

Table 70

Participants Who Reconstructed Ethical Dilemmas
in Both Interviews, by Agency

Agency	Number of Participants
Medical Center	2
Family Service	1
Total	3

Table 71

Participants Who Reconstructed Ethical Dilemmas
Exclusively in Interview One, by Agency

Agency	Number of Participants
Medical Center	1
Family Service	3
Total	4

Table 72

Participants Who Reconstructed Ethical Dilemmas
Exclusively in Interview Two, by Agency

Agency	Number of Participants
Medical Center	2
Family Service	0
Total	2

Table 73

Participants Not Reconstructing Ethical
Dilemmas in Either Interview, by Agency

Agency	Number of Participants
Medical Center	5
Family Service	6

What accounts for the apparent inability of the four participants to duplicate their reconstructions of ethical dilemmas from Interview One to Interview Two, especially the three from the family service agency? As the expectation of the author was that awareness of the area of research, and of the ethical aspects of practice, would increase, she found this "aberration" surprising. In order to answer the question posed by these findings, the author examined the responses of

those participants whose awareness appeared to decrease between the interviews, and the responses of those participants whose awareness appeared to increase.

Decrease in Awareness of Ethical Dilemmas

Of the medical center cohort, the one participant who reconstructed an ethical dilemma in Interview One but did not do so in Interview Two, reported an inability to think of one, and, thus, offered no reconstruction of any kind. The three family service participants who were unable to reconstruct an ethical dilemma in Interview Two, after having done so in Interview One, told the author during the second interview that they did not wish to discuss the situation in the organization and preferred to look at other issues. They all denied being prohibited by anyone at the agency from discussing organizational issues. They all offered reconstructions that did not meet the operant definition of an ethical dilemma.

The author believes that this inhibition of the participants impacted the data in two ways. The first, and most obvious, is that removing the organization from consideration limited these participants' options in reconstructing ethical dilemmas. There were, nevertheless,

other areas in which ethical dilemmas could have been found, areas exempting the current agency situation.

The second interpretation of the impact on the data caused by this inhibition is more subtle, and has its antecedent in the literature review. That interpretation is that organizational dysfunction can cause an impairment in the cognitive abilities of the employees of the organization. An earlier citation found in the literature review merits restatement at this point. "Judgments made under uncertainty are not only emotionally demanding but are also open to cognitive strains and predictable biases [of the individual]." ¹⁶⁵ The author surmises that the participants were preoccupied with the situation at the family service agency, and that the cognitive ability to perceive ethical dilemmas they had evidenced in the first interview became constricted, thus handicapping them from reconstructing a second ethical dilemma.

The family service agency was chosen for the research because it represented a small social work agency, in contrast to the medical center, much larger, and in which social work is a "guest" discipline. Like the medical center, however, the family service agency has a classical hierarchical structure, is run by rules, and has top-down communication.

¹⁶⁵ Beck Black, op. cit., pp. 11-25.

It was this type of communication that was at the heart of the situation at the family service agency at the time of the research. The administration of the agency had effected the forced resignation of an experienced staff member whose colleagues felt they had no access to the administration to protest or appeal this action. The overriding impact of this type of bureaucracy demonstrates that "the organizational variables ... [exert] the predominant control over individual behavior,"¹⁶⁶ including responses to research of the type undertaken by the author.

Increase in Awareness of Ethical Dilemmas

Evidence of an increase in awareness of ethical dilemmas can be seen from two perspectives. First, two participants who were unable to reconstruct an ethical dilemma in Interview One, were able to do so in Interview Two. Second, all five participants who reconstructed ethical dilemmas in Interview Two recognized the ethical obligations in those dilemmas. Only three of the seven participants who reconstructed ethical dilemmas in Interview One recognized the ethical obligations inherent in those dilemmas. For the sake of clarification, the requirement for meeting the operant definition of an

¹⁶⁶ Perrow, "The Analysis of Goals in Complex Organizations," op. cit., p. 66.

ethical dilemma consisted of reconstructing a situation in which the author could identify two or more ethical principles in conflict. It was not necessary for the participants to identify these principles, or the obligations assumed under them. In contrast, the case histories were developed with conflicting principles as well as extra-ethical elements, all of which were available to the participants for reference.

Examples from Interview One of reconstructed ethical dilemmas with unidentified obligations are:

I felt this was absolutely the wrong thing to do... I was a new staff member and I had no choice but to go along with this....

and;

My director said that's what I should do... That made the balance of what to do....

In comparison, four of the seven participants who reconstructed dilemmas in Interview One did note the obligations inherent in the conflicting principles.

A patient...was undocumented and the agency didn't want to take the patient for services... She had rights as a patient in the hospital.

The question is whether it is better to give a psychiatric diagnosis to a client in order to obtain reimbursement...as long as it's not harmful to the client or the therapeutic process... It has to be made for the benefit of the agency... Ultimately, it's the clients' interests that have to come first.

In Interview Two, all five participants who reconstructed ethical dilemmas identified the ethical obligations in

conflict. For example, the following participant explored a conflict between the needs of a mother and the needs of a child.

The ethical dilemma...was...should this be reported as child neglect... The conflict is...whether one does more damage by reporting this because...diagnostically, this women is beyond borderline and this might totally destroy her, and we don't know what will happen to the child. On the other hand, there is greater harm if it is not reported... I don't think there is a mandatory reporting [in this case]....

Another participant saw a conflict between his obligation to a client needing treatment and his obligation to a colleague who thinks this treatment in not indicated.

The ethical dilemma is: What is my responsibility?... It seems like [it] is...to the kid. And yet I am a full time employee here and...[colleague] said no... I will have to go to [the director]... It might cause some conflict...[but] if they're assigning me to do that work over there, then they have to back me up. There are not going to sacrifice me...and pull their resources away....

In addition to the evidence of increased awareness of ethical dilemmas noted above, the two participants who reconstructed ethical dilemmas exclusively in Interview Two, when asked for feedback on the research process, were the only two participants who felt they would change their responses to the case histories in Interview One. These two participants had reflected on the first interview during the intervening time between the interviews. It appears that the demonstrated increase in awareness was related to thinking

about ethical elements in practice. An implication of these findings is that a process similar to the interviews with these participants can have an impact on the ethical awareness of practitioners.

Relationship Between Reconstruction of Ethical Dilemmas and Application of Ethical Principles

The implication above may be tempered somewhat by the fact that little if any relationship existed between the ability of participants to reconstruct ethical dilemmas and the ability to identify and apply the ethical elements in the case histories.

A study of the totality of responses of the two participants who reconstructed ethical dilemmas exclusively in Interview Two demonstrates the absence of a relationship between the responses to the case histories and the reconstructions.

Participant (A)'s first reconstruction was coded as legal because he was informed primarily by a legal mandate to contact a child protective service.

I knew that I had to report [the child abuse]... What made it less conflictual to me is that [the client] knew that I am a mandated reporter and called me.

Participant (A)'s second reconstruction was coded as an ethical dilemma dealing with conflicting obligations between the employing organization and clients.

The conflict is between the rights of the kids and the rights of the agency... As the budget crisis continues in health care...they really cut prevention... I have to squash [the clients' complaints about lack of funds]....

Participant's (A)'s responses to all three case histories referred to the inherent ethical principles. In response to Case History #1, that of Ms. Misfortune, he referred to four ethical principles: self-determination, resistance to pressure, prevention of discrimination, and the right to be fully informed.

There is a choice that people can make about not having surgery... [The client] deserves to have a certain kind of respect and a choice in how and when they are going to die... And here is a stand that she is taking...as strongly as she can, being disenfranchised for as long as she has been... Once somebody took a stand on this the doctor would...back off.

In response to Case History #2, that of Ms. Ivy and Mr. Clean, Participant (A) explored the conflict between the primacy of clients' interests and confidentiality on the one hand, and commitment to the employing agency.

I don't think you can go around telling people... It's the confidentiality... I think that it is a life-threatening thing and one could say that they could easily tell him because there is a threat on his life. On the other hand, I don't know what that means in terms of a value that one would place on all H.I.V. positive... There are tremendous repercussions and tremendous stigmas... People wouldn't come to get treatment for something that you can help them with because they would be afraid....

Finally, in response to Case History #3, Participant (A) referred to five ethical principles: prevention of discrimination, resistance to pressure, primacy of clients' interests, and ensuring access to resources as opposed to commitment to the employing organization.

Some of what the administration says about cut backs is true, and some of it is exaggeration... I think that a lot of clients can be serviced in groups...but...it has to be done by a case by case review... One of the roles of the social worker is...representing a client who has less access to the system [and]...fight[ing] for patient care... Patient care is an issue worth pursuing....

Within the structure of this research methodology, Participant (A) demonstrated a high, and growing, level of awareness to ethical principles.

Unlike Participant (A), Participant (B) did not have a primary reference to ethical principles in any of his responses to the case histories. In Interview One, Participant (B) reconstructed a situation in which he was informed primarily by a sense of personal discomfort when considering the inadequate work of a colleague.

My dilemma was...there was improper documentation in the chart to allow the patient to [be transferred] at this time... I could have done the [transfer] and blown the whistle too...[but] I'm not comfortable doing the whistle blowing....

In Interview Two, Participant (B) reconstructed a conflict in ethical obligation between his employer and his client.

I was working with a Chinese-only speaking patient... The hospital was waiting...for this patient to get into a nursing home...[for] four weeks... [The family] turned down one bed...[because] that nursing home did not have Chinese-speaking staff... He has the right to be able to voice his needs...when he gets there... I think I'll go to bat for the family...because... [sending him to a non-Chinese speaking nursing home] is very inhumane...and dangerous... If [the hospital] decides to override me and send him anyway, I will still maintain my perspective....

In responding to Case History #1, Participant (B) referred to the power of the physician.

I didn't know what else I could do to make it absolutely clear in my mind that it was the best thing to do except to say to myself 'well this is a doctor that has a lot of experience and...maybe he was doing the right thing'... I'd have to back off. I have to keep my job too.

In response to Case History #2, Participant (B) perceived that he would be attacked if he considered informing Mr. C. of his risks. He developed possible defenses and actions. He was coded as referring to power and personal elements in his response.

I'd look for other people who would advocate for me... If everyone says 'no, we can do nothing,' and they all refer me back to my agency, I might have to terminate working with these patients... I would seek my own personal comfort and an ability to be a better professional person... I am not responsible for all [clients].

Finally, in response to Case History #3, Participant (B) focused on the clinical issues involved with group work.

