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A TRAINING PROGRAM TO PREPARE
SOCIAL WORKERS FOR PROFESSIONAL REVIEW

by

ROSLYN H. CHERNESKY

A dissertation submitted to the Graduate Faculty
in Social Welfare in partial fulfillment of the
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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

A TRAINING PROGRAM TO PREPARE SOCIAL WORKERS FOR PROFESSIONAL REVIEW

by

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The 1972 Amendments to the Social Security Act, under Title IX, provide for the creation of Professional Standards Review Organizations (PSROs) designed to involve physicians and non-physician health care practitioners in the ongoing review and evaluation of health care services covered under Medicare, Medicaid and the Maternal Child Health programs. The PSRO is responsible for assuring that health care under these programs is medically necessary and consistent with professionally recognized standards of care. The legislation is based on the concepts that health professionals are the most appropriate individuals to evaluate the quality of medical service and that effective peer review is the soundest method for assuring the appropriate use of health care resources.

The mandate is a response to the need for greater accountability of professionals, and has been embraced by social work. It comes at a time when the social work profession, long concerned with its effectiveness

and with supervision as a method of control, is faced with the need to prove its worth and is seeking increasing professionalization.

There are many reasons to anticipate that social work practitioners may be negative or resistant toward professional review. If the experience of physicians, and their reaction to mandated professional review and to peer control, is any example, it may be necessary to prepare social workers for their role and responsibility in professional review if professional review is to be effective.

The attitudes and reaction of social workers to professional review, and an attempt to deal with the issue of staff participation in professional review, are the focus of attention in this project.

The attitudes of social work staff at one New York City hospital were studied, using two instruments constructed to gauge the direction and magnitude of staff predisposition toward professional review: a summated rating scale and a semantic differential scale. As one of the first attempts to study the attitudes of professionals toward professional review, social workers were found to be generally favorably inclined toward professional review, although some aspects were more negatively viewed.

A training program was conducted with a group of randomly selected social work staff at the same hospital to prepare them to engage in professional review. Staff was provided with the necessary technical skills and the opportunity to be involved with the planning for the professional review system of the social work department. The approach used was to have staff become involved with professional review, to

experience it in such a manner that they would come to see its value and, as a result, develop a sense of commitment toward its effective implementation.

The attitudes of staff who participated in the training were examined following the program and the staff's one month experience with professional review. Their attitudes, and any changes, were compared to those of staff who engaged in one month of review after only a brief orientation to professional review, and to those of staff who did not engage in review and were not formally introduced to it. The differences in the way the two staff groups actually engaged in review were also compared.

The results of the study and the training program are presented. The implications of the findings suggest factors to be considered for effective professional review and in attempting to establish professional review systems.

ACKNOWLEDGEMENTS

At the time I was selecting a project to fulfill the requirement of my doctoral study, I was with the Department of Social Work Services at the Long Island Jewish-Hillside Medical Center and had been responsible for the initial planning of the Department's quality assurance program. It was almost by chance that I became involved with quality assurance and professional review, and for that I am grateful to Dr. Abraham Lurie, the Director of the Department. With his enthusiasm and foresight, he convinced me that here was a growing area that demanded the attention of administrators, practitioners, and researchers. It was not difficult to be persuaded by his interest and encouragement to take advantage of the opportunity to work on professional review in the dynamic setting of the LIJ-HMC. The fact that I would also be able to work closely with Dr. Gary Rosenberg, Associate Director of the Department for the Hillside Hospital division was a further reason, and one for which I will always be thankful. Together they saw to it that I could carry out my project under the most favorable conditions. I am especially grateful to the social work staff at Hillside who were so cooperative in both the studies and the training program. I hope they have gained as much as I have from the experience.

Since the training program at Hillside, I have had the opportunity to prepare the social work staff at the Mt. Sinai Medical Center for professional review, using an approach similar to the one used at Hillside. This valuable experience has provided me with new insight into the training of social workers for professional review and into the use of professional review in social work, much of which has contributed to my understanding and thinking, and has undoubtedly made its way into my concluding discussion in Chapter 8. For their confidence in my ideas and their invitation to have me work with the professional review committee of the Department of Social Service, I wish to express my appreciation to Dr. Helen Rehr, the Director of the Department, and Alma Young, Assistant Director.

I am very thankful to Professors Harold Weissman and Eugene Shinn of the doctoral faculty for the stimulation they provided in and out of the classroom, and for their support of my work.

To my family and friends, whose understanding and help made my studies and this project so much easier, I give a very special thanks.

TABLE OF CONTENTS

ACKNOWLEDGMENTS	vii
Chapter	
I. INTRODUCTION	1
II. THE PROBLEM: PROFESSIONAL ACCOUNTABILITY AND PROFESSIONAL CONTROL	5
Professional Control	7
Making Professionals Accountable.	10
Notes	14
III. ALTERNATIVE SOLUTIONS: PEER CONTROL VERSUS PROFESSIONAL REVIEW	17
Peer Control.	17
Professional Review	21
PSRO Legislation	21
Visibility of Performance	23
Criteria for desired performance.	25
Surveillance.	27
Exercise of authority	28
Notes	30
IV. THE SOCIAL WORK PROFESSION: ACCOUNTABILITY AND CONTROL.	32
Supervision	34
Professional Vs. Administrative Authority	35
Professional Review	37
Notes	41
V. ATTITUDES OF SOCIAL WORKERS TOWARD PROFESSIONAL REVIEW.	43
Setting	43
Instruments	46
Summated scales	46
Semantic differential scale	47
Social judgment-involvement approach.	49
Findings	50
Summary	59
Notes	61

VI.	A TRAINING PROGRAM IN PROFESSIONAL REVIEW FOR SOCIAL WORK STAFF	63
	Theoretical Approach	64
	Project Design	66
	Participants in the Training Program.	67
	Program Description	69
	Analysis of the Training Program.	74
	Participants' Evaluation of the Training Program	81
	Notes	85
VII.	THE EFFECT OF THE TRAINING PROGRAM ON SOCIAL WORKERS' ATTITUDES AND PARTICIPATION IN PROFESSIONAL REVIEW	86
	Research Design	86
	Changes in Attitudes of Participants and Non-Participants in the Training and Orientation Programs.	92
	Summary	101
	Social Workers' Attitudes Toward Critical Aspects of Professional Review Before and After Training and Orientation Programs	103
	Summary	106
	Comparison Between Training and Orienta- tion Program Participants' Engagement in Professional Review.	108
	Notes	112
VIII.	A DISCUSSION OF THE PROJECT AND ITS IMPLICATIONS	113
	Notes	125

APPENDICES

1.	Questionnaires - Social Workers' Attitudes Toward Professional Review	126
2.	Letter Accompanying Attitude Questionnaire	138
3.	Training Program Package and Materials	142
4.	Social Service Case Records.	173
5.	Memorandum to Staff from Training Program Participants	190
6.	Final Report of Training Group Participants	193

7. Questionnaire - Participants' Evaluation of Training Program.	197
8. Questionnaire - Survey of Participants	201
SELECTED BIBLIOGRAPHY	204

LIST OF TABLES

1. Favorable Attitudes Toward the Value of Professional Review	51
2. Acceptance of Professional Review, In Percentage	52
3. Responsibility Toward Colleagues' Work	53
4. Confidence in Professional Review.	54
5. Attitudes Toward the Use of Records.	56
6. Impact of Professional Review on Work and Colleague Relations	56
7. Meaning of Professional Review	57
8. Meaning of Professional Review by Means Scores of Factors	58
9. Participants' Evaluation of Training Program, In Percentage.	83
10. Participants in Programs and Study	90
11. Positive and Negative Attitudes Toward Professional Review, Pre and Post Test Scores on Rating Scale.	92
12. Positive Attitudes Toward Professional Review, Pre and Post Test Scores on Semantic Differential Scales	93
13. Meaning of Professional Review, Mean Scores on Pre and Post Semantic Differential Tests	94
14. Direction and Magnitude of Change in Rating Scale Scores	97

15.	Sign Test and Wilcoxon Matched-Pairs Signed Ranks Test Applied to Semantic Differential Scales for Social Workers with No Program	99
16.	Spearman Rank Correlation of Before and After Test Scores on Rating Scale and Semantic Differential Scales.	100
17.	Mean Scores on Selected Items of Rating Scale on Before and After Tests.	104
18.	Change in Mean Scores of Selected Items of Rating Scale on Before and After Tests	107

ILLUSTRATIONS

1. Frequency Distribution of Rating Scores, Attitudes Toward Professional Review	50
2. Before-After Research Design	87

CHAPTER I

INTRODUCTION

The increasing concern today with the quality of care poses a challenge to professionals involved with the provision of health and social welfare services. Professionals are being asked to account for services rendered and to justify the effectiveness, the need, and the efficiency of their work. Social workers, as well as physicians, nurses, and other health professionals, must now develop programs and procedures to assure the high quality of care.

Professional review is one kind of program currently suggested to satisfy the need for accountability. It has, in fact, been mandated by the federal government in 1972 through the Professional Standards Review Organizations (P.S.R.O.) legislation. Among its characteristics is the requirement that professionals monitor and evaluate the practice of their colleagues on an ongoing and systematic basis to determine if performance is in accordance with professional standards.

The project undertaken here began with the premise the professional review can be one of a variety of meaningful accountability mechanisms, especially if attention in its planning and implementation is given to those critical areas that are likely to influence its effectiveness. One such area, which is the focus of this project, is that of attitudes and reactions of professional staff to participa-

tion in a professional review system.

The training program described in this project report was a deliberately planned effort to deal with the issue of staff participation in professional review. It was an attempt to minimize some of the strains and reactions that could be dysfunctional and to maximize some of the conditions that could be functional for successful review. The need for the program and its design reflected three major assumptions:

1. Professional staff are likely to react negatively to the mandate that they engage in a formal process of professional review
2. The attitudes and reactions of staff toward professional review are likely to influence successful implementation of a professional review system
3. Professional staff are more likely to view professional review favorably if the system were consistent with and supportive of professional autonomy and control

The program was conducted with a small group of social workers who were randomly selected to serve as professional reviewers from among all line, M.S.W. social work staff in a hospital social work department. The purpose of the training was to prepare staff for the role and tasks of reviewers by providing them with the necessary technical skills and the opportunity to be involved with the planning for the professional review system of the department. The approach used in the training program was to have staff become involved with professional review, to experience it in such a manner that they would come to see its value and, as a result, develop a sense of commitment toward its effective implementation.

Chapter 2 is devoted to the issue of social control among professionals which is the problem area addressed by the project. The review of the literature of professional control provides the context in which the concern with professional accountability can best be understood.

In Chapter 3, peer control and mandated professional control, are examined and compared. Some of the concerns with peer control are discussed in order to illustrate how mandated review differs from informal control and why mandated review is likely to be resited. Because much of our understanding of peer control and professional review comes from investigations of physicians, their experiences are drawn upon in this discussion.

The issues of professional control and accountability in social work are discussed in Chapter 4. An examination of the social work profession's traditional approach to each through supervision, and of some of the problems with it, provides an understanding of the potential importance of mandated professional review to the profession.

Chapter 5 presents some of the findings from the study on the attitudes of social work staff toward professional review which was conducted as part of the project. Two instruments were constructed to gauge the direction and magnitude of staff predisposition toward professional review; a Likert-type summated rating scale and a semantic differential scale. As one of the first attempts to investigate the attitudes of professionals toward professional review, the study indicates a generally favorable inclination among social workers and points to those aspects of professional review that are negatively

viewed.

The training program is described in Chapter 6. Emphasis is given to the approach used, its rationale, and the program's content and format. In addition to describing each of the ten sessions, an analysis of the process that took place is given. The participants' evaluation of the program is presented.

Chapter 7 describes the research design used to evaluate the effect of the training program and presents the results. A before-after design with two comparison groups allowed for an analysis of change in participants' attitudes toward professional review following the training program. The findings indicate that such a training program can have a positive effect on staff attitudes and that the absence of a program can have a negative effect. The surprising positive effect of the comparison group, in which staff attended one orientation session on professional review, is discussed. The difference in the way the participants in the training program and the participants in the orientation program engaged in one month of review of six social service case records is also presented.

The results of the project, this one experience with the use of mandated professional review with social workers and their implications, are discussed in a broader context in Chapter 8. The administrative implications, especially for social work departments and agencies establishing professional review systems, are suggested.

CHAPTER II

THE PROBLEM:

PROFESSIONAL ACCOUNTABILITY AND PROFESSIONAL CONTROL

The concern today with assuring the quality of care provided and improving the quality of service rendered requires that attention be given to the issue of accountability. Accountability implies a quest both for efficiency and effectiveness. It acknowledges the right of the public and the consumer to the confidence that public money is not being wasted through fraudulence or incompetence, that providers of services are responsible for the consequences of those services, and that the care given is necessary, of high quality, and cost effective.¹

The responsibility for assuring effectiveness and efficiency rests with all the participants of a service delivery system. Along with administrators, boards of directors, legislators, sponsors, and funders, professionals too are accountable for their decisions and the results of those decisions.

It is the responsibility of the professional staff for accountability that has aroused increasing interest and is the focus of this study and project. Questions regarding the regulation of professional behavior and control over professional work for effective accountability have been addressed for some time by sociologists with interests in organizations and the professions.

Our understanding of professional control stems from a more general knowledge of social control in organizations.² The need for control

in organizations to achieve conformity, compliance or performance at a level of expectation was first addressed by Weber in his classical conception of control as authority in his bureaucratic model.³ Parsons referred to it as integration, one of the four basic problems which all social systems must solve.⁴

The diverse means by which organizational control and influence are attained have been explored. Control systems may include formal mechanisms such as the formulation of policies and rules, the exercise of hierarchical authority, and application of rewards and sanctions for conformity or deviance. Effective informal mechanisms may include such techniques as the involvement and participation of staff, the promotion of worker identification with the organization, and the use of impersonal mechanisms

Several conceptualizations of the way organizational control over workers can be exerted have been formulated. Katz and Kahn offer a classification of bases of control or what they term, motivational patterns for producing various types of required behavior, which contrasts externally induced from internally induced compliance.⁵ Etzioni generates a typology of compliance structures based upon power applied by organizations to lower participants and the involvement in the organization of lower participants. In the same work, Etzioni concludes that effective control depends upon organizations having the correct or appropriate mechanism and that there is a tendency for organizations to move toward the establishment of appropriate structures.⁶

Recent studies of social control in organizations suggest there is considerable variability in the amount and distribution of control and emphasize the importance of control mechanisms congruent with organi-

zational types.⁷ It is this need for congruency that helps us to understand the difficulties organizations experience in regulating professionals and controlling their work.

Professional Control

In what ways can organizations exert control over the work of professional staff? How can organizations regulate professionals behavior? What mechanisms are effective to assure that professionals conform to expectations and comply with standards?

The expectation has been that professionals would exercise control over their own work. The assumption of self regulation among professionals grows out of the very definition of professional. The granting of the status of profession implies that the profession will command and assert authority which extends to the setting and upholding of standards and ethics.

As Goode explains, a profession is supported by an organized body of knowledge, theory and skills which is shared completely only with its recruits and members. Consequently outsiders, be they from other disciplines, clients, or administrators, lack their insight and understanding and must concede to professional judgements and professional autonomy in decisionmaking. A profession is thus invested with authority, specific to its area of expertise, a part of which is control over who shall be accepted and rejected as members and by what criteria and methods. To assure the public that the power and privileges granted to it will not be abused, the profession establishes a code of ethics and agrees to enforce its observance.⁸ A profession is thereby given considerable leeway to regulate itself through both formal and informal

means. Discipline is exercised formally primarily through professional associations and informally primarily through the working relationships and mutual interdependence among members, and peer control.

Professions differ in the extent to which they have been able to preserve the right to police their members' work performance. All have, however, maintained some authority to exercise control by claiming they are most qualified and capable of judging competence properly, and that they are heavily invested in ensuring that professional performance lives up to the profession's standards. As a result, professions have been able to avoid all but the minimal administrative controls placed upon them by organizations.⁹

Attempts to impose bureaucratic controls on professional behavior and performance have, in general, been viewed as a source of conflict by professionals with their right and responsibility for self regulation and control. Although organizations, as part of their need for accountability, require adherence to policies, procedures and expectations, they find that their efforts to exercise control over their professional staff tend to be resisted. The organization's need for hierarchical control on the one hand, and the profession's need for collegial control on the other, are seen as incompatible.

This incompatibility exists because the type of control structure professionals demand differs greatly from that used in a bureaucratic organization. Blau and Scott state:

The source of discipline within a bureaucracy is not the colleague group but the hierarchy of authority. Performance is controlled by directives received from one's superiors rather than by self-imposed standards and peer-group surveillance, as is the case among professionals. This difference in social control, which is related to that between expertness and discipline..., constitutes

the basic distinguishing feature between professional and bureaucratic institutions, which have otherwise may similar characteristics. The significance of this difference is brought into sharp relief if one examines people who are subject to both forms of social control; that is, professionals in a bureaucracy.¹⁰ (Italics mine.)

Etzioni describes the incompatibility between administrative and professional authority in the following manner:

... the autonomy granted to professionals who are basically responsible to their consciences (though they may be censured by their peers and in extreme cases by the courts) is necessary for effective professional work. Only if immune from ordinary social pressures and free to innovate, to experiment, to take risks without the usual social repercussions of failure, can a professional carry out his work effectively. It is this highly individualized principle which is diametrically opposed to the very essence of the organizational principle of control and coordination by superiors-- i.e., the principle of administrative authority. In other words, the ultimate justification for a professional act is that it is, to the best of the professional's knowledge, the right act. He might consult his colleagues before he acts but the decision is his. If he errs, he still will be defended by his peers. The ultimate justification of an administrative act, however, is that it is in line with the organization's rules and regulations, and that it has been approved--directly or by implication--by a superior rank.¹¹

The incompatibility between the organizational requirement and the norms and values of the profession has been a subject of considerable concern. The ways in which organizations impinge upon and accommodate to professionals and the ways in which professionals adapt to employment in organizations have received extensive study.¹² While most of the investigations confirm the existence of the bureaucratic-professional conflict, it has recently been suggested that the conflict may not be either inherent or universal.¹³

It is likely that any perception of conflict is related to the degree of infringement upon professional autonomy. Administrative controls seem to be more acceptable as long as they do not curtail what

is considered to be the freedom of the professional to practice in accordance with his training and professional judgement. Thus, as Freidson learned, there is a considerable range of administrative regulation that is accepted as legitimate by professional standards.¹⁴ Engel found that moderate bureaucratic controls are associated with increased feelings of professional autonomy as opposed to nonbureaucratic or highly bureaucratic settings.¹⁵ Hall suggests that less conflict may exist in autonomous organizations where professionals are the dominant source of autonomy and not subject to administrative controls and in heteronomous organizations where professionals are subordinated to an externally derived system. And, more conflict may exist in departments where professionals are part of a larger organization and have little impact on the way their work is structured.¹⁶

Making Professionals Accountable

The belief that professional autonomy is necessary to maintain high quality of professional service and therefore must be preserved by organizations for effective accountability is being questioned today. How responsibly and effectively professional control has been exercised has posed both a theoretical and practical question. Further examination of the way professional control is exercised and the difficulties with it is the focus of the following chapter.

There is some evidence to suggest that the greater the autonomy, the less effective may be the system of professional control. The medical profession, for example, is believed to have one of the most fragmented and ineffective systems.¹⁷ At the same time, there is increasing recognition that only through the strengthening of administrative and

bureaucratic mechanisms of control are professionals likely to become more accountable.¹⁸

Recognizing the need for organizations to exercise effective control which must encompass regulation of professional behavior, while recognizing the commitment of the professions to self regulation, it will be necessary for the kinds of control mechanisms that are established to balance the two requirements. Efforts to achieve this balance which would result in effective control has long been a goal of students of administration.

The literature offers some suggestions on how this balance might be achieved. A traditional response has been that of the phenomenon of the administrative professional--a professional promoted or appointed to the role of administrator. The administrative professional represents an attempt to weave the horizontal control associated with professionals into the hierarchical control, a response Etzioni proposes.¹⁹ Another traditional approach has been that of dual supervision whereby a worker is administratively responsible to one supervisor and professionally responsible to another and thus is subordinated to two authorities at the same time.²⁰

Others emphasize the need for the organization to develop strong links between staff motivation towards career and work so that rewards are given for desirable work performance, exercise of initiative, responsibility and effort.²¹ McGregor, in his conceptualization of Theory Y, concludes that people can achieve best by directing their own efforts toward organizational objectives.²² Katz and Kahn also stress the need to have workers regard goals as their own personal values and objectives. As a result, the worker internalizes organiza-

tional goals or, as Barrett states, integrates his own needs and interests with organizational objectives.²³

Oorganizations are more likely to bring about this commitment, it is said, by involving the worker in the organizational system. Lewin and his colleagues pioneered research indicating the relationship between participation in a decision and being willing to carry it out in the spirit intended. Drawing upon this early research, administrative and management specialists cite the value of the formal involvement of staff in the exercise of control, primarily through participation in decision making, for effective worker performance.²⁴

There seems to be some agreement that the more effective approach for attaining compliance or controlling worker performance is one that emphasizes internal control. The intent is to have the worker feel responsible for his own actions and direct his actions in a way that is consistent with the organization's goals not because he has to or will be sanctioned if he does otherwise but because it is both desirable and rewarding, in themselves, for his to do so. External control which relies upon the organization's hierarchical structure and makes use of programming and sanctions to reward and punish is apparently less effective. As early as 1938, Barnard referred to the differential value of the use of incentives and sanctions and others have continued to do.²⁵

Internal control is thought to be most effective with professionals because it is consistent with the professional norms of authority and autonomy. External control is considered to be inappropriate and therefore less effective if used with professionals. One of the more recent explorations of the use of internal control mechanisms with professionals by Hage tests "socialization with information feedback",

a technique held to be consistent with professional autonomy. Hage suggests that professionals are controlled more fully as they are given more autonomy, but by more subtle means, and that self control through a mechanism such as socialization can influence behavior and attitudes to a greater extent than a system of sanctions.²⁶

In general, two opposing points of view are expressed regarding professional control and accountability. The more accepted view that indirect or internal means of control can be effective in the regulation of professional performance is based on the belief that for control to be effective it must be supportive of professional autonomy and authority and result in minimal dissatisfaction and conflict on the part of professionals. The second, and less expressed view, whose proponents remain skeptical about the value of enhancing professional autonomy and authority for the attainment of the best provision of service and the highest quality of care, stresses the need for greater administrative controls regardless of the reactions of professionals. It is likely that both parties would support a solution that enables a true balance between professional and administrative authority, if one were envisioned.

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23. Katz and Kahn, Social Psychology of Organizations, p. 380: Jon H. Barrett, Individual Goals and Organizational Objectives (Ann Arbor: University of Michigan, 1970).

24. A good summary of the research of Lewin and his colleagues appears in Cyril Sofer, Organizations in Theory and Practice (New York: Basic Books, 1972), Chap. 5, "Kurt Lewin, Field Theory, and Group Membership," pp. 84-102. A good summary on participation appears in Arnold S. Tannenbaum, ed., Social Psychology of the Work Organization (Belmont, Calif.: Wadsworth, 1966), Chap. 7, pp. 84-102.

25. Chester I. Barnard, The Functions of the Executive (Cambridge: Harvard University, 1968), p. 270. For further discussion of various approaches to achievement of desired work performance see, Barrett, Individual Goals and Organizations: Katz and Kahn, Social Psychology of Organizations, Chap. 12; Howard C. Kelman, "Compliance, identification and Internalization: Three Processes of Attitude Change," Journal of Conflict Resolution 2 (1958), 51-60.

26. Jerald Hage, Communication and Organizational Control: Cybernetics in Health and Welfare Settings (New York: John Wiley, 1974), pp. 23, 46.

CHAPTER III

ALTERNATIVE SOLUTIONS:

PEER CONTROL VERSUS PROFESSIONAL REVIEW

Peer Control

The primary means of regulation used by professions is peer control. Because of the difficulties in the way it functions, questions have been raised as to whether professional control is responsible, effective and accountable.

Peer control is the informal process of self regulation and policing by which professionals evaluate colleagues. In order to be minimally effective, the process requires: 1) criteria and standards upon which to base evaluations be set and shared, 2) sources of information about the quality of work of professionals be available, 3) knowledge of and findings about professional performance be communicated, 4) pressure to change or improve performance be exercised, and 5) sanctions for failure to change or improve be employed.

The operation of peer control among physicians has been a subject of interest and study.¹ From these investigations, we have come to understand how and why some forms of professional behavior and work performance and not others are subject to peer control and, as a result, some of the reasons for its effectiveness.

Freidson suggests that a fundamental rule exists among physicians which has a major influence on the peer control process:

One owed one's colleagues (and was owed by them) respect, trust, and protection unless overwhelming evidence pointed to the contrary.²

This rule of colleague solidarity that governs relations and loyalty is one of the basis norms of a profession. It helps to explain why professionals generally restrain from commenting upon or criticizing the work of their colleagues. Not surprisingly, this norm along with others that emerge through informal relations in a work setting, influence the way work is to be carried out and how violators are to be treated.³

Not only is there this tendency among professionals to avoid criticizing colleagues but there is also a tendency to avoid recognizing poor performance and, for that matter, discriminating between the practice of right and wrong. The failure of physicians to use the word "mistakes" as the layman does has been noted. While physicians may agree that "mistakes will happen," these are considered normal and understandable and are not to be confused with more serious violations of rules or "glaring mistakes." The former are excusable in contrast to the latter which imply either ignorance or neglect, deficiency in competence or conscientiousness.⁴

The understanding among physicians of the state of medical knowledge, of the pressures and constraints imposed by the conditions of practice, and of the intangible nature of professional judgment leads to the ease by which normal mistakes are accepted and excused. Much of physicians' practice therefore is beyond their reproach because a rather wide range of acceptable performance exists once the reasons for "mistakes" are taken into consideration. As Freidson found "... only a comparatively small segment of the universe of work which fail-

ed to conform to expectations was likely to be considered appropriate for the exercise of negative sanctions--for direct criticism or worse."⁵

Even if professionals were willing to criticize errors or deviation from performance expectations, they would have to be in a position to notice or observe the work of colleagues. The information about performance, its availability and accessibility, are often not sufficient to provide either enough or reliable data to colleagues to involve them in a systematic exercise of control.