If everyone has to enter a group, then a lot of people will lose out, because it is not a choice...and you will have a lot of clients who are very unhappy... It could be fine if you were doing some concrete services... Some people who are having difficulty...don't want to talk about it...with everyone else....

Although both Participants (A) and (B) demonstrated increased awareness of ethical dilemmas between Interview One and Interview Two, there were no similarities in their responses to the case histories. There was no consistent relationship in the sample as a whole between reconstructions and responses to case histories. This finding suggests that there is a difference between being able to identify an ethical dilemma and being able to analyze the components of an ethical dilemma. The implication that some participants developed increased awareness of ethical dilemmas does not extend to an improved ability, or change, in decision-making when confronted with these dilemmas. That is to say, social workers can be aware of ethical dilemmas, but base their actions on considerations apart from ethical principles. It may also be that changes in awareness of ethical elements can

begin more readily in practitioners' own service situations than in any generally applicable sphere.

Awareness without concomitant action is not uncommon to the social work practitioner. Many clients request help for destructive or self-destructive behaviors without a clue of how to change those behaviors. As the responses to the case histories required decisions, an examination of those responses might shed light on the process by which behavior in ethical dilemmas changes.

Responses to Case Histories

The task posed for the participants in the case histories was to read through an ethical dilemma, and discuss what elements influenced them in arriving at a decision for the resolution of the dilemma.

There was progressive growth in the number of participants who cited ethical principles as guiding them to resolutions of the case histories. Seven participants (thirty five percent) were informed by ethics in Case History #1; eight participants (forty percent) were informed by ethics in Case History #2; ten participants (fifty percent) were informed by ethics in Case History #3 (see Table 74).

Table 74
Percentage of Participants Guided by Ethical Principles
In All Case Histories

Case History	Percentage
Case #1	35%
Case #2	40%
Case #3	50%

Of the seven participants whose thinking was guided by the ethical principles in Case History #1, five were similarly guided in Case History #2, joined by three participants who were not guided by ethical principles in Case History #1. For all of Interview One, therefore, ten participants were guided by ethical principles in Case Histories #1 and #2 combined.

In Interview Two, only one case history was presented. Ten participants were guided by the ethical principles in Case History #3. The frequency of response to the ethical principles between the two interviews, therefore, remained the same, but was more concentrated in the second interview (see Tables 75 and 76).

Table 75
Number of Participants Guided by
Ethical Principles in Interview One

Section of Interview One	Number of Participants
Case History #1 Only	2
Case History #2 Only	3
Both Cases	5
Total	10

Table 76
Number and Percentage of Participants Guided by
Ethical Principles in Each Interview

Interview	Number	Percentage
Interview One	10	50%
Interview Two	10	50%

Further examination of the responses reveals four distinct groups: the five participants (twenty five percent) who were guided by ethical principles in both Interview One and Interview Two; the five participants who were guided by ethical principles in Interview One only; the five participants who were guided by ethical principles in

Interview Two only; and the five participants who were not guided by ethical principles in either interview (see Table 77).

Table 77
Categories of Participants Guided by Ethical Principles

Category	Percentage
Guided by Ethical Principles Exclusively in Interview One	25%
Guided by Ethical Principles Exclusively in Interview Two	25%
Guided by Ethical Principles in Both Interviews	25%
Not Guided by Ethical Principles in Either Interview	25%
Total	100%

To continue to try to understand these findings, these four groups will be reviewed thusly: (1) the frequency of reconstructions of ethical dilemmas within each group; (2) the frequency of the categories of extra-ethical elements cited in each group; and (3) the characteristics of decision-making within each group.

Frequency of the Reconstruction of Ethical Dilemmas

Three participants each in the group guided by ethical principles in both interviews and in the group guided by ethical principles exclusively in Interview One, reconstructed ethical dilemmas. Two participants in the group guided by ethical principles exclusively in Interview Two reconstructed ethical dilemmas. Four participants in the group guided by ethical principles in neither interview reconstructed ethical dilemmas (see Table 78).

Table 78

Frequency of Reconstruction of Ethical Dilemmas, by Group

Category	Number of Reconstructed Dilemmas in Interview One	Number of Reconstructed Dilemmas in Interview Two
Guided by Ethical Principles Exclusively in Interview One	2	1
Guided by Ethical Principles Exclusively in Interview Two	2	1
Guided by Ethical Principles in Both Interviews	1	1
Not Guided by Ethical Principles in Either Interview	2	2

Once again, therefore, the lack of relationship between the reconstructions and the responses to the case histories is demonstrated.

Frequency of Category of Extra-Ethical References

The most noteworthy finding in this area is that the group of participants who were not guided by ethical principles in either interview exhibited the greatest likelihood of being influenced by issues of power and compliance in their decision-making (see Table 79). The implication of this finding is that, in the absence of ethically informed practice, agency social workers are more vulnerable to the power wielded by others in the organization in making decisions.

The other differences among the groups, in the citation of extra-ethical elements, appear to be related to the substance of the case histories. For example, the group of participants who were not guided by ethical principles in either interview, and the group of participants who were guided by ethical principles exclusively in the first interview, relied more on organizational elements than the other two groups (see Table 79). As Case History #3 (the administrative directive to increase caseloads) had a strong organizational component, those participants not guided by

ethical principles found the organizational references the most compelling in resolving the situation. This accounts for the higher frequency in organizational citations in the two groups who were not guided by ethical principles in Interview Two.

In a like manner, the group of participants who were guided by ethical principles exclusively in the second interview were more likely to cite clinical elements as having influenced them (see Table 79). As Case History #2 (Ms. Ivy and Mr. Clean) had a major clinical component, those participants not guided by the ethical principles were likely to cite the clinical elements as influencing them.

The frequency with which the influence of power was cited was the only finding from among the extra-ethical elements that was not explainable as a function of the substance of the case histories. The literature review had noted that organizations often use various forms of power to accomplish their goals. Agency social workers often find themselves at the boundary between organizational demands and clients' needs. The data above suggests that those agency social workers who are able to recognize and practice through the ethical principles of the profession are much less likely to succumb to the organization's use of power at the expense of service to their clients.

Examining the four groups yields information about the characteristics of how their constituent participants resolved the ethical dilemmas posed by the case histories.

Table 79

Frequency of Reference to All Elements, by Group

Category	Ethics	Organization	Power	Clinical	Personal
Guided by Ethical Principles Exclusively in Interview One	8	6	1	0	3
Guided by Ethical Principles Exclusively in Interview Two	5	2	2	7	1
Guided by Ethical Principles in Both Interviews	12	1	0	2	1
Not Guided by Ethical Principles in Either Interview	0	6	8	3	3

Characteristics of Decision-Making

Participants Guided by Ethical Principles In Interviews One and Two

There were five participants who were guided by ethical principles in both interviews: two from the medical center and three from the family service agency (see Table 80). Three of the five were guided by ethical principles in two of the three case histories. The other two were guided by ethical principles in all three case histories (see Table 81). In those responses wherein the first three cited extra-ethical elements as having influenced them, there were two clinical references and one reference each to personal and organizational elements (see Tables 80).

Table 80

Number of Participants Guided by Ethical Principles in Interviews One and Two, by Agency

Agency	Number of Participants
Medical Center	2
Family Services	3
Total	5

Table 81

Ethical and Extra-Ethical Elements Used by
Participants Guided by Ethical Principles in
Interviews One and Two

Participant	Case History #1	Case History #2	Case History #3
Part. (A)	Ethical	Ethical	Ethical
Part. (B)	Ethical	Ethical	Ethical
Part. (C)	Ethical	Clinical	Ethical
Part. (D)	Ethical	Clinical	Ethical
Part. (E)	Personal Organizational	Ethical	Ethical

Table 82

Ethical and Extra-Ethical References by
Participants Guided by Ethical Principles in
Interviews One and Two

References	Number of Participants
Ethics	12
Organizational	1
Power	0
Clinical	2
Personal	1

The outstanding feature of this group's decision-making characteristics was the ability to discern and act upon the ethical principles inherent in the case histories. Excerpts from the responses to the case histories by two of these participants will be used to demonstrate the group's characteristics. Participant (A) was guided by ethical principles in all three cases. Participant (B) was guided by ethical principles in Case Histories #1 and #3.

In response to Case History #1, Participant (A) persevered in advocating for Ms. Misfortune's right of self-determination.

I do [take a strong advocacy position]... 'Cause why are [they] in such a hurry to cut a seventy-five year old women who has cancer... I guess it's...a respect for the person... Kind of like the person being responsible for what they want.

In response to Case History #2, Participant (A) cited three ethical principles that influenced his decision-making: the primacy of the clients' interests, confidentiality, and commitment to the employing organization.

I really don't feel good about someone who I am seeing, who is H.I.V. positive, having sex with someone else that it's not discussed... Ethically, I don't agree with it, and I don't think ethically I could sit there and allow them to make a lot of money and kept the A.I.D.S. virus alive and well in the clinic... Because the virus will spread within the clinic... It sounds like...[they] want to maintain confidentiality because [they] want to see more people and make more money.

In response to Case History #3, Participant (A) cited four ethical principles: primacy of clients' interests, responsibility for the quality of service, prevention of discrimination, and commitment to the employing organization. He viewed his obligation to the organization within the context of the delivery of the professional service. When the administration was viewed as not caring about his work, he saw it as indifference to the needs of the clients.

I would want to work for an organization that cares about what I am doing... We are supposed to be working to help people...help themselves...and that is hard work... The other part is the financial part. So it doesn't matter if you help them to do better, we just want you to try to help as many as you can... But there are only a certain amount that we can effectively work with to help them do better, so then you are kind of perpetuating the mental health system... It is like the poor. Only the students work with the poor. All the good ones [social workers] then do private practice, so the poor don't get help....

Participant (A)'s approach to the case histories was similar to Participant (B)'s. In response to Case History #1, Participant (B) cited the principles of self-determination and resistance to pressure as having influenced his decision.

I have strong feelings about this. You are there for the client... I will go back to self-determination and social work values... If employment goes along with the social work...values, then there is no conflict... So I would fight, if it was a client's wish....

In response to Case History #2, Participant (B) relied on a clinical analysis of the situation, rather than on a resolution of the ethical dilemma.

In thinking in terms of confidentiality, what I'm sorting through my head...is the issues of suicide, homicide, child abuse, and imminent danger... It comes down to the danger and the risk. Just like when I am trying to assess someone that is going to harm somebody. I have to assess what is the real severity... If you went truly by the guidelines of confidentiality...there is not imminent danger... I would really [concentrate on] safe sex education and working individually with both of them.