Information about colleague performance comes primarily from patients who voice complaints that may serve as indicators of possible problems. Colleagues also pass on information about each other that is obtained from first hand contacts, reputation or through opinions of close and respected friends. Direct experience through professional referrals and consultations is another major source of information. Each of these sources, however, provides only a certain amount and kind of information about performance. The picture of the quality of professional practice remains incomplete. The process of selectivity restricts the information conveyed through these sources and limits the availability and accessibility of knowledge about performance which would be essential for effective control of peers.⁶

And what if criteria for good performance were clear, reliable information about performance were available, and peer judgement led to the conclusion that performance fell below accepted standards? Freidson suggests that the response to such findings would be somewhat limited because of the careful and judicious use of sanctions by professionals. The use of sanctions by physicians was guided by their belief that the punishment must be appropriate for physicians as well as

for the findings. Certain sanctions were considered incompatible with the status of physician and therefore useful only in extreme cases. In general, only compatible sanctions were deemed reasonable, those that appealed to the physicians' personality and conscience. Colleague exhortation and confidence in continuing education were most often relied upon. These were based on two assumptions: 1) if physicians knew their undesirable performance were to be made known to all their colleagues they would be motivated by shame or pride to avoid it, and 2) to receive the stamp of approval from professional peers was sufficiently desirable to serve as a strong factor in motivation adherence or improvement. Physicians therefore depended upon a personal and confidential approach that did not shame the offender in public. Occasionally they might withdraw from a reciprocal working relationship in which cooperation was optional or openly complain to other colleagues.⁷

Procedures for actually disciplining peers were, in effect, not available. The dilemma that the application of appropriate sanctions poses for physicians is clearly captured in the following letter which appeared in The New York Times, February 12, 1976, in response to the newspaper's series on the medical profession and the quality of health care:

To the Editor:

Your article on the reluctance of physicians to report errant colleagues accurately describes an important issue. One problem is the lack of a method for disciplining doctors without destroying them.

I recently saw a man of mediocre skill make a lazy error which led to a death. Having seen this man treat dozens of patients adequately, I had no desire to threaten his license or to subject him to a major malpractice suit. I also know that I may make a mistake myself some day. So I did nothing.

Physicians simply will not move against their colleagues, except in extreme cases, until some method of discipline is devised which is based on graduated degrees of punishment, such as a confidential requirement for more education or for a period of practice under supervision. The present situation keeps us silent because it demands an all-or-nothing response.

WILLIAM L. CLOVIS, M.D.
Asst. Clinical Prof. of Psychiatry
Hahnemann Medical College
Philadelphia, Jan. 29, 1976

Thus, it is apparent that the form of control traditionally relied upon by professionals has considerable limitations. Although some degree of self regulation occurs, it is not adequate in either its breadth or depth. It is not systematic nor an exercise of control. Inefficient and incomplete, the system depends upon the value of trust and esteem among colleagues in order to influence professional performance or behavior.

Professional Review

Federally mandated professional review for the purpose of accountability grows out of the informal peer control process. It attempts to strengthen that process by requiring those very elements whose omission was responsible for the ineffective system of professional self regulation.

PSRO Legislation.

The 1972 Amendments to the Social Security Act, under Title IX, provide for the creation of Professional Standards Review Organization (PSROs) designed to involve local practicing physicians in the ongoing review and evaluation of health care services covered under Medicare, Medicaid and the Maternal Child Health programs. The PSRO is responsible for assuring that health care paid for under these programs is medically necessary and consistent with professionally recognized standards of care as well as with the medical care needs of patients. It must also seek to encourage the use of less costly medical care where appropriate. The PSRO is required to review services provided in and by hospitals and other health care institutions, i.e., short-stay general hospitals, tuberculosis hospitals, mental health hospitals, skilled

nursing facilities, and intermediate care facilities. The PSRO review must cover the institution, physician and patient profiles. Therefore, it is an evaluation of the quality of care given by an individual practitioner and the quality of care provided to patients by health institutions.⁸

The legislation is based on the concepts that health professionals are the most appropriate individuals to evaluate the quality of medical service, that effective peer review is the soundest method for assuring the appropriate use of health care exists, and that practitioners can be evaluated in accordance with these standards. The mandate, therefore, reaffirms the principle that a profession as a group has the responsibility for self regulation and for safeguarding the public and itself against fraudulence and incompetence.

The translation of this legislation into practice requires designated PSR organizations (within hospitals or geographic areas) to establish:

1. Professionally recognized standards of care and norms of acceptable and nonacceptable performance
2. An ongoing and systematic evaluation process by which professionals actively engaged in practice appraise the quality of care rendered by their colleagues to determine whether it is in accordance with designated standards and criteria
3. A corrective mechanism to deal with deficiencies identified as related to individual performance of behavior and to organizational or system problems.

Although the PSRO legislation is more or less accepted today by the medical and health professions, it was not initially greeted with

appreciation or enthusiasm. In fact, most physicians expressed strong disapproval with the mandate and feared that compliance would prove to be detrimental to the quality of medical practice and medical care.⁹ A sampling of titles of editorials and articles that appeared in the medical journals in 1973 and 1974 illustrates their concerns.

"The Peril of 'Non-Peer Peer Review'." Illinois Medical Journal, December 1973

"Blueprint for Control: No Knock Peer Review," Modern Hospitals, July 1973

"PSRO--Tyranny in the Making," Hawaii Medical Journal, February 1974

"PSRO--12 Steps Toward Repeal," Journal of Medical Association of Georgia, March 1974

"PSRO--On the Way, But to Where," New England Journal of Medicine, June 24, 1974.

How does the formal professional review system differ from the informal mechanism of peer control? There seems to be four critical differences between the two methods. The professional review approach incorporates: 1) visibility of performance, 2) criteria for desired performance, 3) surveillance, and 4) the exercise of authority.¹⁰ These four attributes attempt to remedy the weaknesses associated with the informal process. While mandated professional review gives the impression of supporting professional autonomy and authority, it also functions to strengthen bureaucratic controls. As such, it may represent the necessary balance sought between professional and administrative authority.

Visibility of Performance.

One of the problems identified with informal peer control was the absence of visibility of professional work and therefore the failure to

have adequate and reliable sources of information about performance. The use of the medical record or chart to review the quality of care, an increasingly common and essential method of quality assessment, may overcome that obstacle.¹¹

The existence of records in which professional notes describe actual care given is considered a potentially valuable and easily accessible source for review. Since notations are made at the time care is given and independently of the need for review, and remain on the record permanently, they are thought to be objective measures of quality and less subject to distortion and selectivity. The use of records for review assumes, however, that the essentials of performance can be found in a record and that a systematic sample, properly reviewed, will produce an accurate and reliable picture of the quality of individual performance.

The use of medical records for review poses a considerable threat to professionals.¹² Physicians have expressed their belief that to use the record for formal review and to evaluate performance from it is neither valuable nor proper. In fact, while the medical record was always available to physicians to be used in their own informal peer review, it was not used in that way. The possibility of checking on physicians who were suspect of wrong doing by examining chart notations was not entertained for the most part.

The reasons for the disapproval of the use of records to monitor performance center upon the conviction that it is impossible to record as fully as required, and that no matter how complete, recording cannot accurately reflect the quality of care provided. There is some basis to these concerns of physicians. The use of records is not necessarily

a reliable source of information. Records have been found to be inadequate at times; often they are incomplete and contain errors.

But the value of their use cannot be easily dismissed. Blau has commented, although in reference to a nonmedical setting, on the consequences of bureaucratic emphasis on the use of statistical records as a technique to improve performance. Although dysfunctions resulted, including worker attempts to make a good showing on the record as an end in itself, the function of records as an indirect as well as direct means of control was noted:

Records of performance were considered a potent force because they make differences and deficiencies in performance generally visible, not only to every official, but also to colleagues and superiors. ... It is the visibility of everyone's shortcomings that sets into motion attempts to overcome them.¹³

Donabedian also suggests that the behavior of physicians in the management of care may be expected to change almost immediately because of the physicians' awareness that their practice has been made visible to colleagues and others.¹⁴

It is likely that requiring the use of medical records for evaluation of professional performance will be problematic as professionals will resist their use, in spite of their value. Where chart review has been imposed, we find that physicians pay lip service to its value while saying it is unnecessary--that is, they subscribe to it in principle but reject it when it pertains to them directly. And, although they go along with it out of necessity, they tend to refute and reject the findings.¹⁵

Criteria for Desired Performance.

Assessment of professionals can focus on many characteristics.

Any number of qualities of an individual professional, including achieved or ascribed attributes, may be singled out as a basis of appraisal. Achievement of organizational goals of conformity of organizational rules may also be used. Failure to set criteria that are meaningful and acceptable to those who will be evaluated constitutes a major deficiency in evaluation systems as was the case with informal peer control. The mandated professional review system requires that professionals be evaluated on the quality of performance. Evaluation is limited to the process of care of the extent to which practice (as recorded) meets professional standards of good care.

Evaluation requires a careful determination of the standards to be judged. Criteria must be established which will specify what dimensions will be taken into account in making the evaluation, whether all dimensions will be considered of equal importance, and what level of performance will be judged as acceptable or unacceptable, good or bad. It is the establishment of these standards and criteria, by either normative or empirical means, and their application to the individual's practice that is the heart of performance appraisal. Unlike informal peer control, the formal process enables discrimination between right and wrong.

This is not to suggest that the establishment of criteria is without difficulties, many of which reflect concerns expressed by professional and physicians in particular. Dimensions of professional performance are indeed complex and the process of arriving at commonly accepted, valid and reliable criteria is likely to be complicated. Moreover, the idea that fixed and formal criteria of performance can be established and applied has been resented by physicians. The develop-

ment of criteria, and the rigidity and standardization it portends, is viewed as pure bureaucracy that deprives the practitioner of discretion and professional judgement.¹⁶

Surveillance.

The establishment of an ongoing and systematic process of evaluation, despite its many difficulties concerning the establishment of criteria and location of sources of information, also differs from informal peer control by the nature of its being a surveillance mechanism.¹⁷ Mandated professional review functions for the purpose of actively searching for problems and deficiencies. Checks are made periodically where there is no doubt or suspicion of poor performance of incompetence.

The effectiveness of this approach lies in the desire of professionals not to get caught and in the apprehension that they might be caught. A study conducted in a non-medical setting reports on the effects upon performance when an audit is anticipated. Individuals who were informed, or otherwise led to believe, that a review would occur modified their behavior before the event in the direction of desired behavior in conformance with the real or expected criteria.¹⁸

Freidson notes that the surveillance aspect of chart review was particularly disturbing to physicians:

... seemed to strike at the very core of the way physicians conceived of themselves and their work. It implied that they were not to be trusted; that, as when they were students, they had not yet grown up and were not capable of responsible, unsupervised performance.¹⁹

A further problem with an evaluation process such as this is not only the requirement that professionals be regularly monitored but that the surveillance be carried out by colleagues. Having to review col-

leagues is likely to be resented and resisted as much as having to be reviewed.

Goss describes the reactions of hospital physicians under these circumstances. When asked to review colleagues, physicians tended to become uneasy and anxious. They were reluctant to comment incisively and offered no more than routine or fairly obvious suggestions. They were fearful that colleagues whose work was under review would justifiably take offense if given evaluations that were less than informed and well grounded.²⁰ Freidson also found that physicians considered it repugnant to go beyond offering suggestions or advice to a colleague and giving unsolicited opinions. Such an audit by colleagues, rather than superiors, would be "degrading", one physician commented.²¹

The impact of the role conflict that peer review creates on the effectiveness of the professional review system is yet unknown. There is reason to believe, however, that as with most role conflict, problems are likely to result.

Exercise of Authority.

Perhaps the key characteristic of the professional review system that differentiates it from informal peer control is the existence of a link between the evaluation of performance and the exercise of authority. Peer evaluations can be translated into control through the legitimate exercise of power. Thus, professional review serves as both a mechanism of organizational control and professional control.

Those conducting professional review function as "organizational evaluators," that is, their evaluations can influence the distribution of organizational rewards and sanctions.²² Although reviewers may differ considerably in their ability to determine the distribution of incen-

tives, as long as they are perceived to be in a position to effect them, the review system is both formalized and legitimized. Of course the more staff values the incentives controlled by the organization, and the more influence a reviewer has on the allocation of those sanctions, the more importance staff will attach to the evaluation process and the more effective it will be.

In addition to collecting the kind of information that can have an impact upon the rewards and sanctions received by those being evaluated, mandated professional review requires that the findings of the evaluations be shared not only with the administrators of the organization. Administrators, in turn, will be reviewed to determine what, if any, corrective action was taken. Thus, built into this system is the responsibility for responding to results as well as the responsibility for gathering results through the evaluation process.

Although the mandated professional review system is based upon the informal mechanism of peer control, and purports to incorporate those elements deemed essential for a control system to be effective, these are the very elements that are likely to contribute to resentment and resistance on the part of professions and thereby negate the system's potential value.

NOTES

1. Eliot Freidson is the major sociologist whose research in this area has resulted in a number of publications, several previously noted: Doctoring Together: Professional Dominance; Profession of Medicine (New York: Dodd, Mead, 1970); and with Buford Rhea, "Knowledge and Judgment in Professional Evaluation," Administrative Science Quarterly 10 (June 1965), 107-124; and "Processes of Control in a Company of Equals," Social Problems 11 (Fall 1963), 119-131.