In response to Case History #3, Participant (B) was influenced by the following ethical principles: primacy of clients' interests, responsibility for the quality of service, and commitment to the employing organization. He articulated a strong sense of responsibility for the quality of the service he provides. He began by attempting to mediate the plan for reorganization, but, failing that, felt that a decision had to be made between the needs of the organization, as enunciated by administration, and the obligation to serve his clients with integrity.

I would want to come together as a group in order to open a dialogue where other options could be considered in terms of the financial situation... If...administration was still not open...and was very firm about their decision...it would...come down to...a...decision... Would I be willing to work in a place where I felt they were not providing quality service for financial reasons?... The reason I am here, or in any role that I take, is in the best interest of the client... If I felt that their needs were not being met...I would rather go someplace else where an agency is...in line with my values....

The most striking characteristic of this group is the persistent clarity the participants demonstrated in their recognition of the ethical principles involved in the dilemmas being presented. They recognized the extra-ethical elements that were at work, but they did not permit those elements to cause them to lose track of their professional obligations. As there was no "superprinciple"¹⁶⁷ that could guide their actions in all cases, these participants used their understanding of social work ethics in the way Brandt described as a "living telephone book,"¹⁶⁸ calling on the appropriate ethical principles in the dilemma at hand. This process was easily distinguished from the group of participants who were not guided by ethical principles in either interview.

Participants Not Guided by Ethical Principles in Either Interview

For the group not guided by ethical principles, the extra-ethical elements in the case histories were, of course, most influential, especially that of power. The approach to the dilemmas by this group was characterized by a sense of

¹⁶⁷ Richard Brandt, op. cit., p. 247.

¹⁶⁸ Ibid., p. 247.

helplessness and a constricted view of alternatives. There were numerous attempts at establishing rules that could be applied to the situations, rather than reference to complex principles. The five participants in this group, in response to the three case histories, had eight references to power, six to organizational elements, and three each to clinical and personal elements (see Tables 83, 84, and 85).

Table 83

Extra-Ethical References of Participants Guided by
Ethics in Neither Interview One Nor Interview Two

References	Number of Participants
Ethics	0
Organizational	6
Power	8
Clinical	3
Personal	3

Table 84

Extra-Ethical References of Participants Not Guided by
Ethics in Either Interview One or Interview Two, by Participant

Participant	Case History #1	Case History #2	Case History #3
Part. (A)	Power	Power	Clinical
Part. (B)	Power	Power	Power Organizational
Part. (C)	Organizational	Power Organizational	Organizational
Part. (D)	Personal Power	Clinical	Power
Part. (E)	Personal Organizational	Clinical	Personal Organizational

A noteworthy aspect of this group is that it is composed of four participants from the medical center, and only one from the family service agency (see Table 85). Excerpts from the responses of one medical center participant and the only family service participant in the group will demonstrate how the members of this group dealt with the dilemmas.

Table 85

Number of Participants Not Guided by Ethical
Principles in Either Interview One or
Interview Two, by Agency

Agency	Number of Participants
Medical Center	4
Family Services	1
Total	5

In response to Case History #1, that involving Ms. Misfortune, Participant (A) saw the social work role of advocate as limited by the organizational structure. He referred, as well, to a personal sense of weariness or awkwardness as guiding his decisions.

Knowing the structure of a hospital, it is very difficult for a social worker to supercede a medical professional's judgement. My first reaction would be...to speak to the doctor again...and then...go to my supervisor and discuss the matter with him or her... Then I would discuss it with my colleagues... There is always safety or power in numbers... Am I that ambitious to do that?... It depends on how strongly I felt. Right now I'm not [strong]....

Participant (A) viewed Case History #2, that involving Ms. Ivy and Mr. Clean, as a clinical problem, analogous to marital therapy.

I have...taken this oath to uphold confidentiality... If somebody is in danger of harming themselves or harming others...that is the only time you are supposed to breach... It's like a...wife calls up and says 'I have a marital problem, I want to discuss it with you... I don't know if [my husband] will come'... So you to see her alone. She tells you everything about the affairs...and he's not to know. So immediately you're stuck with the secret and you know from there on whatever therapy you are going to do with this couple is out the window, unless you say at the outset don't tell me any secrets....

Finally, in response to Case History #3, the administrative directive to increase productivity, Participant (A) looked at organizational alternatives, and ultimately based his decision on his personal issues.

There are...things...[that can be changed] like dictation...[and] how many minutes in a session... I would love to run groups, but I know that we charge less for a group...so [it] wouldn't even meet the cost... The social workers could make an effort to do more...[but then] there is a risk of burn-out... You have a choice, you try to...adapt or you leave... [I base my decision on] how stressed I am feeling at work or personally, or what my other goals are in life....

Participant (B)'s response to Case History #1 is strikingly similar to Participant (A)'s in its view of the power given to the physician.

What is comes down to is...the futility or the lack of futility of [advocating]... The reality of the situation...is the doctor...makes the decision... If ultimately I was unable to change the decision...I would...change the focus...with the patient...to make this really odious idea more palatable.

In response to Case History #2, Participant (A) was guided by established marital therapy techniques. In like

fashion, Participant (B) looked for established organizational policy to guide his decision.

I think I would speak to other workers... This is a really overwhelming situation to handle... I would probably go to [supervising director] and [administrative director], and the legal person... I'm looking for some sort of policy to guide my decision....

Participant (B) noted the organizational elements in Case History #3, but was primarily influenced by administration's threat to lay off workers, as was Participant (A).

The bottom line is that people want to keep their jobs...and I don't want to lose my job... It is very real... We have had two layoffs and we are over-worked... In the short run, I would go along with it. I don't want to lose my job....

This group of participants looked for rules to give "direction and purpose to [their] action;"¹⁶⁹ failing that, they perceived the power of those around them to be decisive, or simply felt personally helpless in having an impact on the situation.

Why was this characteristic more prevalent in medical center participants? One explanation, consistent with the literature review's findings, is that working in a large bureaucratic organization effects participants' ability to see and respond to alternative ways of decision-making. More than in their smaller counterparts, large bureaucracies foster

¹⁶⁹ Lewis, The Intellectual Base of Social Work Practice, op. cit., p. 42.

constraint in decision-making, through the use of layers of policies and procedures, all within the context of long tables of organization. The ultimate seats of power in these organizations are distant and mysterious. The apparent lack of access to the sources of power, and the ubiquitous evidence of their existence, have the effect of diminishing the confidence of professionals in their values, and turning them to the rules generated by the organization. The results of the extension of this process were demonstrated by Milgram (see Literature Review), in dramatic fashion.

Participants Guided by Ethical Principles in Interview One Exclusively

This group of five participants is composed of three from the family service agency and two from the medical center. As Interview One had two case histories, the group is composed of participants who were guided by ethical principles in response to either of the two case histories. Three of the participants, in fact, were guided by ethical principles in their responses to both case histories, while two participants were influenced by organizational elements in the first case history. Of course, none of these participants were guided by ethical principles in Interview Two, Case History #3. The frequency of references to all elements in the three case

histories were as follows: eight references to ethical principles, six references to organizational elements, three references to personal issues, and one reference to power and compliance (see Tables 86, 87 and 88).

Table 86

Ethical and Extra-Ethical References of Participants
Guided by Ethics in Interview One Only

Reference	Number of Participants
Ethics	8
Organizational	6
Power	1
Clinical	0
Personal	3

Table 87

Number of Participants Guided by Ethical Principles in
Interview One Exclusively, by Agency

Agency	Number of Participants
Medical Center	2
Family Services	3
Total	5

Table 88

Ethical and Extra-Ethical References of Participants Guided by
Ethical Principles in Interview One Exclusively

Participant	Case History #1	Case History #2	Case History #3
Part. (A)	Ethical	Ethical	Organizational
Part. (B)	Ethical	Ethical	Personal Power
Part. (C)	Ethical	Ethical	Organizational Personal
Part. (D)	Organizational Power	Ethical	Organizational
Part. (E)	Organizational	Ethical	Personal Organizational

The obvious conundrum in this group is that the participants who were able to discern and base their analyses of at least one of the case histories in Interview One on ethical principles, appeared to lose this ability one month later when confronted with Case History #3. On the face of this finding, awareness of ethical principles, and their influence, would appear to have decreased after Interview One. Examining the responses of Participant (A), characteristic of this group, suggests some explanations for this phenomenon.^{SA} Participant (A) moved from Interview One to Interview Two, his ability to make ethically informed decisions about the dilemmas in the case histories became hampered.

In Case History #1, Participant (A) referred to the principles of self-determination and resistance to the pressures of the physician in charge of Ms. Misfortune's medical care.

You have your ethics and you've done what...you know is right...but then you get 'God' speaking to you in the form of a doctor... I think in a situation like this, if people are forceful enough...some period of time would be provided... I feel that I am doing something I believe in...based on my trust in the social work profession... I would [advocate].

In Case History #2, Participant (A) recognized the dilemma between his professional obligation to Mr. C.'s interests, and an obligation to Ms. Ivy's right to privacy. He ordered the principles involved.

I could tell him...to prevent him from getting this illness... I think this is really an exception to confidentiality, that a person's life is at risk... If it was something less serious that would not threaten his life, then I guess I would live with it. But I couldn't live with this.

In his response to Case History #3, Participant (A) demonstrates a shift in thinking, from a primary reference to ethical principles, to a response based on power and personal elements. Although he perceived the ethical dilemma between the commitment to the organization and his responsibility for the quality of his service, he was guided in his decision by a personal need to work and the threat of loss of employment.

I would probably do what they want... I am doing it in reality...because I have to work. But what is really suffering is the quality of the work... It is quality of service or the survival of the agency... I have...a personal need [to work] so now I have to do groups... That is what I would do... It's all too real....

As discussed in Chapter Four, most of the participants in the entire sample noted how close to home Case History #3 hit. Many of them, in fact, responded to elements present in their own experience but absent from the text of the case history itself. The case history was designed without specifics to allow for maximum interpretation by the participants. As both agencies were either undergoing, or had undergone, situations similar to that described in Case History #3, the participants readily brought their own experiences to their responses.

Because of the familiarity to recent events at their agencies, the participants' responses to Case History #3 might have been qualitatively different from the responses to the previous two case histories.