Mary E.W. Goss has also conducted research in this area and published "Physicians in Bureaucracy: A Case Study of Professional Pressures on Organizational Roles," (Ph.D. Dissertation, Columbia University, 1959); "Influence and Authority Among Physicians in an Out-patient Clinic," American Sociological Review 26 (February 1961), 39-50; and, "Patterns of Bureaucracy Among Hospital Staff Physicians," Eliot Freidson, ed., The Hospital in Modern Society (New York: Free Press, 1963), pp. 176-179.

2. Freidson, Doctoring Together, p. 122.

3. The impact of informal group norms on workers has been of interest to sociologists for some time. For a discussion and summary, see, Blau and Scott, Formal Organizations, pp. 89-96. Professional norms are discussed in Harold L. Wilensky and Charles N. Lebeaux, Industrial Society and Social Welfare (New York: Russell Sage, 1965), Free Press ed., pp. 303-308. For one example of the influence of professional and work norms, see, Howard S. Becker, "The Teacher in the Authority System of the Public School," Journal of Educational Sociology 27 (November 1953), 128-141.

4. The selective use of "mistakes" was first discussed by Everett C. Hughes, "Mistakes at Work," Canadian Journal of Economics and Political Science 7 (August 1951), 320-327. See, also, Joan Stelling and Rue Bucher, "Vocabularies of Realism in Professional Socialization," Social Science and Medicine 7 (September 1973), 661-675; and, Freidson, Doctoring Together, pp. 127-137.

5. Freidson, Doctoring Together, p. 138.

6. Ibid., pp. 138-166.

7. Ibid., pp. 196-197, and Moore, The Professions, pp. 149-156.

8. For further information on the Amendment, P.L. 92-603 and Professional Standards Review Organizations (PSROs) see, Legislative History of Professional Standards Review Organization Provisions of the Social Security Act Amendments, (Department of Health, Education and Welfare, November 1972); The P.S.R.O. Program Manual, (Department of Health, Education and Welfare, March 15, 1974); Barry Decker and Paul Bonner, eds., PSRO: Organization for Regional Peer Review, (Cambridge, Mass.: Ballinger, 1973); and Michael Goran, "The PSRO Hospital Review System," Medical Care 13 (April 1975 Supplement), 1-33.

9. Not all in the medical profession were opposed to PSRO. In fact, The Joint Commission on Accreditation of Hospitals and The American Hospital Association proposed standards and suggested guidelines for monitoring the care provided in hospitals. The American Medical Association published its Peer Review Manual in 1971.

10. A recent effort to study organizational control systems that relies upon the evaluation process may be found in Sanford M. Dornbusch and W. Richard Scott, Evaluation and the Exercise of Authority (San Francisco: Jossey-Bass, 1975). Although the research does not specifically pertain to professional review, there are sufficient similarities to allow for application of the theory to the following sections of the chapter.

11. The use of records for evaluation is discussed and compared with other methods by Avedis Donebedian, "Evaluating the Quality of Medical Care," Millbank Memorial Fund Quarterly 44 (July 1966), Part 2, 166-201.

12. Freidson, Doctoring Together, pp. 167-185.

13. Peter M. Blau, The Dynamics of Bureaucracy (Chicago: University of Chicago, 1963), p. 50.

14. Avedis Donebedian, "A Guide to Medical Care Administration," Vol. II (American Public Health Association, 1969), 14-96.

15. Freidson, Doctoring Together, pp. 179-181.

16. Ibid., pp. 174-177.

17. For an interesting discussion of surveillance as a control mechanism, see, William A. Rushing, "Organizational Rules and Surveillance: Propositions in Comparative Organizational Analysis," Administrative Science Quarterly 10 (March 1966), 423-443.

18. N.C. Churchill and W.W. Cooper, "Effects of Auditing Records: Individual Task Accomplishment and Organization Objectives," in W.W. Cooper, H.J. Leavitt, M.W. Shelly, eds., II, New Perspectives in Organization Research (New York: John Wiley and Sons, 1964), pp. 250-265.

19. Freidson, Doctoring Together, p. 179.

20. Goss, "Influence and Authority Among Physicians."

21. Freidson, Doctoring Together, p. 176.

22. Dornbusch and Scott, Exercise of Authority, pp. 94-97.

CHAPTER IV

THE SOCIAL WORK PROFESSION: ACCOUNTABILITY AND CONTROL

The issue of professional accountability is of growing significance to the social work profession. One area of concern centers on the question of social work's effectiveness, a subject of renewed interest. Since the 1930's, more than seventy studies have attempted to examine the effectiveness of casework services. Eleven of these studies were recently analyzed by Fischer who concluded that casework failed to demonstrate that it is effective and that this lack of effectiveness appears to be the rule rather than the exception. Another review of fourteen studies of social work intervention by Mullen and his associates suggested that the available research fails to provide a conclusive answer about social work effectiveness.¹

While demonstrating the effectiveness of social work can be considered a sound endeavor, one that Briar suggests any scientifically based profession would ask of itself, the times are such that social work has been selected out for considerable pressure to prove that what it is doing is worth supporting.² Upon entering the 1970's and the age of accountability, the social work profession found it could not make grandiose or unsubstantiated claims about its accomplishments, or assert that the nature and uniqueness of its task prevent either the identification of standards or their measurement. The profession realized that it must make clear what the standards are that govern the quality of service provided by social work, and demonstrate

and guarantee that they are being met.

The profession has engaged in a serious and constructive effort in response to the demand for accountability. The issue has received considerable attention in the professional literature.³ Agencies are searching for ways to evaluate their programs through more rigorous means and it is expected that these attempts will increase. Moreover, the profession has deepened its commitment to the establishment and maintenance of high standards. Through its professional association, NASW, social work has assumed greater control over recruitment and certification, and for upgrading professional standards and competence. Although regulation by the professional association is limited, and the policing of members once they are practicing in the field is virtually nonexistent, there is a concerted effort to develop a more effective system of control.⁴

Along with this emphasis upon accountability, the profession appears to be moving toward greater acceptance of the individual social worker's role and responsibility for accountability. Gradually the professional social worker is being viewed not as accountable to the agency for the fulfillment of defined responsibilities but rather to himself and to his clients for the quality of service given. Increasing emphasis is being placed upon the independent and autonomous practitioner -- able to critically assess his practice and to determine whether it meets professional standards, to take responsibility for his professional development and for raising the level of his practice, and to seek consultation, read professional literature, write professional articles and engage in research.⁵

Within this context, it is perhaps not surprising that the social

work profession is once again expressing dissatisfaction with its traditional form of accountability -- supervision.

Supervision

Supervision in social work, as Miller states, "is essentially an administrative process for getting the work done and maintaining organizational accountability."⁶ Williamson provides a working definition of supervision in one of the first books on the subject in social work:

...process by which individuals and workers who have direct responsibility for carrying out some part of the agency's program plans, are helped by a designated staff member to make the best use of their knowledge and skills, and to improve their abilities so that they do their jobs more effectively and with increasing satisfaction to themselves and to the agency.⁷

Thus, supervision was always seen as an administrative process through which the worker was helped to do a better job for the agency and thereby ensure that the agency's purpose is fulfilled through the provision of adequate service to clients. Some of the difficulties with supervision as an administrative process were identified as early as 1952 by Berkowitz.⁸

Over the years the social work profession has been increasingly critical of supervision and the problems created by it. Supervision has been viewed as dysfunctional to the worker and to the profession. Objections have been raised by practitioners dissatisfied with their status, with the limitations upon their autonomy and their initiative, and with the manner in which supervisory authority and control are exercised. It has been claimed that supervision creates dependent workers, limits workers' professional contacts within the agency, weakens the assimilation of knowledge and the internalization of standards by workers because of its emphasis on external controls.⁹

Alternatives to supervision have been offered. The use of a collegial organizational structure for staff to interact with one another as peers, through group supervision and peer consultation, have been suggested as ways of vesting accountability for the quality of service in the professional practitioner instead of in the supervisor.¹⁰ A useful case example of one agency's experience in eliminating supervision and placing direct, professional accountability for the quality of service with the professional staff is presented by Fizdale. The mechanism of peer consultation in which collective knowledge, observation and skills of the group were shared on behalf of the client was used but it remained the responsibility of the individual practitioner to determine how he would use what was offered to him in light of his own professional judgment.¹¹

Professional Vs. Administrative Authority

Although social work is critical of its supervision, in which the positions are filled by social workers themselves, it has important advantages for control. Scott has noted:

The supervisor is able to exercise considerable surveillance and control over worker actions, but in a manner which is consistent with his own professional self-image. The therapeutic supervisor does not issue directives to caseworkers nor does he threaten them with punitive action for noncompliance. He attempt to refrain from using the sanctioning power attached to his office as supervisor and relies instead on his superior knowledge and casework skills to guide and control the caseworker. ...In this way, the supervisor emphasizes his role as educator rather than administrative superior and confirms his self-image of professional rather than bureaucrat. The caseworker, for his part, is also likely to perceive the benefits associated with this approach. If he sees himself as a professional person, this supervisory orientation reinforces that image, granting him freedom from overt direction and access to professional consultation which assists with his case prob-

lems and his own professional development. Finally the agency itself was probably a beneficiary of this supervisory technique, which by masking the power differences present in the administrative structure protected the professional self-images of both supervisors and subordinates and thus contributed to job satisfaction and morale of the professional staff.¹²

From this point of view, it would seem that the social work profession has adopted a control mechanism that successfully balances the two sources of authority, professional and administrative. Social workers are guided and controlled not only from within by internalized norms and values of the profession but also by bureaucratic rules and procedures and by superiors in the organizational hierarchy. Administrative controls pertain to some areas yet the professional retains autonomy and authority in making professional judgments regarding clients.¹³

The opposition to supervision by the social work profession, however, suggests that the mechanism of control is not satisfactory nor has it eliminated the incompatibility between professional norms and values and bureaucratic authority. Debureaucratization of the agency which will enable the strengthening of the exercise of professional autonomy and authority is sought.¹⁴

At a time in which the desire is to decrease the autonomy of the medical profession in order to attain a higher quality of service and greater accountability, social work, having had less autonomy, is looking toward the enhancement of its autonomy through additional professional control. The move to strengthen bureaucratic control over physicians thus takes place while social work attempts to strengthen its professional controls at the expense of what has been a traditional and seemingly entrenched bureaucratic control structure.

Although there is no relationship between the two attempts, both

are reactions to the demand for increased accountability. Physicians are being forced to accept more administrative control which is a threat to the prerogative of professionals to regulate themselves. Social workers, on the other hand, are asking for greater self regulation and are seeking to rid themselves of supervision as a mechanism of control, as a major step toward increased professionalization.¹⁵

Professional Review

Evidence of the social work profession's interest in greater self regulation may be found in the way it has embraced the PSRO mandate. Social work, as one of the non-physician health care practitioners that eventually will be involved in professional review, has been vigorous in its attempts to obtain the inclusion of the profession in the PSR organizations at the local and national level. The professional association, NASW, exercising leadership in this area, cites several reasons for the profession's participation:

1. To aid in better health service delivery through attention to the psycho-social components of health
2. To ensure that a full spectrum of integrated services are developed and related to the range of community resources
3. To bring professional consideration of the personal and social needs of patients and their families during the rendering of health services, and provide linkages with community resources
4. To guarantee that quality standards for social services and social work practice are established by the social work profession.¹⁶

In addition, the profession has stimulated interest among hospital social work departments in the establishment of their own professional review systems and has suggested guidelines to assist them.¹⁷

Despite the sense of enthusiasm for involvement in professional review shown by the social work profession as a whole, is there not reason to suspect that individual social workers will respond in the same way as physicians reacted? Will social workers be cautious, if not negative? Will they be anxious, if not resistant? Will social workers also be threatened by mandated professional review?

In many ways, social workers are subject to the same kinds of norms and threats as are physicians. Professional norms that govern colleague relations and loyalty, and contribute to the difficulty in peer evaluation exist. Temptations toward protection and rationalization that grow out of an appreciation of the difficulties in providing service and of the constraints upon optimal practice exist. There is probably a mutual recognition of the unofficial ways in which workers have adapted to these conditions which, under close scrutiny, could reflect poorly on all. There are, undoubtedly, the same tendencies to magnify virtues, excuse errors, and discount mistakes which lead to the avoidance of taking notice of incompetent practice and of reporting on others. Thus, the professional and informal work norms that effectively deter peer control in the medical profession may very well operate in the social work profession.

In addition, social work performance is not really more visible than physician performance. Information about colleagues' work is as unreliable and inadequate among social workers as among physicians. The use of the medical record (in which social work notes are maintained) for review might therefore be equally threatening to social workers. Were it not for the tradition in social work of recordings and chart notations being available to and used by supervisors as part

of supervision, it is likely resistance to their use for review would be considerable.

The standards and criteria for desired performance are somewhat vague and ambiguous in social work. Instead of clear and meaningful performance criteria, emphasis tends to be placed upon results and their effectiveness, on such personal qualities as attitude conformity and value commitment, and on the adherence to organizational policies and procedures such as timely submission of statistical records and chart notations.¹⁹ Although the absence of performance criteria and standards of adequate practice may serve to support the contention that social work tasks are unique and complex and not amenable to identification or measurement, the establishment of them may engender resistance.

Social workers, in contrast to physicians, seem to have become accustomed to surveillance. Supervisors have assumed the administrative responsibility for checking on and monitoring worker performance. This surveillance has also been well linked to organizational rewards and sanctions, and to the exercise of authority. The very nature of the supervisory position in the organizational hierarchy, which is filled by promotion upwards of line social workers who are deemed appropriate, is a clear illustration of a bureaucratic incentive system. Social workers thus appear to be more vulnerable to surveillance and control by the organizations in which they are employed. As a result, the introduction of these two aspects of mandated professional review, surveillance and the exercise of authority, may be of little concern and less of a threat to social workers.

It may be that the critical differences between informal peer control and mandated professional review which contributed to negative re-

actions of physicians will be less meaningful to social workers. Less experience with informal control, and more accustomed to organizational evaluation linked to the use of medical records and sanctions, social workers may be less adverse to and more accepting of professional review.

However, the very fact that professional review constitutes a bureaucratic control mechanism, and an additional one under the guise of professional control, leads to the expectation of negative reactions from professionals already heavily subject to organizational controls and invested in their elimination. Although the move toward peer evaluation supports social work's own growing demand for the elimination of hierarchical evaluation through supervision, the goal in principle may be more warmly received than the goal in reality. Traditional acceptance of the legitimate function of more experienced superiors to check and evaluate performance is not easily converted to acceptance of peers in the same role. Moreover, the state of equilibrium that results from a fairly stable control mechanism such as supervision, whereby the evaluator and the evaluatee learn to accommodate to one another for the effective exercise of authority, is subject to alteration by the introduction of any new control system, no matter how desirable it may be. The possibility of this alteration presents a considerable threat in itself.

NOTES

1. Joel Fischer, "Is Casework Effective? A Review," Social Work 18 (January 1973), 5-20; Edward J. Mullen, James R. Dumpson and Associates, Evaluation of Social Intervention (San Francisco: Jossey-Bass, 1972). For alternative interpretations of the studies, see, Alan L. Grey and Helen E. Dermody, "Reports of Casework Failure," Social Casework 53 (November 1972), 534-543 and Walter W. Hudson, "Casework As A Causative Agent in Client Deterioration: A Research Note on the Fischer Assessment," Social Service Review 48 (September 1974), 442-449.
2. Scott Briar, "The Age of Accountability," Social Work 18 (January 1972), 2.
3. See, for example, Reed Henderson and Barbara K. Shore, "Accountability for What and To Whom," Social Work 19 (July 1974), 387-389, 507; George Hoshino, "Social Services: The Problems of Accountability," Social Service Review 47 (September 1973), 373-383; Edward Neuman and Jerry Turem, "The Crisis of Accountability," Social Work 19 (January 1974), 5-16; Mauro Rosenberg and Ralph Brody, "The Threat or Challenge of Accountability," Social Work 19 (May 1974), 344-350; and Emanuel Tropp, "Expectation, Performance and Accountability," Social Work 19 (March 1974), 139-148.
4. Sheryl K. Ruzek, "Making Social Work Accountable," Freidson, ed., The Professions and Their Prospects, pp. 230-232.
5. Laura Epstein, "Is Autonomous Practice Possible?", Social Work 18 (March 1973), 5-12; Ruth Fizdale, Social Agency Structure and Accountability (New Jersey: R.E. Burdick, 1974).
6. Irving Miller, "Supervision in Social Work," Social Work Encyclopedia (New York: NASW, 1971).
7. Margaret Williamson, Supervision: New Patterns and Processes (New York: Association, 1961), 19.
8. Sidney J. Berkowitz, "The Administrative Process in Casework Supervision," Social Casework 32 (December 1952), 419-423.
9. See, for example, Laura Austin, "An Evaluation of Supervision," Social Casework 37 (October 1956), 375-382; Charles Levy, "The Ethics of Supervision," Social Work 18 (March 1973), 14-21; B. Mandell, "The 'Equality' Revolution and Supervision," Journal of Education for Social Work 9 (Winter 1973), 43-54.
10. There is an extensive literature on alternatives to supervision which suggests the use of the group approach. See, for example, Tsuneko K. Apaka et al., "Establishing Group Supervision in a Hospital Social Work Department," Social Work 12 (October 1967), 54-60; John J. Appleby et al., "A Group Method of Supervision," Social Work (July 1958), 18-22;

George S. Getzel et al., "Supervising in Groups As A Model for Today," Social Casework 52 (March 1971), 154-163; Iadwiga Judd et al., "Group Supervision: A Vehicle for Professional Development," Social Work 7 (January 1962), 96-102; John Wax, "Pros and Cons of Group Supervision," Social Casework 40 (June 1959), 307-313; and Gladys Weinberg, "Dynamics and Content in Group Supervision," Child Welfare (June 1960), 1-6.

11. Fizdale, Social Agency Structure and Accountability, pp. 117, 120.

12. W. Richard Scott, "Professional Employees in a Bureaucratic Structure: Social Work," Amitai Etzioni, ed., The Semi-Professions and Their Organization (New York: Free Press, 1969), p. 108.

13. The difference in the way professional and administrative authority is related in semi-professional organizations, which includes social work, has been discussed by Etzioni, The Semi-Professions, xiii-xvi, and Nina Toren, Social Work: The Case of a Semi-Profession (Beverly Hills, Sage, 1972).

14. "Debureaucratization" was referred to by Archie Hanlan, "Casework Beyond Bureaucracy," Social Casework 52 (April 1971), 195-199.

15. The concept of professionalization and its relationship to social work is discussed by William J. Goode, "The Theoretical Limits of Professionalization," Etzioni, ed., The Semi-Professions, pp. 266-313.

16. National Association of Social Workers, P.S.R.O. Basic Information for Social Workers (1976), p. 3.

17. See, for example, Report of the New York City Task Force on PSRO (February 1976).

18. It is this lack of visibility, Miller suggests, that leads to supervision as a method of control and, Etzioni suggests, that leads to the granting of less autonomy to the profession.

19. Toren makes the point that professions that have less autonomy have considerable pressure on them to demonstrate effectiveness. They are judged more by results than skill and effort. Ironically, she comments, the ineffectiveness may be attributed to, among other reasons, the relative low autonomy and authority afforded them within the organization.

CHAPTER V

ATTITUDES OF SOCIAL WORKERS TOWARD PROFESSIONAL REVIEW

As part of the project described in the following chapter, the attitudes of social work staff toward professional review were measured. The purposes of the study were: 1) to arrive at some understanding of what social workers thought about professional review in general, and about the potentially controversial aspects in particular, 2) to establish a baseline measure in order to determine any changes in attitudes that might result from the training project, and 3) to provide additional information about social work staff that might be useful to our understanding of the way social workers actually engage in professional review.

Setting

The study and project were conducted at the Hillside Hospital Division of the Long Island Jewish-Hillside Medical Center. The hospital is one of three that were affiliated with Long Island Jewish Hospital within the past few years to comprise the medical center. The center includes Queens Hospital Center and South Shore Hospital, in addition to the Hillside and Long Island Jewish Hospital divisions. Hillside is a 200-bed psychiatric facility with full outpatient services in addition to in-hospital treatment. It provides comprehensive mental health services to the counties of Queens and Nassau which in-

clude a broad scope of community based programs.

In this multidisciplinary setting, the Department of Social Work Services, founded twenty-five years ago, has grown rapidly, reaching a staff of about 100, the majority of whom have professional degrees in social work. The Department has long been highly regarded in the social work field; a leader in the provision of quality service and in research, it is also a major instructional center for professional social work education. Social workers play a prominent role at the hospital. The primary goal of the social work department continues to be contributed to patient care by helping families in distress. The social work staff has been unionized for several years. All but the administrative staff belong to one of the major unions of non-professional health care personnel.

At the time of the project, the Hillside Division Social Work Department had participated, along with the other divisions, in a year of planning for its quality assurance program that was based on a professional review system.¹ A second interdivisional, representative staff committee would be established shortly to continue the work of the previous year and to focus upon implementation procedures. In addition to the department's effort to establish a review system, a center wide quality assurance program was initiated. Physicians and nurses were also involved with professional review.

A recent study of the Hillside Division social work staff indicated a relatively young, female staff who received their professional degrees within the last eight years and who have been working at Hillside less than four years. Nearly all brought previous experience in health or mental health settings (including graduate field experience)

to their jobs. The majority had been employed elsewhere as social workers before joining the Hillside staff.²

This study and project were concerned only with the line social work staff, those holding Masters degrees in social work and positions with the title of Social Worker. Supervisors, both clinical and administrative, were eliminated as were Social Work Associates and Assistants. In addition, all part-time social workers and staff employed for less than three months at Hillside were excluded.

In September of 1975 all social workers who met the criteria of title, education, and length of employment received a set of three questionnaires on professional review.³ Of the 51 questionnaires distributed to staff, 91%, or 46 responses were completed and returned.

A cover letter accompanied the questionnaires and explained the intent of the study and requested staff cooperation.⁴ It was assumed that staff had a passing familiarity with professional review; departmental planning for it as well as the eventual implementation of it were known. It was also assumed that the idea of professional review was rather unclear and vague. It was thought unlikely that staff understood what their own role and responsibility would be in the system, much less the consequences of professional review. That kind of information had not yet been shared with staff. The staff probably was aware of the department's eagerness to implement its professional review system but it is likely staff attributed this interest less to an enthusiasm for professional review per se and more to a desire by the department to establish itself as a leader in the area. The cover letter therefore concisely explained professional review and reminded staff that it would soon be implemented. As a result, the letter served

as a stimulus, common to all respondents.

Instruments

The attitudes of social work staff at Hillside Hospital toward professional review were measured with three instruments constructed to evaluate the direction and magnitude of staff predisposition toward professional review; a Likert-type summated rating scale, a semantic differential scale, and the social judgment-involvement technique.⁵ Each instrument relied on self ratings and closed questions to measure attitudes. To allow for the expression of attitude in various ways and to yield a better representation of the intended attitude, multiple item sets were used in each assessment. More than one method to assess staff attitudes toward professional review was used to provide more meaningful and reliable data about attitudes. Responses were scored separately for each instrument yielding three gross measures of the direction and magnitude of attitudes.

Summated Rating Scales.

Summated scales have been widely used in the study of attitudes. They provide a basis for a rough ordering or ranking of individuals in terms of the favorableness of their attitudes toward a given object. Respondents were asked to react to a series of 33 statements about professional review by indicating their agreement or disagreement with each item on a nine point scale.⁶ Nine positions were included in the scale to allow for sufficient degree of differentiation in attitude expression, accurate placement of respondents on an agreement-disagreement continuum, and greater response variance. The 33 items selected were intended to elicit responses that were psychologically related to the attitude being measured, to differentiate among people who are at dif-

ferent points along the dimension, and to represent clearly favorable or definitely unfavorable reactions--neutral and slightly favorably or unfavorable items were avoided.

Respondents were given a total score by the summing of the scores of all 33 statements; a score of one was given to strongly unfavorable toward professional review, five to undecided, and nine to strongly favorable. In addition, each statement was given a mean score and analyzed.

Semantic Differential Scale.

The semantic differential scale developed by Osgood and his associates provides additional information on staff attitudes toward professional review. This procedure has been shown to be useful as a generalized attitude measurement technique by providing a richer picture of the meaning of an attitude object. By combining judgments made on a number of semantic differential scales representing the evaluative, potency and activity factors of meaning, assessment can be made about how much alike or how different are the attitudes of individuals with identical scores. In addition, the semantic differential allows for a somewhat improved prediction of individual behavior. The technique has also been shown to be a fairly sensitive measure of attitude change.

Staff attitudes were directed toward the evaluative, activity and potency meaning of three concepts; professional review, having one's work and practice evaluated by colleagues, and having to audit and evaluate the work of colleagues. The latter two concepts were considered to be critical aspects and were selected because of the likelihood that the meaning of each might differ for respondents who might otherwise have identical or very similar attitudes toward professional review in

general. One's picture of having his own work evaluated by peers may not coincide with his picture of his evaluating colleagues' work or his picture of professional review. In Osgood's terms, the three concepts were thought to cover various parts of the total semantic space.

Respondents were asked to react to the three concepts using twelve scales.⁷ Each scale consisted of the same bi-polar adjective pairs: eight evaluative factors, two potency factors, and two activity factors. In general, adjectives that were identified and empirically tested by Osgood and were considered relevant to the concepts were selected; adjectives that appeared to be irrelevant were used sparingly. Individuals' scores for each factor were obtained for each concept and differences between concepts for respondents were examined to determine, first, how each "sees" the concept, that is, the relative value he places on the different concepts and, secondly, which concepts are close together and far apart in his meaning space. The lowest possible score of one on each scale was given to a negative meaning and the score of seven was given to a positive meaning.

Correlations between the summated rating scale and each of the three semantic differential scales were done as a means of validation to see if it was likely that the intended attitudes were actually being measured. The rating scale showed a statistical significance at the .01 or .02 level when correlated with each. The relationship (r) between the rating scale and "Professional Review" is .77, with "Having Your Work and Practice Evaluated by Colleagues" is .63, and with "Having to Audit and Evaluate the Work of Colleagues" is .74.