As noted in the discussion earlier in this chapter of the reconstructions of dilemmas, there is a difference between awareness of ethical elements and action based on that awareness. The responses of this group of participants in Interview One demonstrated an awareness of ethical principles, and a desire to practice within the obligations of those principles.

Two possible explanations for the diminution of reliance on ethical principles by this group of participants in Interview Two present themselves. First, it is possible that this group was able to establish a safe "theoretical" distance from the situations in Case Histories #1 and #2, allowing them to maintain a cognitive grasp of the ethical principles, and a commitment to the professional obligations inherent in the first two situations. Because of the direct relevance of Case History #3, this safe distance was removed, and whatever cognitive grasp and professional commitment was demonstrated during Interview One fled in the face of day-to-day reality.

A second explanation, closely related to the first, is that the organizational instability present at both agencies, the forced resignation at the family service agency and the

layoffs at the medical center, had had a general effect of impairing these participants' ability to discern and commit themselves to the ethical obligations inherent in Case History #3.

No matter how this finding is viewed, it clearly demonstrates the impact that organizational constraints and power can have on the behavior of agency social workers, even those with the best of intentions. To re-cite Michels' observation: "... people of good will with liberal values become transformed, through institutional processes that sociologists are adept at studying, into people who compromise their original goals ... in the interest of preserving their own position."¹⁷⁰

Participants Guided by Ethical Principles in Interview Two Exclusively

This group of five participants had referred to extra-ethical elements in Case Histories #1 and #2 to address the dilemmas posed in Interview One, but were guided by the ethical principles in Case History #3 to resolve its dilemma. Of the five participants, two were from the medical center and three were from the family service agency. The frequency with which these participants referred to all elements of the three

¹⁷⁰ Perrow, op. cit., Complex Organizations, p. 170.

case histories were: five references to ethical principles, two references to organizational elements, two references to issues of power, seven references to clinical elements, and one reference to personal issues (see Table 89, 90, 91).

Table 89

Number of Participants Guided by Ethical Principles in Interview Two Exclusively, by Agency

Agency	Number of Participants
Medical Center	2
Family Services	3
Total	5

Table 90

Ethical and Extra-Ethical References of Participants Guided by Ethical Principles in Interview One Only

References	Number of Participants
Ethics	5
Organizational	2
Power	2
Clinical	7
Personal	1

Table 91

Ethical and Extra-Ethical References of Participants
Guided by Ethical Principles in Interview One Exclusively,
by Participant

Participant	Case History #1	Case History #2	Case History #3
Part. (A)	Power	Clinical	Ethical
Part. (B)	Personal Organizational	Clinical	Ethical
Part. (C)	Organizational	Clinical Power	Ethical
Part. (D)	Clinical	Clinical	Ethical
Part. (E)	Clinical	Clinical	Ethical

Except for Case History #1, in which the two medical center participants referred to clinical elements in their decision-making while the family service participants referred to organizational and power elements, the pattern of responses from both sets of participants was similar. Excerpts from the responses of two of the participants, one from the medical center and one from the family service agency, will demonstrate this group's characteristic approach to the dilemmas.

Participant (A) maintained a position of advocacy for Ms. Misfortune's right to decide whether or not to have surgery.

His position was based on the clinical presentation of the case, rather than on an ethical obligation.

I think you need to know what the patient was thinking..., how the patient defines the problem. It's not my problem, it's their problem... So...the first step before you come to a solution is to explore... It is a more psychoanalytic approach....

In response to Case History #2, Participants (A) again relied on clinical expertise to inform his actions. He judged that Mr. Clean should, or did, know his risks in the situation, and therefore had the responsibility to use the assumed knowledge in whatever way he chose.

I would...just discuss safe sex with them. I don't feel that you can do more than that. You can't get into [their] bed. You can't insist that they use condoms... They already have all the facts... If they want to sleep together and get A.I.D.S., as horrible as I think that is...my clinical training tells me that I don't make the ultimate decisions....

In Case History #3, Participant (A) referred to the following ethical obligations: responsibility for the quality of service, resistance to pressure, maintaining conditions of competence, and commitment to the employing organization. He recognized the dilemma posed by the threat to the agency on the one hand, and the threat to the quality of service on the other hand. He felt strongly that there needed to be resistance to a precipitous reorganization, and sought a role for the social workers in defining any changes in the services offered by the agency.

Social workers have to be aware of the fact that institutions have financial problems. It shouldn't be taken lightly, but I think they can participate in the change... There have been...techniques developed of which [administration] are clearly not ready to discuss. So there's just a lot of animosity... There's a point where you have to save...the program, and it may mean that people [suffer]... I don't think putting people on a waiting list...is theoretically or technically wrong, but I think it's not good service to force people to do work they can't possibly do... I'd rather wait and give them the service they deserve than give them half-assed s--t... It's a constant battle. And you have to know...how far you're gonna go....

Except for Case History #1, Participant (B)'s references were almost identical to Participant (A)'s. In Case History #1, Participant (B) felt his actions to be limited by organizational constraints and personal preferences, unlike Participant (A) who offered a clinical resolution to the dilemma.

I know that a social worker in a...hospital is low man on the totem pole... I have to understand what my own feelings are... Do I feel comfortable with the [advocate] role... Advocacy is so difficult because you really have to believe in what you are doing... I wouldn't want to be ostracized....

In response to Case History #2, both Participants (A) and (B) relied on clinical expertise to inform their actions.

First...the line of questioning I would ask would be clinical... It's a process... The end part of that would be to try to get her in a position for her to tell him... I would talk to him...in a clinical way... I can't follow him around twenty-four hours a day... He now has the information and it's up to him what he does with it.

In Case History #3, Participant (B), as Participant (A), attempted to establish a dialogue with the administration

regarding the reorganization, and raised similar questions about its impact. He also questioned the effect such a reorganization might have on his ability to function with his clients, and on his integrity. He referred to the ethical obligations of primacy of clients' interests, responsibility for the quality of service, and commitment to the employing organization.

First,...there's an institution...in financial difficulty... An organization like this is trying to get more [funds] to service more [clients]... The workers should get some explanation about...what efforts were made by the institution to generate income... Open up a dialogue... Will this thirty percent increase in productivity really be so taxing?... How are the clients going to be affected?... If it really came to that I was so stressed that my thinking became impaired, or I was missing important things...then I would have to rethink staying...because of my professional integrity....

Reviewing this group's responses to the case histories in Interview One indicates a characteristic preference towards a clinical approach. Notable in Case History #1, however, is that the two family service participants were influenced by organizational and power issues, while the medical center participants used a clinical approach. This may be explained by the family service participants' unfamiliarity with working in large medical settings. Several family service participants expressed a view of the medical center as a daunting, leviathan-like structure in which social workers are lost. The medical center participants, having familiarity with the workings of such an institution, were less impressed

with the organizational structure, and relied on their characteristic clinical approach to this case.

What explains this group's move from resolution of Case Histories #1 and #2 through clinical techniques, to an ethical analysis of Case History #3 in Interview Two? It is possible that the experience of Interview One had heightened this group's awareness of ethical elements in practice. It is also possible that the clinical approach was less viable in Case History #3, as the dilemma did not specify any particular clients or staff, and had a strong organizational component. Because the dilemma in Case History #3 was not really resolvable through clinical interventions, these participants had to call on other means. This group demonstrated, for the most part, in Interview One, an absence of reaction to organizational and power elements in the cases. They were not moved by the threats of Ms. Ivy's family and the clinic's administration in Case History #2. In Case History #3, therefore, without a clear clinical strategy to utilize, they were able to resist the influence of the organizational/power elements enough to analyze the situation as an ethical dilemma, and act accordingly.

Improvements In the Research Design

Case History #1 was designed to set in opposition the ethical obligations to the client (Ms. Misfortune) and the medical center. None of the participants perceived an obligation to the employing medical center. All of the participants began their responses to this case by advocating for Ms. M., and many remained undeterred throughout their responses. None of the participants, however, perceived the potential negative consequences to the medical center of such prolonged processes taking place generally. Although the text of the dilemma made reference to the issue of resource scarcity, it appears, in retrospect, that not enough emphasis was placed on this element to establish a conflict in the minds of the participants. Because the purpose of the case histories was to examine participants' responses to ethical dilemmas, the imperceptibility of this dilemma to them posed a problem in the reliability of this part of the design.

This problem could be addressed by greater emphasis of the issue of Diagnostic Related Groupings, and embellishment of the shortage of hospital beds in the community, the back-up of patients in the emergency room, and the fiscal problems of the medical center. Additionally, the question at the end

of Case History #1 can be rephrased from "what, if any, role does the social worker have in advocating for Ms. M.'s assertion that she does not wish to have surgery?" to "what obligation(s), if any, does the social worker have to Ms. M. and to the medical center?"

Case History #3 also was designed to set in opposition the commitment to the employing organization with one or more other ethical obligations. Not many of the participants clearly assumed an obligation to the organization, although references to this principle were implied in their responses. The design of this case might be improved by changing the question at the end from "what is your thinking about this situation?" to "articulate what, if any, obligations do you have in this situation?"

Aside from these issues, the overall design appeared to function quite well for its purpose.

Findings and Implications

This dissertation proposed to study the degree to which agency social workers were aware of, and able to use, the ethical principles of the profession, in resolving on-the-job ethical dilemmas. It also proposed to study the impact of various extra-ethical elements normally found in agency social work on the decision-making of agency social workers

confronted with ethical dilemmas. Furthermore, the study intended to determine whether awareness of ethical dilemmas and ethical principles would be effected by exposure to the research design.

The operant definition of "ethical dilemma" in this dissertation is a demanding one; as such, prior to presenting the major findings, another examination of this definition seems warranted.

Meeting the operant definition of an ethical dilemma required participants to reconstruct situations in which the author could identify two or more ethical principles in conflict. The case histories developed by the author were designed with two or more ethical principles in conflict, as well as with extra-ethical elements, all of which were available to the participants for reference.

It should be noted that there is a difference between an unethical situation and an ethical dilemma. Situations in which social workers' actions violate a principle in the Code of Ethics can be considered unethical. Not hiring job applicants on the basis of race, age, religion, or gender, for example, are situations that can be viewed as unethical. One could, of course, create scenarios in which these actions might be mitigated by circumstances rendering the actions within the ethical boundaries of the Code of Ethics, but the actions in isolation are, per se, unethical actions.

An ethical dilemma, however, is a situation in which two or more ethical principles in the Code of Ethics are in conflict, and where a response is required that must honor one or more principles at the expense of one or more other principles.