Social Judgment-Involvement Approach

Staff attitudes toward professional review were also measured using the social judgment-involvement technique developed by Sherif and Sherif which, unlike the summated rating scale or the semantic differential method, provides information on the degree of personal involvement in an issue at hand.⁸ By having respondents indicate from among a range of positions on an issue which statements he finds acceptable (latitude of acceptance), objectionable (latitude of rejection), and which statement he has no opinion (latitude of noncommitment), the approach differentiates respondents according to their tolerance to, involvement in, and commitment to the concept being measured. The value of this approach over a single preference score or average has been substantiated in a number of studies. All, for example, who receive the same score, thereby indicating the same degree of approval or favorable on a summated scale may differ in involvement and therefore in terms of likelihood of active support or resistance, openness of closeness to considering other opinions, etc.

Respondents were asked to indicate their acceptance and rejection to a set of nine statements, worded in essentially the same way, and representative of a range from strong approval to strong disapproval about the value of professional review in five contexts; in the interest of quality of social service rendered, in the patients' interests, in the respondent's own interests, in the interests of the social work profession, and in the interests of the Department of Social Work Services of Hillside Hospital. Only responses of acceptable were used in this analysis.

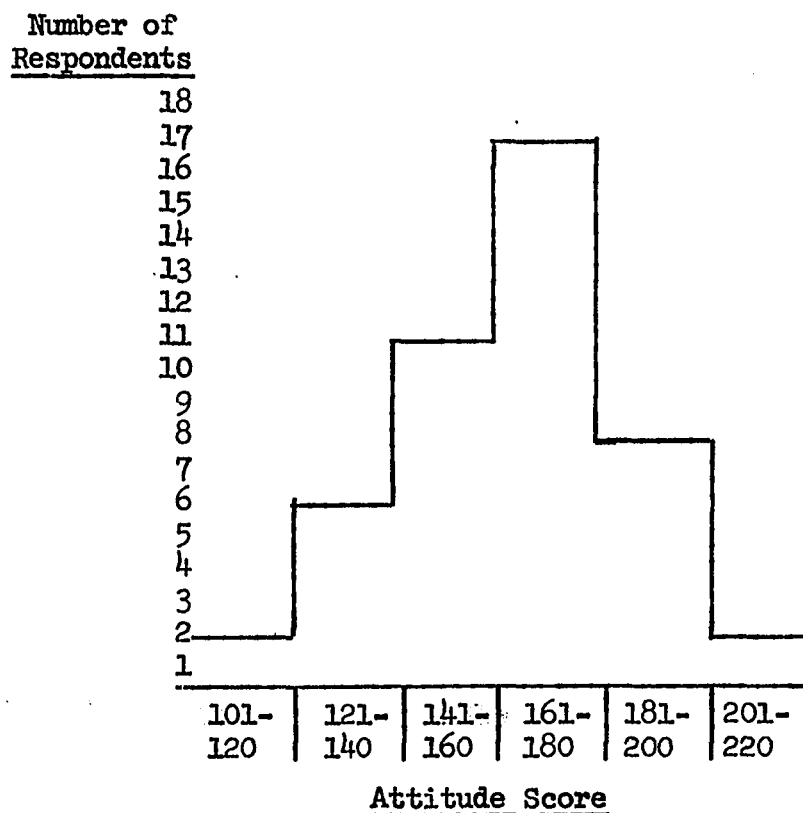
Findings

Analysis of data from each of the three instruments indicate a generally favorable attitude toward professional review on the part of the social work staff at Hillside.

Only one-third of the respondents scored below the mid point of the rating scale (155) and in the unfavorable range. The distribution of scores that theoretically could have ranged from 31 through 279, actually ranges from 105 to 112 as illustrated in Figure 1. Neither extreme of positive or negative attitudes were expressed by staff and the responses were normally distributed.

Figure 1

FREQUENCY DISTRIBUTION OF RATING SCORES ATTITUDES TOWARD PROFESSIONAL REVIEW



N= 46
Mean=163
Median=166

A closer examination of responses indicates that not all items were viewed favorably. Positive attitudes toward professional review centered on approval of it in principle. Statements oriented toward the value of professional review elicited favorable response. As indicated in Table 1, respondents generally viewed professional review as valuable for the new information it would provide, for themselves, especially for the social work profession, and to a slightly lesser extent, for the clients.

TABLE 1
FAVORABLE ATTITUDES TOWARD THE
VALUE OF PROFESSIONAL REVIEW

Item	Percent Favorable	Total
Profession will be better off with professional review	70	(46)
Own interests would be better off with professional review ^a	65	(46)
Audits will provide new information ^b	63	(45)
Clients will get the most out of professional review	57	(46)

^aItem is reversed and written in positive for consistency in this table.

^bItem is reversed and rewritten. Item in questionnaire reads, "These audits are not going to tell us anything we don't already know."

The findings from the social judgment-involvement scale, presented in Table 2, support the conclusion and further point out the extent to which staff views the value of professional review. When asked to indicate the one statement that best expressed their most acceptable view of

professional review, at least 80% considered it essential, in the best interests of, or better for patients, the profession, the Department of Social Work at Hillside, and for the general provision of social services. Only two-thirds considered it as valuable for their own interests.

TABLE 2
ACCEPTANCE OF PROFESSIONAL REVIEW, IN PERCENTAGE

Degree of Acceptance	In the interest of				
	Patients	Self	Profes- sion	Depart- ment	Quality Service
Necessary ^a	33	18	38	38	31
Good idea ^b	51	48	51	42	56
Neither good nor bad ^c	13	27	9	18	11
Bad idea ^d	2	7	2	2	2
Total	100% (45)	100% (44)	100% (45)	100% (45)	100% (45)

^aCombines items A and B; see Questionnaire in Appendix.

^bCombines items C and D; ^cItem E; ^dCombines items G, H, and I.

Respondents were most indecisive and negative about the value of professional review in reference to themselves. And while no staff viewed professional review as detrimental to any of the interested parties, and very few thought it best or preferable to do without it, some admitted that it was hard to decide whether professional review would be advantageous or disadvantageous.

Part of the favorable attitude toward professional review may be a result of strong positive feelings about one's own responsibility in peer

control and for weeding out those practitioners that may be performing below standard. As Table 3 illustrates, on two of the three items intended to elicit attitudes toward such professional responsibility, two indicated very strong feelings. On the one item, suggesting a more generalize responsibility, half of the respondents expressed agreement and half expressed disagreement. It is possible that the item had a different connotation from the other two for the respondents and therefore drew a different response. Or, the idea that professional and personal responsibility begin only after problems are identified may have brought mixed reactions.

TABLE 3
RESPONSIBILITY TOWARD COLLEAGUES' WORK

Items	Percent		Total
	Agree	Disagree*	
I don't see it as my responsibility to be my "brothers' keeper."	13	87	100% (45)
So what if there are a few rotten apples in this department, it's not my job to throw them out.	13	87	100% (45)
We are all responsible for each other's work.	50	50	100% (45)

*Includes undecided responses.

Positive staff attitudes may also be attributed to a sense of confidence in that professional review can be implemented and can work. Respondents were generally positive about the feasibility and practicality of it. Most importantly, they seem to believe that those who would be

engaged in the review could be trusted; they would be serious, objective and honest. Considerably less confidence was expressed, however, in the belief that the results of the review would be put to good use. Perhaps having less factual knowledge about the consequences of professional review, staff was more negative about this item. On the other hand, the confidence felt regarding colleague participation in the review may not extend to the participation of administration. Table 4 highlights these findings.

TABLE 4
CONFIDENCE IN PROFESSIONAL REVIEW

Item*	Percent			Total
	Positive	Unsure	Negative	
Will be critical	81	4	15	100% (46)
Will be serious	78	11	13	100% (46)
Will be objective	76	2	22	100% (46)
Will be honest	70	13	17	100% (46)
Is practical	65	22	13	100% (46)
Will work	54	35	11	100% (46)
(Results) will be put to good use	37	41	22	100% (44)

*See Questionnaire in Appendix for exact working of items, numbers 1, 5, 7, 8, 9, 11 and 24.

Negative staff attitudes toward professional review are most clearly seen in the analysis of responses that pertain to those aspects of the mandated system that were considered to be controversial and likely

sources for resistance. Table 5 summarizes the responses on the items that refer to the use of medical records for the purposes of review. Table 6 summarizes the responses on the items that refer to the awareness of the possible impact of professional review on the informal relations and norms in the work setting.

Social work staff expressed strong negative attitudes about the use of medical records for review. More than three-fourths state that it is not all right to judge the quality of service by what workers record; less than ten percent believe it is all right to do so. Almost two-thirds of the respondents considered it unfair to evaluate social work practice from recordings. The suggestion that recordings might be inappropriate for review because they are susceptible to alteration, doctoring or deliberate change for the purpose of review was rejected by just over one-third of the staff. Resistance to the use of records stems not from distrust of how colleagues might use them to their advantage but from a more general notion of what is fair and what is right.

The items that attempted to measure awareness of professional review on work and colleague relations and its influence on attitudes were responded to differentially. Most agreed with the items that were directly related to the possible impact upon their own relationships with colleagues, and thereby expressed negative attitudes. However, what appears to be an inconsistency is found with the fourth item within that context. Only thirty percent of the respondents say they would not want their colleagues to know that they had evaluated them. The two items referring to a more generalized influence on the work climate received less an expression of negativism than might have been expected. Only fifteen percent thought professional review would affect peoples' dis-

TABLE 5
ATTITUDES TOWARD USE OF RECORDS

Items	Percent			Total
	Agree	Undecided	Disagree	
It's not allright to judge the quality of service by what workers record*	78	13	8	100% (46)
It's not fair to evaluate social work practice from case recordings	63	11	26	100% (46)
Anyone can fix his recordings so that his work will look good	61	2	37	100% (45)

*Item is reversed and written in negative for consistency in this table.

TABLE 6
IMPACT OF PROFESSIONAL REVIEW
ON WORK AND COLLEAGUE RELATIONS

Items	Percent			Total
	Agree	Undecided	Disagree	
It isn't easy to tell your colleague what you think of his work	85	0	15	100% (46)
I'd rather not know who I am reviewing	78	9	13	100% (46)
I wouldn't be surprised if my colleagues took offense with my evaluations	65	22	13	100% (46)
These kinds of evaluations can dampen staff morale	39	17	44	100% (46)
I wouldn't want my colleagues to know that I evaluated them	30	13	57	100% (46)
It will be hard to keep a pleasant disposition while this is going on	15	20	65	100% (46)

position and thirty-nine percent thought it would affect staff morale. Almost a fifth of the respondents were unsure of what the impact would be.

Perhaps the two most sensitive items to favorable or unfavorable attitudes toward professional review in the summated rating scale are those that provide the respondents with the opportunity to express what they would do about professional review if they could. Fifty-seven percent of the staff agreed that they would just as soon get out of having to do audits if they could; five percent were undecided. Sixty-five percent of the staff agreed that they would resent being evaluated by some of the social workers in their Department; another nine percent were undecided. Thus we find that considerably less than half of the staff would choose to participate in professional review.

The data from the semantic differential scales also shed light on social workers' attitudes. On each of the three concepts thought to be an essential component of attitudes toward professional review, respondents were favorably inclined. Responses fell well above the mid point

TABLE 7
MEANING OF PROFESSIONAL REVIEW*

Concept	Total	Mean	Median	Range
Professional Review	(45)	47.5	47.8	42
Having to Audit and Evaluate Colleagues	(45)	48.4	48.5	38
Being Audited and Evaluated by Colleagues	(45)	45.4	46.2	45

*Based on ten scales.

of 35 and in the positive range. As with the rating scale, extreme scores of negative or positive were not given. Again we find that the distribution of scores is approximately symmetrical. As shown in Table 7, there are only slight variations among responses to each concept. Respondents are slightly less positive to the idea of being audited and evaluated by colleagues. Not surprisingly, being reviewed by peers is more objectionable than reviewing colleagues, but is not really viewed with disfavor. From these findings, it would seem that the three concepts are quite close together in semantic space and therefore are alike in meaning for staff.

Examination of the mean scores of the evaluative, activity, and potency factors of the attitudes toward each concept provides additional insight. Table 8 provides a summary of the data. Although there is no difference in the strength (potency) of feeling toward each concept, it

TABLE 8
MEANING OF PROFESSIONAL REVIEW
BY MEAN SCORES OF FACTORS

Concept	Factors			Total
	Evaluative	Activity	Potency	
Professional Review	34.9	8.1	4.5	(45)
Having to Audit and Evaluate Colleagues	35.5	8.0	4.6	(45)
Being Audited and Evaluated by Colleagues	33.8	7.3	4.2	(45)

is not a strong feeling that is being expressed. Despite the favorable attitudes that have been measured, respondents do not appear to feel strongly about professional review. The relatively low potency factor scores suggest a rather lukewarm although positive attitude and a probable lack of commitment to it. The difference in activity factor scores, although slight, points to a somewhat greater anxiety about being reviewed by colleagues. Being audited and evaluated by peers seems to be more disturbing to staff than having to evaluate others. The evaluative factor scores seem to further suggest that the respondents feel negatively toward being reviewed. In comparison to the other two concepts, social workers are least favorable toward and most anxious about being reviewed.

Summary

Social workers at Hillside Hospital were, at first glance, positive about professional review. They seemed to appreciate its value for the profession, for clients, and for quality service. They also recognized its value for themselves, although to a lesser degree. They seemed to believe that professional review is both feasible and workable. This belief appears to stem primarily from the confidence they expressed with the way review would be carried out and with the way colleagues would approach it; critically, objectively, and honestly. Admission of a general sense of responsibility to monitor one's professional colleagues may also have contributed to their positivism. Less favorable, and indeed unfavorable, attitudes were indicated regarding those areas that are thought to be critical elements of mandated professional review.

In particular, the use of medical records for review was viewed unfavorably despite the staff's previous experience with them in supervision. In the same vein of physicians' expression of concern, the social work staff questioned the idea of obtaining a valid or reliable measure of quality by perusal of notations on case records. The awareness of the potential impact of professional review on colleague relations, and on norms of work and the professions, suggests concern and also contributes to some negative attitudes. In general we find a kind of disparity between staff support of professional review in principle and in reality. The positive attitudes may be more related to wanting to believe it is worthwhile. Although staff is agreeable to engaging in professional review, they would prefer to do the reviewing than to be reviewed.

NOTES

1. See, Roslyn H. Chernesky and Abraham Lurie, "Developing a Quality Assurance Program," Health and Social Work 1 (February 1976), 117-130.

2. Although these findings are unpublished, the study was conducted as part of a larger project. See, Roslyn H. Chernesky and Abraham Lurie, "The Functional Analysis Study: A First Step Toward Quality Assurance," Social Work in Health Care 1 (Winter 1975-76), 213-223.

3. A copy of the questionnaires is in Appendix 1.

4. A copy of the covering letter is in Appendix 2.

5. Fred N. Kerlinger, Foundations of Behavioral Research (New York: Rinehart & Winston, 1964), pp. 479-502, 564-580; Charles Osgood, G. Suci, and P. Tannenbaum, The Measurement of Meaning (Urbana, Ill.: University of Illinois, 1957); Carolyn W. Sherif and Muzafer Sherif, eds., Attitude, Ego-Involvement, and Change (New York: John Wiley and Sons, 1967).

Preliminary testing of the instruments was done with a social work staff in a psychiatric hospital in a neighboring state. Responses indicated that major revisions were not necessary. Response categories were refined; some items were recorded or eliminated. The testing showed that the instruments, although seemingly long and involved, could be administered with relative ease, and that staff would cooperate. Preliminary testing also indicated that each scale was measuring the attitude, and as expected, a combination of all three provided more meaningful information than any one.

6. The 33 items were correlated. Two items did not correlate significantly with at least one other item and were therefore eliminated from the analyses. Thus, all analysis refers to 31 items on the rating scale. These two items were: "Hardly anyone will be able to meet the standards that will be used"; and, "Colleagues seldom understand a case well enough to make a really just decision." Note, too, that the questionnaire lists 35 items; 15 and 16 repeat 13 and 14 as a result of typographical error.

Preliminary testing of the instrument with a five point scale indicated the need for a broader range scale. Since most respondents were favorable about professional review, it was necessary to have a greater degree of fineness.

7. Two of the twelve scales were eliminated from the analysis because they failed to correlate significantly with the other items. Thus analysis refers to 10 items in each scale; 7 evaluative factors, 2 activity factors, and 1 potency factor. The two items that were eliminated were: "severe-lenient," and "fearful-courageous."

8. Although it was thought to be particularly useful as an attitude measure in this kind of project where degree of involvement or commitment might be an important indicator, the social judgment-involvement approach was resisted by respondents. This questionnaire had a higher proportion of unanswered items and inaccuracies in the following directions. Preliminary testing had indicated a potential problem with its use and led to the decision to include three related items in the rating scale. Because of the quality of response, and of the addition of the demographic questionnaire to the post-test, it was decided to eliminate this questionnaire later on. The analysis is used only in this initial discussion of attitudes of social workers and not in the later chapter in which pre and post measurement are compared.

CHAPTER VI

A TRAINING PROGRAM
IN PROFESSIONAL REVIEW
FOR SOCIAL WORK STAFF

At the time this project was designed, the Department of Social Work Services at Hillside Hospital was preparing to establish a PSRO program. Consideration had not been given to the probable reaction of the staff to the imposition of professional review, nor to the possible consequences of the staff's reaction on the effective implementation of a PSRO program. It was assumed that, as highly dedicated professionals, the social workers would support the system with full cooperation. There were no plans to train the staff for their role and responsibility as reviewers, nor was there an appreciation of the value of such training.

From our understanding of the meaning of bureaucratic control to professionals, and our knowledge of physicians' reactions to mandated professional review, there was reason to believe that unless the staff's attitudes and concerns were dealt with, it was unlikely that a meaningful professional review system could be established. The critical problem to be addressed was: What might be done to help professional social work staff to effectively participate in the regular monitoring and evaluation of colleagues? In pursuit of these answers, this project was undertaken.

The project is a beginning attempt to learn how a potentially threatening mechanism of control, such as professional review, might be seen as less threatening and more acceptable to professionals required to engage in it. The project represents one example of how a department attempted to deal with these concerns through the use of a specially designed training program in professional review.

Theoretical Approach

The approach used in this project was to have staff become involved with professional review, to experience it in such a manner that they would come to see its value and, as a result, develop a sense of commitment toward its effective implementation. It was anticipated that commitment would most likely result from feeling identified with professional review, and from feeling closely bound to and responsible for its success. In effect, we sought to have the organizational goal of professional review become the individual worker's goal as well. To achieve this, it was thought necessary to involve the professional staff in a process that fostered worker autonomy and responsibility. Our hypothesis was that participation in this process would influence workers' acceptance of professional review, their willingness to engage in it and, in turn, the way they engage in it.

The thrust of the approach was based upon two schools of thought:

- 1) professionals will be more accepting of control that is considered supportive of and consistent with professional autonomy and authority;
- and 2) professionals will be more accepting of control if they have participated in defining their role and were given responsibility for shaping the policies and procedures related to them. The operationaliza-

tion of both required the formation of a peer group among social work staff which would be given departmental responsibility for professional review.

The formation of a peer group, as a new channel of communication, was expected to allow for higher levels of interaction, information feedback and socialization.¹ Staff interaction around professional review provides the opportunity for group discussion, sharing of experiences, and decision making about the review system. The process provides for members a forum for further learning. Staff finds out how social work is practiced throughout the hospital, learns of the kinds of problems staff encounters, and keeps abreast of new ideas and techniques. The group provides additional and often new sources of information for its members as well as models for reference or comparison that enable workers to assess their own practice and problems. The sharing of information among colleagues serves as a monitoring device and allows for critical information about problems or the quality of service to be brought to attention at an early stage and well before it reaches a crisis level. The feedback of this information to the group arouses an increased sense of individual and collective responsibility to do something. Even when the kind of information conveyed is not of a critical nature, the public knowledge of it is bound to have an influence on the way new information is heard and handled. In addition to the group problem solving that results, interaction gives rise to the establishment of group norms around acceptable quality of performance, to competition among members for peer approval, and to the internalization of the group's decisions, all of which play a part in influencing the attitudes and behavior of members.

If the group were given responsibility for professional review, it

would be expected to do the following:

1. Identify cases to be reviewed by determining the basis for selection, e.g., random, by social service problem, by hospital service
2. Review selected records using audit instrument
3. Examining review results to identify areas of substandard care or problems and to determine probable cause
4. Differentiate between individual practitioner deficiency and group patterns of inadequate service
5. Develop solutions to the problems or recommend remedial action to be taken
6. Take steps to implement solutions or actions
7. Repeat review of workers or service in which problems were identified after suitable interval to determine if action brought about improvement
8. Redesign audit instrument and/or revise standards and criteria as necessary
9. Revise review procedures as necessary

By focusing on these tasks, the group would be involved in shaping the professional review system and in planning for its implementation. At the same time, attention to these responsibilities would provide the kind of information, experiences, and learning necessary for the group process.

Project Design

The project consisted of a training program designed to prepare the social work staff at Hillside Hospital, who were required to review colleagues, that is, to engage in professional review. The program's

immediate objectives were to familiarize staff with the professional review process and with their expected role and responsibility as reviewers, to develop staff competence and proficiency in the use of the social work audit instrument, and to increase staff's confidence in knowing how to review. These objectives were to be attained by emphasizing the development of staff's technical skills in audit and review through the practice of professional review.

The procedure used to lead the training group was intended to foster peer group interaction and discussion. The program's content was selected to stimulate learning, deliberation, and decision making. The program's format was planned to provide the opportunity for staff to consider problems in social work performance and to recommend steps to be taken regarding those problems. Both the content and the format were intended to encourage and allow for staff participation in the planning of the Department's professional review system. Participants were thus actively involved in professional review and in a process that was expected to foster autonomy, responsibility and commitment.

Participants in the Training Program

Eleven social work staff members at Hillside Hospital, selected through a random procedure, participated in the training program. Participants were selected from among all fifty, professional, line social workers who were employed full time at the hospital prior to June 1975. All social work supervisory and administrative staff were excluded as were staff with titles of social work associate or assistant.

Fifteen randomly selected social workers had received a memorandum from the Director of Social Work Services of the Hillside Hospital divi-

sion two weeks prior to the program's first session. The memorandum asked them to serve as the Department's professional reviewers to monitor the quality of service of the social work staff, notified them of the eight week training program to prepare them to review which they were expected to attend, and asked that they arrange their schedules accordingly. Staff having difficulty clearing the time and dates of the training program were asked to let him know. The memorandum also noted that the Director would meet with the group at its first session and introduce the training leader. The memorandum and its tone were consistent with the Director's style of informing staff of decisions or appointments. It was intended to convey a strong administrative mandate. As such it provided minimal explanation, limited opportunity for staff redress, and high expectation of staff compliance. Recruiting participants in this manner was thought to result most accurately in the kinds of feelings and reactions among staff typical of any staff selected to do professional review.

Two of the original sample of fifteen were unable to participate in the training program because their schedules did not permit their attendance. One worker, with the title of associate, had been selected in error and another had just submitted a resignation notice.

Thus there were eleven social workers in the training program; three men and eight women. The participants represented both the in and out patient services as well as one of the community based outreach programs. As a group, the attitudes toward professional review ranged from the most negative of all staff in the Department to almost the most positive. The mean of the group's scores on the rating scale was 159, slightly more negative than the mean score of the total staff. Similar-

ly, on each of the three semantic differential scales, the group mean indicated more negativism than was found in the total staff. Although a random procedure of selection was used, the participants in the training group were less favorable about professional review than might have been expected.

Program Description

The training program consisted of them, one hour sessions. Nine sessions ran consecutively each week from October through December 1975, but because of the Thanksgiving holiday, the sessions actually ran through ten weeks. The tenth and last session was held in early February after the staff participants had completed one month of review of six records. The initial program design called for eight sessions of one and a half hours each. Because of the time demands upon the social work staff, it was necessary to plan for shorter sessions. By the sixth session, participants expressed a desire for additional training sessions. Two more sessions were added, and it is likely that the group would have appreciated additional sessions.

A summary of the plan for each of the ten sessions follows:

First Session. Purpose: Introduction and Overview

1. To inform participants of the purposes of the training program and the plans for it
2. To acquaint participants with the basis for their selection/assignment as professional reviewers
3. To provide an overview of professional review; its relationship to the PSRO legislation, quality assurance, and utilization review; its characteristics

4. To introduce the professional review process; the steps in it; how it works; and what participants will be doing as reviewers. The Director of Social Work Services met with the group at the beginning of the session to greet the staff and express interest in having staff be trained in professional review. That this training program was one of the first attempts to prepare social work staff for professional review was acknowledged as was the need to evaluate the training program when it was completed. The Training Package was distributed.²

Second Session. Social service record of "Mrs. C." was read and reviewed.³ The record was selected as the first to be used in the training program because it is relatively brief and therefore the review of it can be completed in one session. The record is also good for beginning review because it clearly points out inadequate social work service and enables participants to move quickly into looking at a case record critically and into exercising professional judgment. The technique used to involve participants in professional review with this case was the same as was used with all other cases. Participants received copies of the social work notations and read them silently. The leader then asked for someone to begin reading and answering the questions on the audit form. As each was answered, the group expressed agreement or disagreement. When differences were expressed, group discussion took place in an attempt to understand the reasons for the different answers and to eventually arrive at a consensus on the best answer. Discussion of possible reasons for different answers led to considera-

tion of differences in interpretation of questions, in the standards used to judge what is acceptable practice, in understanding of the constraints imposed upon the practitioner, and the like. As the group moved on to each new question on the audit instrument, discussion led to some consensus. At times the leader raised questions to redirect the group discussion or to introduce other ideas or points that might be useful in the group process. The leader helped the group move along in its review and from getting bogged down with any one question, decision, or theoretical point.

Third Session. Social service record of "Anthony" was read and reviewed. The record was selected because it was an example of good recording and was therefore likely to well received by reviewers. Review of this record enabled participants to see that a well written record does not necessarily mean good social work practice and that it was possible, as well as essential, to differentiate good recording from good practice.

Fourth Session. Social service record of "Mr. W." was read and reviewed. The record was selected because it pointed out a performance deficiency of the worker. The intent of this session was to have the group move on to the other stages of the professional review process, especially to the identification of possible causes of performance gaps and to the consideration of alternative corrective actions.