The author believes that the distinction between these two kinds of situations is important in understanding how agency practitioners make decisions when dealing with ethical material. Although dealing with an unethical situation can cause personal discomfort, and may even be quite painful, managing an ethical dilemma requires of the practitioner a cognitive sophistication and stamina not necessarily a prerequisite for a response to unethical practices.

Because of this, the management of ethical dilemmas is a professional task to which professional education can, and in the author's opinion, must be addressed.

Major Finding of the Reconstructions

Heightened Awareness of Ethical Dilemmas or Ethical Principles

In Interview One, seven participants (thirty-five percent) reconstructed ethical dilemmas. In Interview Two, five participants (twenty-five percent) reconstructed ethical dilemmas. This decrease between interviews was primarily reflected in the responses of the family service participants.

It is the author's opinion that the decrease in the number of reconstruction of ethical dilemmas by the participants at the family service agency was due to the organizational context of disruption occurring there. This interpretation is supported by the literature which points to the impact of organizational style on the decision-making of employees.

Although there was a decrease in the number of participants reconstructing ethical dilemmas between Interviews One and Two, all five participants who reconstructed ethical dilemmas in Interview Two recognized the ethical obligations in those dilemmas. Only three of the seven participants who reconstructed ethical dilemmas in Interview One recognized the ethical obligations inherent in those dilemmas.

This finding suggests a greater awareness of ethical principles was achieved through exposure to the research design. It should be restated that little if any relationship existed between the ability of participants to reconstruct ethical dilemmas and the ability to identify and apply the ethical elements in the case histories. Stated another way, social workers can be aware of ethical dilemmas, but base their actions on considerations apart from ethical principles.

The author sees this phenomenon as suggesting there is a multi-step process which begins with awareness and moves towards behavioral change. Awareness without concomitant

action is not uncommon to the social work practitioner. Many clients request help for destructive or self-destructive behaviors without a clue of how to change those behaviors.

Time Lapse

In the first interview, eight of the twenty participants (forty percent) reconstructed situations that had occurred more than one month prior to the interview. In the second interview, only two of the participants (ten percent) reconstructed situations that had occurred more than one month previous. This finding suggests a sensitization to issues understood to have ethical content from the first interview that was reflected in the second interview.

Ethical Dilemmas and Organizations

In the first interview, seven of the seven ethical dilemmas presented (one hundred percent) involved an organizational component. In the second interview, three of the five dilemmas (sixty percent), involved an organizational component. This finding supports the reference in the introduction to the uneasy relationship between agency social workers and their employing organizations.

The family service participants showed a diminished frequency of references to organizational elements in their reconstructions (either ethical or extra-ethical) from the first to the second interviews. Sixty percent of the family service participants referred to organizational elements in their reconstructions in the first interview, while only thirty-three percent of the family service participants referred to organizational elements in their reconstructions in the second interview.

The implication of this finding is that the disruption at the family service agency not only impaired these participants' ability to reconstruct ethical dilemmas of any kind, but also appeared to have a chilling effect on their ability to refer to the organization in any context.

Case Histories

Frequency of Ethical References

In Interview One, two case histories were presented. Ten participants were guided by ethical principles in Case Histories #1 and #2 combined. In Interview Two, only one case history was presented. Ten participants were guided by the ethical principles in Case History #3.

Although the frequency of reference to the ethical principles between the two interviews remained the same, these responses were more concentrated in the second interview. There was progressive growth in the number of participants who cited ethical principles as guiding them to resolutions of the case histories. Thirty five percent were informed by ethics in Case History #1; forty percent were informed by ethics in Case History #2; fifty percent were informed by ethics in Case History #3.

The implication is that heightened awareness of ethical principles resulting from Interview One had a residual impact on participants' ability to make decisions on ethical dilemmas in Interview Two.

Frequency of Extra-Ethical References

The group of participants who were not guided by ethical principles in either interview exhibited the greatest likelihood of being influenced by issues of power and compliance in their decision-making. The implication of this finding is that, in the absence of ethically informed practice, agency social workers are more vulnerable to the power wielded by others in the organization in making decisions.

Relationship Between the Family Service Agency and the Medical Center

Case Histories #1, #2, and #3 found little difference between the responses of the participants from the medical center and the family service agency, either in the numbers of participants who perceived an ethical dilemma, or in their perception of the ethical principles in the cases.

This finding speaks to the similarities in the contextual issues within the two agencies. Although the family service agency is a small social work agency, the type of problems that were manifest, and the manner in which they were managed, was similar in style to that of a large bureaucratic organization like the medical center.

Relationship Between Outcome and Ethical References

Case History #1

There was a statistically significant relationship ($p < .0005$) between the decision whether or not to continue to advocate for Ms. M. and participants' references to ethical principles or extra-ethical elements.

In Case History #1, all seven participants who were informed by ethical principles in arriving at a decision,

persevered in advocating for Ms. M. Of the thirteen participants who were not primarily informed by ethics, ten relented in advocating and only three persevered.

Case History #2

There was a statically significant relationship ($p < .00003$) between participants who relied on ethical principles and informed Mr. C., and participants who did not rely on ethical principles and did not inform Mr. C. Of the eight participants who relied on ethical principles, seven informed Mr. C. of Ms. Ivy's condition, and one was undecided. Of the twelve who did not rely on ethical principles to come to a decision, eleven did not inform Mr. C., and one was undecided.

Case History #3

In a like fashion, there was a statically significant relationship ($p < .003$) between participants who relied on ethical principles and contested the administrative directive and participants who did not rely on ethical principles and did not contest the directive. Nine of the ten participants citing conflicting ethical principles in their responses to

Case History #3 stated they would have contested the administrative directive. In contrast, of the ten participants who were primarily informed by extra-ethical issues during their analyses of the case, four would have followed the administrative directive, two would have contested the directive, and four were uncertain of whether or not they would have followed the directive.

These findings suggest that social workers who are aware of ethical principles are more likely to resist organizational pressures on their professional discretion and decisions than are social workers who are not aware of ethical principles.

A reasonable explanation for these findings is that those participants who felt they could rely on ethical principles to decide their actions were better able to withstand the extra-ethical elements that opposed their positions, while those participants who were informed by those extra-ethical elements were less likely to maintain an ethically informed position.

In each case history, the available number of extra-ethical references was greater than the available number of ethical principles to be cited. In Case History #1, the number of elements in opposition to maintaining an advocacy position for Ms. M. was greater than the number supporting that position. In Case History #2, the number of elements in opposition to informing Mr. C. was greater than the number of

ethical principles supporting informing Mr. C. In Case History #3, the number of elements in support of the administrative directive was greater than the number opposing the directive.

In the absence of ethically informed influences, social work practitioners tend to be reliant on organizational rules and/or therapeutic techniques.

Implications

The Code of Ethics

The research findings indicate that there is a major distinction between the practice of social workers who rely on rules as compared to social workers who rely on ethical principles. Because rules aim at simplifying situations and rendering prescribed actions, while principles aim at recognizing and organizing the complex phenomena (inclusive of values) in situations, reliance on rules is more facile and less time-consuming than reliance on principles. When faced with the complexity of an ethical dilemma, however, the use of rules tends to distort reality in order to yield a simplified response.

As the profession of social work moves with other professions towards specialization and technological

enhancement, and schools of social work develop concentrations in industrial, psychiatric, medical, psychoanalytic, family, and various other forms of practice, the only force that binds social work practitioners to the profession is the value base enunciated in the Code of Ethics. In order to continue as a profession, social workers must practice within defined limits. The Code of Ethics presents and endorses limits to practice. The Code of Ethics links social work practitioners to their historical roots. A practice devoid of ethical principles, guided solely by technique, is not a social work practice.

The research undertaken by this dissertation has demonstrated that the Code of Ethics is an accessible resource for practitioners. Half of the participants used its principles as a guide to the analysis of difficult ethical dilemmas. The problem, as noted in the introduction to the dissertation, is the gap between the Code and its implementation. Although the author believes that certain principles require more precise language, like that of the principle of commitment to employing organizations, the issue that the author believes is most pressing is for the profession to infuse the values represented in the Code into the education and practice of the professional constituency. The National Association of Social Workers, the unifying body for the profession, has a vital and urgent role in this

process. The Code of Ethics should be a living part of professional life, rather than an historical artifact.

The Social Worker in the Organization

Of the twelve ethical dilemmas reconstructed in both interviews, seven had an organizational component (fifty-eight percent). In the responses to the case histories, it was difficult for the participants to articulate any obligation to the employing organization. The organization was generally seen as something that the social worker either had to resist, or had to succumb to. For many of the participants, the organization acted to constrict their cognitive abilities and undermine their professional obligations. Although the author discussed organizational constraints and power heuristically, the participants blended these elements, giving to the organization power not necessarily inherent in it from the texts of the case histories.

These findings all suggest that agency social workers indeed have an uneasy relationship with their employers. The recent layoffs at the medical center and the upheavals at the family service agency offered ample evidence of this finding, apart from the responses to the research.

Although many of the participants felt resigned and helpless when dealing with organizational constraints, several demonstrated that ethically informed positions taken in response to these constraints can support the agency social worker, and, consequently, can support the provision of quality social work services to clients.

In fact, because responsibility for services to clients is the primary principle in the Code of Ethics, there is a confluence between ethically informed practice in agencies and advocacy for services to clients. Such advocacy, of course, must take place within the context of other ethical obligations, and with an understanding of the forces that may be summoned in opposition to it. As several participants noted in response to Case History #3, it is not the survival of social service agencies per se that is the compelling issue; rather, it is the survival of the intended functions of these agencies in behalf of clients that is at stake. Those participants who responded to the organizational directives and the threats to employment as the central feature of Case History #3, were unable to either discern, or act on the ethical dilemma. They experienced a sense of fear and despair. Those who recognized the threat to services for clients were far more apt to see the dilemma and act in a principled way to assure the quality of their services to their clients.

A plausible forum for addressing these concerns is an ethics committee, either organization-wide or departmentally based, that could both act as an ongoing educational component for staff, as well as offering a vehicle for the analysis of questions brought by staff, where ethics are the essence of the questions being raised. Such a forum, by dint of its mere existence, would heighten the awareness of staff to ethical concerns, and, by its accessibility, would permit discourse about issues which would otherwise have no convenient structure for examination. This type of function parallels that of quality assurance committees that are currently required in most, if not all, human service agencies, and might dovetail quite well with such committees.

The Education of Social Workers: Awareness of and Reliance on Ethics

This study found evidence of greater awareness of the ethical elements of practice through the process of attempting to reconstruct and to resolve ethical dilemmas. This heightened awareness was not accompanied by a greater ability to make decisions based on the ethical content of the dilemmas. The author believes that heightened awareness may be the beginning step in the educational process whose end is the application of this awareness in practice.

An ideal format for the education of social workers toward the practical application of ethical principles would combine a thorough review of the Code of Ethics, a study of the frameworks devised for the analysis of ethical dilemmas, an understanding of organizational and power elements that influence the practice situation, and exercises recognizing and working through ethical dilemmas. These four components are necessary in combination to be effective.

A review of the Code of Ethics alone does not create the ability to use the ethical principles in practice situations. As noted in the introduction of this dissertation, a gap appears to exist between the profession's stated policy, as reflected in the Code of Ethics, and its implementation. The research undertaken revealed that awareness of ethical principles does not assure their implementation.

The study of frameworks alone would degenerate into a search for rules of behavior, rather than creating an ability to analyze complex dilemmas. As the research evidenced, many agency social workers seek rules, policies, procedures, and techniques to simplify the complex situations that occur in practice. The use of frameworks is helpful only when the situation being addressed is understood in the fullness of its complexity.

Understanding organizations and power in isolation is a sociological enterprise unless it is seen through a context

of professional values. Because ethical practice does not take place in a vacuum, and because social work continues to have a strong agency commitment, it is advisable that agency social workers should be aware of the impact of organizational and power elements on practice situations. The ability to discern these elements would render agency social workers less likely to be victimized by what may appear to the untrained eye to be omnipotent and inaccessible forces.

Exercises recognizing and working through ethical dilemmas cannot be undertaken meaningfully without first learning the principles involved, the other forces at work in the practice arena, and the work of social work scholars in the application of these principles.

The Future of Agency Social Work

The research undertaken in this dissertation supports the statement in the introduction that although the mission of the social work profession is historically rooted in agency services, there is evidence that the relationship between the social work profession and employing agencies has become increasingly uneasy. As agencies that employ social workers experience ongoing resource scarcity, and as American society moves further away from its commitment to its poor, sick, and disabled members, agency social work will be marked by more

intense social and organizational constraints. Pressures will continue to go up, and salaries, relative to other professions, will continue to decline.

Simultaneous with, and as a consequence of these above forces, is the movement of the social work profession, its schools and practitioners, to the arena of private clinical practice. Karger's letter to Social Work, November, 1989, describes this phenomenon.

This rash of private practice-oriented students has occurred for two reasons. First, students who choose social work as a vehicle for private practice represent the informed consumer. They have shopped around and know that social work is a fast and legitimate avenue to private practice in psychotherapy... The second reason for the upsurge in private practice-oriented students is the profession itself. Desperate for students in the enrollment trough of the early 1980's, social work educators were forced to respond to the pressures of the marketplace. Because of the demands of students-most of whom want to practice psychotherapy-we have changed our orientation. For example, many-if not most-of the advertised social work faculty jobs are to teach clinical skills. Social policy, which is a requirement of the Council on Social Work Education (CSWE), is tolerated by many schools of social work. Students reluctantly take these courses and faculty are reluctantly hired to teach these courses. Besides, what use is social policy in developing a private practice in psychotherapy? Wouldn't a course in accounting principles be more relevant?... The profession of social work is at cross purposes with itself: We argue that we have a historic mission to help the poor, yet we focus our resources and energy in providing a clinical track to train private practice social workers.¹⁴⁸

¹⁴⁸ Howard Jacob Karger, "Private Practice: The Fast Track to the Shingle," Social Work, volume 34, no. 6 (November 1989), p. 566.

Karger does not mention the plight of the social workers engaged in agency practice, although they may be regarded as "misinformed consumers." If social policy courses are irrelevant to private practice students, the study of ethics must be equally irrelevant. After all, "doctors turn away clients who can't afford to pay, so why should social workers be held to higher standards than other professions?"¹⁴⁹

As a consequence of the push toward private clinical practice, and the concurrent impact on curricula of the schools of social work, one can reasonably expect a de-emphasis of the study of "irrelevant" subjects. More and more course content will fall into the "zone of moral indifference" described by Loewenberg and Dolgoff. Those graduates who enter agency practice will be less able to practice ethically, in organizations that will be ever more hostile to the humanitarian values of the profession. As one of the participants observed: "Bad service always drives out good service."

¹⁴⁹ Ibid.

CHAPTER SIX

Participants' Feedback

At the end of Interview Two, the participants were asked the following questions:

- (1) Did you think about the research interview within the past month?
- (2) If yes, what did you specifically think about?
- (3) Do you believe there has been any impact from the research interview?
- (4) If yes, how would you describe the impact?
- (5) How would you describe the research interviews?
- (6) If you had the opportunity to change your responses in the first interview, would you?

Eighteen of the twenty participants thought about the research interview process during the time lapse between the two interviews. Of the eighteen, six participants considered the process a self-evaluative experience during which they had the opportunity to explore their decision-making processes. Six participants thought about how the research interview helped to heighten their awareness of ethical issues. Five participants thought about the content matter of Interview

One, and the feelings evoked by it, during the intervening month (see Table).

Table 92
Feedback on the Research Process

Response	Number
Exploration of Decision- Making	6
Heightened Awareness	6
Contents of Interview One	6
Did Not Think About Interview	2
Total	20

Exploration of Decision-Making

During the time lapse between Interviews One and Two, six participants considered the benefits of exploring their decision-making processes. Of these six, three participants discussed the general benefits, such as:

"Stating how I arrive at decisions was really good for me;"
and,

"It was really helpful to know how I make decisions."

The other three related the research interview to a supervisory process.

It was good. I hadn't had to think that way. They should do that for...regulating licensing... It was like a check-up....

I talked about this in my supervision... I told her [my supervisor] that it was helpful to me. It is what I think supervision could be more like.

I thought about how unconscious you can be about making decisions... I don't get supervision like that... You were coming to me in a non-judgmental way. You were not interested in the result, but how I got to the result and that makes you step back. I find that very useful.

Heightened Awareness of Ethical Issues

Six participants thought about the research process as heightening their awareness of ethics. The following vignettes demonstrate this response.

During the past few weeks I thought about how ethics is an overlay to my practice.

I thought about hospital ethics and H.I.V. status... I've been following it in the news... It is an issue I'm interested in.

I was thinking since we have talked, how much I have noticed about ethics in the newspaper. I wouldn't have thought I was concerned about ethics until we talked.

We make ethical decisions all the time and there are a lot that are more subtle than the big ones. I have more awareness, in working with clients....

Contents of Interview One

When asked to recall if and what they thought about Interview One, six participants discussed the content of the reconstructions and, or the case histories, as well as the feelings that were evoked through the process.

I thought about the H.I.V. [case] because I was so torn about it. I don't remember what I thought about... I thought you had good questions....

I thought that you had your case histories well picked. They are cases I really come across.

The interview brought it all back... The pain and discomfort [my ethical dilemma] caused me.

I was most disturbed about the situation with the woman in the hospital. The case kept coming back to me.

Such a positive, challenging and stimulating experience.

Impact of Interview Process

Seventeen participants believed that there was some impact from the research interview process. Two participants described the impact as an improvement in their ability to think for themselves and defend their positions. Five participants described themselves as more aware of their decision-making processes. Ten participants believed they

were more aware of ethics. Three participants reported no impact from the research interview process.

Table 93
Impact of Interview Process

Response	Number
Improved Ability to Think for Myself	3
More Awareness of My Decision-Making Process	4
More Awareness of Ethics	6
No Impact	2
Total	15

Improved Ability to Think for Myself

Three participants reported an improved ability to make decisions, and to stick by the decisions they make.

I think it pointed out thinking for myself. Maybe my way of doing things is not bad... I have matured in the field.

I am easily persuaded. I am subject to influence. I think possibly that having talked to you helped me to stand my own ground... I thought we got strength from what we talked about.

It feels good...to know that I make a decision... I know there is an end in sight. I feel less anxious about it. I feel clearer... When you make a decision...you are in control of your actions... You don't feel as overwhelmed.

More Awareness of My Decision-Making Process

Four participants discussed the impact of the research process on their awareness of their decision-making.

I have always appreciated ethical types of questions. I think I have to act more. Looking at my responses had an impact. It was quick therapy.

It made me more aware of the process I use because I never thought about it.

It has got me to think about how I make decisions. It gave me some reflective moments... I think if you know the mechanics of why you do something, you can learn more about yourself... If you stop growing, you stagnate.

It is a way I can think about things in the future. You reminded me to be more thoughtful about the process of how I come to a decision. [Knowing the process] helps you make a decision and be more clear....

More Aware of Ethics

Ten participants thought the research interview process had an impact on their awareness of ethics in general, and in their day-to-day work.

The P.B.S. series on ethics and this has got me thinking more about ethics.

One of the things that came up was the importance of continuing to think about ethics, because sometimes we don't think through ethical issues.

It will let my sense of ethics stay in the forefront.

It brought [ethics] back to the forefront.

I am more aware of ethics and...ethical situations... Of course they are all over the place. [The interview] made me more aware that problems are often ethical problems.

Four participants applied this sense of awareness to their work.

I'm thinking about [ethics] more... On a day-to-day basis, there are so many demands and counter demands that it is sometimes easy to forget... I 'm much more clear about responsibility.

The questions that were asked, and the challenge of trying to make decisions...made me think...about my responsibility as a social worker. When we are in school, and when we start working, we get involved with the routine administrative issues, and you really lose touch with what you learn, and don't question issues anymore.

I think I am being more aware as I work with clients. I have been asking myself more questions then I generally do.

My ethics are fading away to what is best for me personally. I am trying to thing about what I could have done to have been more effective....

Description of Interview Process

Five participants responded to this question by discussing how they felt during the research interview, seven discussed the contents of the interview, and eight discussed how the interview helped them in self-evaluation.

Table 94
Description of Interview

Response	Number
Feelings	6
Content	6
Helpful in Self-Evaluation	8
Total	20

Feelings

Four participants reported positive feelings about the interview process.

I felt comfortable. I didn't feel pressured, but it made me think.

You made me have to think. It was mitigated by the fact that I liked you, so I could tolerate that you were making me use my brain.

They [the interviews] were like a treat, to have time to set aside to discuss ethical situations. You don't get that much of an opportunity to do this... It was nice to think aloud... You didn't need to have the answer... It was freeing.

I found it to be a relentless pursuit of me to clarify my position, and I like that... I felt it was easy to talk to you.

One participant was particularly uncomfortable with the first interview.

I didn't feel prepared for the interview. Did she [the researcher] expect me to have an ethical dilemma at my finger tips?

Content

Six participants described the research interview in terms of its contents.

Interesting and extremely valuable. I am looking forward to seeing your results.

Well done, organized, thorough questions. Thought provoking. Professional.

Thought provoking. The organization of it was helpful. The way you organized it, you think from reality to the abstract, and I like that. The case vignettes were equally as intense.

I think you are an excellent interviewer... [It was] stimulating and interesting.

Interesting.

I think you could make it harder. There are other questions you could ask about how people arrived at what they did.

Helpfulness in Self-Evaluation

Eight participants described the interview as being helpful in building their self-awareness.

It was difficult, but meaningful...for [my] own improvement.

Interesting, helpful, useful. It has lasted since the last interview....

Challenging [and] stimulating. It is a brave thing to do, in that you are able to say where you are at, and you confront that in yourself.

I enjoyed it and it was helpful to me personally. You helped me figure out what I was doing.

Interesting. Helpful in making me think about ethics again.

It was very challenging. You really made me think a lot... It was the first evaluation that I had of my performance on this job.

Interesting. Stimulating... Got me to think about the decisions I have to make.

Changes in Responses to Interview One

Two participants reported they would have changed their responses to the case involving Ms. Ivy, Mr. Clean, and the H.I.V. issue. They both retrospectively decided they would have informed Mr. Clean of his danger.

Table 95
Would Participants Change Their Responses
In Interview One

Response	Number
No	18
Yes, Would Tell Mr. C. in Case Two	2
Total	20

Summary and Implications

Although the feedback from the participants indicated many gave considerable thought to the material discussed in Interview One, and many expressed a sense of greater awareness of ethics and ethical dilemmas, there was not a corresponding presence of evidence of these processes in the responses to Interview Two. Several possible explanations for this phenomenon present themselves. One is that the participants' perceptions of themselves do not necessarily reflect their behavior. Another is that they felt obliged to express kind thoughts to the author. A third explanation, which might be true by itself or in combination with the other two, is that awareness is a process that moves from consciousness to

behavior slowly. The data in chapter five, which indicates some increase in the frequency with which participants acted on the ethical principles involved in the reconstruction of ethical dilemmas, supports the possibility of the slow process of shifting from awareness to behavior.

Most of the participants found the experience of engaging in this research to have been challenging and stimulating. Even those who noted how arduous the process was, for the most part felt it was a positive experience. None of the participants felt involvement in the research had caused them any harm. This finding appears to indicate that the author was successful in her attempt to "protect ... participants from unwarranted ... mental discomfort."¹⁷³

When discussing the research instrument, most of the participants felt it was an accurate measure of the issues being addressed by the research, thus supporting the validity of the research design. There was no indication from the feedback that the research design required additional improvement beyond the author's own suggestions based on the administration of the research instrument.

¹⁷³ Code of Ethics, op. cit., p. 4.

APPENDIX A**Case Histories #1, #2 and #3****Case History #1**

You are an M.S.W. employed by the Social Work Department of Major Medical Center. You have recently been assigned by your Department to provide service to the Center's in-patient Gynecology/Oncology Unit. Dr. Marcus Casey, the notable Director of the Gyn/Oncology Division, requests your assistance with a Ms. Misfortune, age seventy-five, who is being transferred from Sticks Suburban Hospital for the purpose of undergoing a hysterectomy at Major Medical. Dr. Casey tells you that Ms. M. normally resides in a nursing home and liaison might be needed during her hospitalization. Upon calling Ms. M.'s residence, you discover that it is, in fact, a supervised Single Room Occupancy setting. The social worker there informs you that Ms. M. has resided at the S.R.O. for seventeen years, since being "deinstitutionalized" from the psychiatric hospital in which she spent twenty-five years from age thirty-three. Ms. M. is known to have been bleeding vaginally for at least six months, and was admitted to Sticks Suburban for a work-up, where preliminary tests indicated the presence of ovarian cancer.

You meet Ms. M. the following morning in her room on the unit. She presents as a disheveled, frightened woman who speaks in broken sentences when she is at all audible. She cringes as you approach her. She has only two or three front teeth and no back teeth. She is overweight, yet it obvious that her abdomen is disproportionately distended. Ms. M. verbalizes that she is afraid of pain, does not want to stay in the hospital, and only wishes to return to her home at the S.R.O.

You accompany Dr. Casey and his Residents on their afternoon rounds. When the team enters Ms. M.'s room, she curls up into a fetal position and repeatedly cries "Don't hurt me!" Dr. Casey informs his Residents that Ms. M. has a psychiatric history and may be unable to make competent decisions for herself. He tells his staff to schedule tests preparatory to probable surgery the following week. As it turns out, all data indicates that Ms. M. has metastatic ovarian cancer, and her prognosis for cure is nil. Surgery would involve a large abdominal incision. The aim of the surgery would be to remove as much of the malignant tissue as possible, to control the vaginal bleeding and any bowel

involvement. Beyond the usual risks involved with surgery, Ms. M. has already been weakened and her age also places her in a high-risk category. She will probably have a difficult recovery period, and it is anticipated she will be started on chemotherapy almost immediately to attempt to control the further spread of the cancer. This would, of course, entail side-effects such as loss of appetite, nausea, hair loss, weakness, and the compromise of her immune system, rendering her vulnerable to infections. Hospitalization would probably be for three to four weeks, following which she might require care not available at the S.R.O.

Your contacts with Ms. M. during the week gradually reveal that she is capable of interaction and discussion. By your third visit to her room, she is able to sit up and speak in complete sentences. She tells you of her childhood, her psychiatric hospitalization, and her life at the S.R.O. She perceives that her family originally hospitalized her because she made them uncomfortable. She discusses her chronic loneliness, and her inability to feel comfortable with men. Her greatest pleasure in life had been eating, and even this has been limited due to her dental problems. She feels she has never been allowed to control what happens to her. She insists she does not wish to have surgery and the subsequent treatment, and she asks you to help her with this request.

You again contact Ms. M.'s social worker at the S.R.O. She agrees that Ms. M. is capable of making decisions, but is concerned about Ms. M.'s regressive behavior under stress. She does not feel she can advocate for Ms. M.'s position against surgery, but gives you the phone number of Ms. M.'s nephew, who accompanied her when she moved to the S.R.O.

When you call the nephew, he informs you that Dr. Casey has already spoken to him, explaining the importance of the surgery and Ms. M.'s inability to make a competent decision. The nephew, who hasn't seen Ms. M. for seven years, supports Dr. Casey's recommendation, and hurries off the phone to go to work.

When you next meet with Dr. Casey and his team, you report your findings. The team then visits Ms. M.'s room on Rounds. She goes into a fetal position and is incoherent. Dr. Casey requests a psychiatric evaluation. That evening Ms. M. is seen by a psychiatric resident whose report you read the following morning. It includes a description of Ms. M.'s regressive characteristics, a history of her psychiatric condition, and a diagnosis of chronic schizophrenia undifferentiated. You also see in Ms. M.'s chart signed consent forms for surgery. The Senior Resident tells you he met with Ms. M. this morning (Friday) and explained the surgery completely, and she signed consent. Although he understands what you have said about Ms. M., he schedules the surgery for Tuesday. He reminds you that since D.R.G.'s have

been instituted in the medical center, the medical staff has been unable to allow for much pre or post operative time. You visit Ms. M.'s room and she tells you the Senior Resident spoke with her, but he appeared hurried, and she was unable to speak with him fearing he would be irritated, so she signed the papers he placed in front of her.

Question: What, if any, role does the social worker have in advocating for Ms. M.'s assertion that she does not wish to have surgery?

Case History #2

You are an M.S.W. working in the Tambourine Methadone Maintenance Clinic for the past five years. The Clinic's philosophy is that the dispensing of methadone must be combined with psychotherapy in order assist clients to reach a drug-free status. All clients in the program are seen weekly and/or bi-weekly for psychotherapy. The goal of the program is to wean clients off both street drugs and methadone. The program is considered a "model program" with a good success rate. Although the social worker is responsible for psychotherapy with clients, the physicians prescribe the medication and supervise the treatment. The physicians consider themselves the "case managers."

You have a caseload of thirty clients. One of your clients is Mr. Clean, a twenty-nine year old student. You have been seeing Mr. C. in individual psychotherapy for three years. He discontinued his substance abuse at the time of entry into the program, and has been methadone-free for three months. He is generally consistent with his therapy appointments, and your assessment is that he is working hard to maintain a drug-free existence. He is about to terminate treatment.

Another client recently added to your caseload is Ms. Ivy, a very attractive twenty-three year old woman referred for treatment by her father, a New York State Assemblyman who chairs the committee that deals with funding of drug treatment facilities. During the first several weeks of therapy, Ms. Ivy needed regular reassurance that her discussions with you are confidential. She was very concerned that her father would have access to information she shared with you. Initially quite guarded, she began to be more candid after about one month into treatment. She sees herself as somewhat reckless and has trouble controlling her impulses. She agreed to follow her father's wishes and begin treatment because she recently found out that she is H.I.V. positive. She currently has no symptoms of A.I.D.S. She believes she can postpone getting A.I.D.S. if she takes better care of her body. She has been living with her drug-dealing boyfriend for the past

four years. She hasn't told him that she wants to stop taking drugs and she hasn't told him that she is H.I.V. positive. She believes that if she finds another place to live she can stop taking drugs. She will not return to live with her family and, as she doesn't work, she cannot afford an apartment.

You have been seeing Ms. Ivy for four months. The immediate goal of your work is to have her admitted to a detoxification unit. She has not been compliant with this treatment plan. She is inconsistent with therapy, and is continuing to use street drugs. Her motivation in therapy is weak.

Mr. Clean and Ms. Ivy meet at the Clinic's annual Thanksgiving party. They spend the afternoon talking. At Mr. C.'s next session, he reports feeling very healthy and determined, and is looking forward to ending treatment at the Clinic. He feels very grateful for the Clinic's help in general, and your help in particular. He feels a sense of debt and responsibility to help others who suffer from drug addiction. He is considering changing his major at school to social work, to pursue a career in substance abuse counseling. He also tells you of his meeting Ms. Ivy, and his desire to help her. He is aware of her current living situation and is considering offering to share his apartment with her. He admits that he finds her quite attractive, and this might have something to do with his desire to help. They have plans to go out on a date this week.

The next day Ms. Ivy comes for her scheduled appointment, but does not volunteer any information about her contact with Mr. C. When you mention that you noticed them together at the party, she acknowledges their contact but does not continue the discussion. She becomes withdrawn and fidgety. You drop the subject, thinking that this might be more your own curiosity than sound clinical judgment.

The following week, during your session with Mr. C., he speaks of his growing infatuation with Ms. Ivy. He believes he can help her clean herself up. He tells you of his plans to continue to date her and he discusses his sexual desire for her. He plans to have her move in with him this weekend. As in the past, you raise the issue of safe sex. He states he always has condoms available, but, being human, he occasionally succumbs to the passion of the moment and disregards his better judgment. He assures you that he is not endangering anyone, as a recent test found him to be H.I.V. negative. In any event, he feels confident because the recent literature reports that it is less likely for a man to contract A.I.D.S. from a woman than vice versa.

Later that week you have your next appointment with Ms. Ivy. She tells you that she has found other living arrangements. She still believes this will help her stop

taking drugs, and agrees to go into a detoxification unit if she is not "clean" after three weeks. When you ask her about the new apartment, she tells you that Mr. C. has invited her to live with him, and she will be moving in this weekend. She is aware that he is attracted to her and she says she really needs a friend and he is very nice to her. She expects their relationship will become sexual, and that is all right with her. When you ask her if she has told him about her H.I.V. status, she says she hasn't because she is afraid he may withdraw his offer, and that she will tell him to use condoms.

When she leaves your office you wonder what responsibility you have to Mr. C., in terms of the risk of his contracting A.I.D.S. You contact your supervising physician and explain the situation. He speaks to the clinic's attorney who says there are no laws governing this area, although there has been discussion regarding various legislative proposals. In the absence of legislation, however, decisions must be ruled by ethical considerations, which are the realm of the professional practitioners.

You meet with the supervising physician. He validates your concern about the situation, but feels that the clinic must be governed by the principle of confidentiality until such time as legislation is written to govern these decisions. He notes that the clinic serves a small community of clients and feels that if the principle of confidentiality was violated, there could be devastating consequences to the program, as this would get around to all of the patients and to the professional community-at-large. This issue would not be as pressing in a more anonymous program, but that, unfortunately, is not the case here. He also points out that Ms. Ivy comes from an influential family, and says he doesn't need to draw a picture of what this means to the clinic. He states that he is sure you have discussed with both clients the issue of safe sex, and that the clinic cannot control the lives of the clients if they choose to disregard the precautions provided through the program. Finally, he asks you to consider whether your concern might have some basis in your counter-transference for Mr. C. with whom you have worked for so long.

You leave this meeting feeling quite uneasy. What action, if any, do you take?

Case History #3

Due to recent financial difficulties in the institution resulting in layoffs, the social work staff was advised by administration they must increase their caseloads by thirty percent. A series of meetings ensued, in which the social work staff advised administration that they were already

working to their limit and that the proposed increase in caseloads would result in deteriorated service for clients. The administration countered by suggesting individual sessions with clients be curtailed, and that more groups be initiated, so that staff would be serving more clients in the same time period. The social work staff expressed the opinion that most of the clients in question needed individual work, and that groups would not meet their needs. The administration pointed out that without an increase in productivity, the organization might have to cut back or cease operation, in which case the clients would receive little or no service at all, and many of the staff would, of course, be unemployed. The administration advised the social work staff to reconsider its resistance to the suggestions for greater productivity, or face the consequences. The decision would have to be made by the end of the week. What is your thinking about this situation?

APPENDIX B**Research Guide****Descriptive Data**

Age_____

Sex_____

Race_____

Religion_____

Type of social work setting_____

Years of employment in the setting_____

Years of social work experience_____

Course or training in ethics_____

Reconstruction: Interview Two

Contextual Issues

Organizational Issues

Power and Compliance

Ethical Principles

Case History #1

The contextual issues

- ___ Ms. M.'s rights as a patient in a medical center.
- ___ Ms. M.'s rights to informed consent.
- ___ Ms. M.'s rights as a psychiatric outpatient.
- ___ Ms. M.'s current clinical (psychiatric) state.
- ___ Ms. M.'s medical problems.
- ___ Ms. M.'s family system.

Organizational structure and constraints

- ___ The hierarchy of authority in a medical center.
- ___ Social work in a host setting.
- ___ The impact of Diagnostic Related Groupings.

Power and compliance

- ___ The uneven power relationship between the surgeon and the social worker.
- ___ The type of power used by the physicians with patients and families.
- ___ The type of power used by the physicians with the social worker.
- ___ The compliance of the family and the medical residents to Dr. Casey.

Ethical Principles

- ___ Primacy of Clients' Interests
- ___ Provide clients with accurate and complete information.
- ___ Foster maximum self-determination.

____ Should not engage in any action that violates or diminishes the civil or legal rights of clients.

____ Adhere to commitments made to the employing organization.

____ Work to improve the employing organization's policies.

____ Act to prevent practices that are inhumane or discriminatory.

____ Act in accordance with the highest standards.

____ Resist the influences and pressures that interfere with professional discretion.

Case History #2

Contextual issues

____ Mr. C. has done very well in the program and is about to terminate.

____ Ms. Ivy is non-compliant.

____ A.I.D.S. is a fatal disease.

____ H.I.V. positive blood is transmittable, and can convert to A.I.D.S. at any time.

____ Condom use is the most effective method of preventing the transmission of A.I.D.S. in sexually active individuals, but some risk remains, and there is an indication that Mr. C. and Ms. Ivy might not always use condoms.

____ Ms. Ivy's lack of candor increases this risk.

____ Violating Ms. Ivy's confidence has great potential to damage whatever therapeutic relationship exists with her.

____ Not informing Mr. C. of Ms. Ivy's condition has great potential to expose him to a fatal illness, and, in a wider sense, expose potential others whom Mr. C. might later infect unknowingly.

Organizational structure and constraints

____ The traditional medical model of authority utilized by the Clinic, which places the physician in a supervising role in relation to the social worker.

____ The potential for financial and program consequences as a result of responses from patients and community to compromising patient confidentiality.

____ The potential for agency and collegial censure, and loss of employment, by violating Ms. Ivy's confidence.

Power and compliance

____ The type of power held by the physician.

____ The type of power held by the agency.

____ The type of power held by the government.

____ The type of power held by the family of Ms. Ivy.

Ethics

____ The primacy of clients' interests.

____ Serve clients with devotion, loyalty, determination, and the maximum application of professional skill and competence.

____ Respect the privacy of clients and hold in confidence all information obtained in the course of professional service.

____ Adhere to commitments made to the employing organization.

____ Work to improve the employing agency's policies.

____ Act in accordance with the highest standards of professional integrity and impartiality.

____ Resist the influences and pressures that interfere with the exercise of professional discretion.

Reconstruction: Interview Two

Contextual Issues

Organizational Issues

Power and Compliance

Ethical Principles

Case History #3

The contextual issues

____The staff is working to full capacity in serving the needs of the clients.

____Altering the service as proposed by administration will dilute the benefit to the clients.

Organizational structure and constraints

____The financial status of the organization appears a genuine concern.

____Administration seems to be inflexible in its approach to the problem.

Power and compliance

____The administration has control over the resources of the institution, and its threat of loss of employment appears genuine.

Ethical

____Retain ultimate responsibility for the quality and extent of the service that individual assumes, assigns, or performs.

____Act to prevent practices that are inhumane or discriminatory against any person or group of persons.

____Act in accordance with the highest standards of professional integrity and impartiality.

____Resist the influences and pressures that interfere with the exercise of professional discretion.

____Primacy of clients' interests.

____Withdraw services precipitously only under unusual circumstances

____ Seek the transfer, referral, or continuation of service in relation to the clients' needs and preferences.

____ Treat colleagues with respect courtesy, fairness, and good faith.

____ Create and maintain conditions of practice that facilitate ethical and competent professional performance by colleagues.

____ Adhere to commitments made to the employing organization.

____ Work to improve the employing organization's policies.

____ Use resources with scrupulous regard.

____ Promote the general welfare of society.

____ Act to ensure that all persons have access to resources.

____ Encourage informed participation by the public in shaping social policies.

APPENDIX C

Explanation of Research Guide

Interview Guide

As all sections of the interview utilize recursive questioning, each participant dictates the exact direction of the interviews. As the researcher is interested in a particular area of study, however, a specific format must be followed. The following is a discussion of the guide developed to assist the researcher.

Interview One

Reconstruction

The reconstruction focuses on the participant's own ethical dilemma. As such, the researcher has no clear way to understand all the elements in an objective manner. She can only understand the dilemma through the eyes of the participant. The researcher will be assisted by the research guide. She will also tape record the interviews.

During this part of the interview, the researcher will listen to the participant describe the dilemma. The researcher will fill in the spaces allocated for each

category. She will note those elements directly discussed by the participant, and have a visible record of those factors the participant did not acknowledge. For example, the participant might describe the particular details of the case, identify organizational constraints, and discuss issues of power. The interviewer can then reflect these to the participant thusly: "Do you mean you believed the administrator had a lot of power?" or, "Are you saying that there were not enough resources to offer the client?"

If the participant appears to have left out the impact of organizational structure and his own impulse to comply or rebel, the researcher will ask the participant about the areas that he did not identify.

Case History #1

The participant is asked to read the case history and verbalize the considerations involved in rendering a decision. As this is a prepared case, the researcher has a list of elements that she will be listening for (see Appendix A). The researcher will numerically check the contingencies as the participant considers them, note any factors the participant raises that are not on the list, and refer to the guide for any elements the participant did not consider.

Case History #2

Case History #2 is handled in an identical manner to Case History #1, except a new form is used (see Appendix A for a complete guide).

Interview Two

Reconstruction and Case History #3

Interview two follows the same process as interview one. There is one reconstruction and one case history.

Feedback

The interviewer ends the interview process by requesting feedback from the participants regarding their experience of the first and second interviews. The following questions will be asked:

- (1) Did you think about the research interview within the past month?
- (2) If yes, what did you specifically think about?
- (3) Do you believe there has been any impact from the research interview?
- (4) If yes, how would you describe the impact?
- (5) How would you describe the research interviews?
- (6) If you had the opportunity to change your responses in the first interview, would you?

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