Fifth Session. Social service record of "Charles" was read and reviewed. This record is much longer and fuller than the others and

required a review of the treatment plan, goal formulation, and social work activity. These three dimensions appear as the last sections of the audit instrument. In reviewing the three previous records, these dimensions were not covered.

Sixth Session. Continuation of "Charles" record. Group also reviewed a draft of a memorandum that it was sending to all social work staff to inform them of what the training group was doing.⁴ The decision to write and send the memo grew out of the discussion the previous week when it was suggested that the rest of the staff was expressing concern about professional review and about what the "secret" training group was doing.

Seventh Session. Social service record of "Mrs. F." was read and reviewed. This record was selected because it allowed the group to focus on the social work activity section of the audit instrument. This session was also used for the group to revise the audit instrument since they had practiced using it. Some corrections were made in wording and any changes that had been offered during the past sessions were finalized.

Eighth Session. The session was devoted to planning for implementation of the Department's professional review system. The group set some guidelines regarding the selection of records, procedures for review, and strategies for making it easier for participants to obtain records for review. Plans for a presentation of the group's experience and understanding of professional review at a departmental staff meeting were discussed.

Ninth Session. A social service record from Hillside Hospital, volunteered by one of the participants of the training program, was used. The purpose of this session was for the group to see what a medical record looked like, to learn how to locate the social service notes within it, and to experience professional review from the actual records. The medical records used by social work staff differ considerably depending upon the service in which one works. Inpatient records tend to be more comprehensive than out patient records; in some services the problems oriented medical record is used and in others it is not.

Tenth Session. Following a month of professional review, this session enabled participants to review their experience, to identify problems they had either with the process or the instrument, and to make recommendations to the Interdivisional Social Work Quality Assurance Committee that was preparing for the implementation of the PSRO program throughout the four hospital divisions.⁵

Each session was planned and conducted as a self contained module with its own objectives and content selected for their attainment. The format was generally similar for each session; practice of a review of a social service record and moving on from there, thus, allowing for a natural flow for group interaction, discussion, and decision making. The training program seemed to provide opportunity for the staff to become involved as professionals, dealing with issues of practice and service that were of vital concern to the profession, and to become involved as responsible workers, dealing with the issues of implementation

of the professional review system that would affect them as social work staff.

Analysis of the Training Program

During the first nine sessions of the training program, the participants seemed to pass through several clearly distinguishable phases of adjustment and acceptance.

Participants began the program with a rather high level of resentment at having been selected to participate as reviewers and at having to attend the eight week training sessions. Training was looked upon as a waste, unnecessary because they thought that professional review would be easy. They resented, most strongly, the time demands that participation would require of them. With already very heavy schedules, the addition of the training and professional review, both of which held no interest for them, was especially disturbing. This concern remained throughout the training program. It lessened considerably as participants became involved in the sessions and they found it easier or less objectionable to rearrange their schedules. Their willingness to fit both into their schedules represents a growing acceptance of and interest in the program; but the fact that it was a burden placed upon them, for which there was no compensation, remained.

By the third session, participants were no longer questioning the need for the eight week training program. They had begun to realize that reviewing was more difficult than they had anticipated and to indicate that more than eight weeks of training might be necessary. As one participant commented, "You have to give us more time than you plan to give us, and go more slowly. We have to have a chance to get comfort-

able." The desire for more time reached almost a level of urgency by the seventh session and the participants, expressing their feelings of being unprepared, requested additional sessions.

Gradually the participants became more comfortable with using the audit form, reviewing, making decisions, and working with their peers. The development of a good working relationship within the peer group took some time. Participants were wary at first of risking themselves with their opinions. They wondered how their colleagues would react to their judgments and were afraid they would be thought to be too harsh or too lenient. All admitted that they were conscious of the impression they would make on their peers -- a new experience for them! They voiced their views guardedly and hesitantly in the beginning. As they became more comfortable with each other, this concern passed, and they felt more free to judge and to criticize.

Increased comfort with reviewing and with the group itself probably accounted for the movement from rather passive participants to more active participants. Silent during the first session, most staff were involved in the discussion by the second session. Only two participants remained somewhat aloof throughout the sessions and resisted attempts to be drawn into the group's deliberations.

What appeared to be a need of the group to test whether it would be allowed to make the kinds of decisions it had been told it could make occurred in the second session. The testing centered on the very first question on the audit instrument. Considerable discussion about the need for revision of the question and for alternative wording took place. It was as though the group wanted to see if it were indeed true that the audit instrument belonged to the group, to be changed, revised, or dis-

carded as need be. Another kind of testing seemed to occur at the same time. The group was no doubt watchful of the manner in which its deliberations would be brought to a conclusion. This issue, as all others, was resolved through consensus. Never again did the group spend so much time or invest so much in one audit question. The testing process apparently had a successful outcome.

It might be construed that rather than testing, the group engaged in a kind of holding action in order to avoid getting into the task at hand -- professional review. If so, they began to weary of it and they were not allowed to lose sight of their total responsibility in professional review.

The participants demonstrated surprising ease and comfort in looking critically at the practice as recorded and in making judgments about its adequacy. They were able to express dissatisfaction with the practice and service they found in the records from the beginning. Participants had greater difficulty, however, in locating the source of their dissatisfaction with the work of their colleagues and in labelling the work as unacceptable even when it was recognized as unacceptable. Both of these problems presented fruitful areas for group discussion.

Participants were able to express their discomfort with saying that practice was unacceptable. They recognized the apparent inconsistency of judging significant gaps, neglected areas, or failures on the part of workers to perform at the minimal level of expectation and yet being unable to give an overall quality rating of "unacceptable". The use of another word, instead of "unacceptable", was not a solution to this problem. The difficulty rested not in the word but in the act itself. It raised for the group questions of fairness, comparison, and differ-

entiation among all those that were not perfect but not poor. Because this concern could be shared in the group, and a mutually agreeable solution could be reached, the participants were able to use this as a learning experience and, more importantly perhaps, to avoid its becoming a stumbling block in their reviews.

As they learned to use the audit instrument, participants began to see how the establishment of standards was used to identify sources of inadequate performance or problems in practice. They were able to focus on workers' problems in the areas of psycho-social history and problem formulation after initial training. But they experienced greater difficulty in identifying the problems in the areas of goal and treatment plan formulation, and social work activity. The persistent reluctance to identify inadequate practice in these areas, despite their ability and willingness to locate it in the other areas, were discussed by the group. Participants admitted that their reluctance was related to their awareness that these were the very same areas that they felt their own practice, and the recording of it, fell short. For the first time, as the group moved into these areas of the audit instrument, participants expressed concern that they might not meet the standards that they were using to judge their peers. As one participant commented at this time of realization, "We are all up shit's creek." With nods of agreement, the group was able to deal with the possible reasons for social workers performing below levels of expectation in these areas and possible solutions.

Discussions about possible reasons and solutions were a struggle for participants. Consideration of why the problems existed led to rationalization rather than clarification. It was often explained that

a worker was overworked, that his job was defined in such a manner as to place special expectations upon him, or that external constraints limited his practice. Seldom was the lack of skill or knowledge given as the reason. As the group gradually began to consider all possibilities, they acquired greater insight into social work practice in general and into their own practice.

As the sessions progressed, the participants began to view their roles more broadly within the context of the training program. They were conscious of the rest of the social work staff growing uneasy about professional review and curious about what their "secret" training group was doing. In the fourth session, the participants discussed the need to do something to alleviate staff concern and agreed to send an explanatory memo along with the audit instrument. This concern with first informing their colleagues and, secondly, with protecting them from possible unfairness placed the group in the position of looking out after their colleagues' interests and of advocating on their behalf for the duration of the training program. This concern helped to mobilize the training group to look at the issues of implementation and to begin recommending some procedures, both of which were among the major objectives of the training program.

Among the ideas generated by the group and considered were: 1) presence of staff at their review; 2) informing staff ahead when they would be reviewed in order for those who desired to "fix up" their records to do so; 3) postponement of the beginning of the review until all staff had a copy of the audit instrument; and 4) clarification of the expectations of the social work role within the Department. The latter was stressed because staff was afraid that if the social work

role was not universally defined but was defined according to the hospital unit or service, it would not be possible or fair to judge all staff by the same standards. The suggestion of these ideas seemed to reflect a continued refusal to accept professional review; however, none was strongly supported.

Despite the range of issues addressed and the encouragement given to the group to make decisions that would shape the policies and procedures of the review system to be used, the participants settled for relatively minor decision making. Most of their effort went into revising the audit instrument. Although they offered some suggestions about the selection of records for review and ways to facilitate the process, it was as though their understanding of how to review and their approval of the audit instrument were more important than influencing plans for implementation.

As the group became more familiar with review, participants also became more familiar with some of its difficulties and limitations. For example, when they experienced knowing the name of the worker under review, they found, to their surprise, that this knowledge created feelings that influenced the way they reviewed. Participants agreed that it was more difficult for them to review when they knew the individual was a good worker through their own personal or professional contacts, although the worker's record did not reflect good practice. Similarly, knowing the patient or of him affected their review. The more they knew of the situation, the more there was to bring to bear on the review process, thus making it more difficult to do the review.

The participants' frustration in trying to reach consensus on each of the audit questions raised the question of how realistic it was to ex-

pect complete agreement. Some ventured to question whether professional review should be instituted if it were not possible to have 100% agreement.

Whenever the group experienced frustration, or seemed to reach an impasse in its deliberations, the general reaction was often to doubt whether the review of social service records was a valid approach to monitoring or evaluating the quality of practice or service.

The existence of the training group enabled these doubts and concerns to be expressed and shared. A positive point or confident note by one participant, or interjected by the leader, would provide the opportunity for the group to constructively deal with the issues. A negative comment would tend also to stimulate helpful discussion.

Although showing neither enthusiasm nor eagerness, and doubting their readiness to begin reviewing colleagues, participants were considered to be adequately prepared and were expected to engage in professional review following the ninth session of the training program. Participants had developed considerable technical skills in professional review. They acquired confidence in their ability to review and were aware of some of the factors that were likely to influence their objectivity and critical acumen. They had seen that it was possible to pass judgment on the work of other social workers and to use social work recordings on patient records as a source of information about the quality of practice. They learned that there was, in fact, inadequate or poor social work practice. Thus, they had the occasion to see the value of professional review for themselves. They also had the opportunity to take on professional review as their own, to make the audit instrument, for example, into their own instrument. They determined

some of the rules under which they would operate. There was no attempt to convince them or persuade them that professional review was valuable or essential. There was no attempt to impose the procedures for them to follow. As staff became involved in the process, they assumed a new role and additional responsibility as professionals in relation to their peers.

Without this kind of training program, beginning reviewers were not expected to have the opportunity to develop either confidence or competence in their ability to review. They would not come to appreciate the value of professional review or their own role in it. More importantly perhaps, they would not have a peer group to use as a forum for their own professional growth and development.

Participants' Evaluation of the Training Program

Participants were asked to complete a brief questionnaire after the ninth session but prior to their actually engaging in professional review.⁶ The questionnaire was designed to evaluate they did not request more time in order to participate more fully in planning for implementation. Their concern about not being ready to review seems to be at odds with the findings of this evaluation. The disparity may also suggest that a group might express feelings of insufficient preparation regardless of the extent of training when time to begin review is forthcoming.

Various aspects of the training program were mentioned by participants as least liked. Three common themes were: 1) "seemingly false sense that the group had autonomy to make important decisions," 2) the amount of time required and the resulting pressure on the job, and 3) "the awareness of having to review the work of my peers and the high probability that much of this work would be seen as unacceptable."

All participants commented that the best aspect of the training program was the peer group experience and the opportunity it provided for the sharing of differences of opinion. Most noted that this was the first time that they met with colleagues on a regular basis involving a professional task, and that being exposed to the ideas and expectations of other workers proved fruitful. The majority of participants commented that the group experience helped them to look more closely and critically at their own practice, and to see how they might improve their performance and recording. The recognition of the impact of the training program on the participants' own work was viewed at the primary value of the program. The opportunity to observe the training program and to learn from the participants whether they thought the program achieved its objectives. The evaluation therefore reflects the participants' reactions to the program and its value before they had the opportunity to use the training.

All participants stated that they felt more prepared to do professional review than they did prior to the training program. Five of the participants said they felt "somewhat" prepared to do professional review; four felt "quite a bit" or "very much" prepared. Asked to comment on the necessity of such a training program, all agreed upon the need for similar training to prepare staff to do professional review. Four felt the training program was "somewhat" necessary; five thought it "quite a bit" or "very much" necessary.

Participants were also asked to evaluate the extent to which the training program achieved its objectives. Table 9 summarizes these responses which suggest that the participants believed that the program was more effective in preparing staff for professional review and less

TABLE 9
PARTICIPANTS' EVALUATION
OF TRAINING PROGRAM, IN PERCENTAGE

Training Program Objectives	Extent Achieved			Total*
	Not At All or Hardly	Some- what	Quite a Bit or Very Much	
Increase understanding of the professional review process	-	11%	89%	(9)
Prepare participants to do professional review	-	33%	67%	(9)
Have participants identify problems with the professional review process as it was designed	-	11%	89%	(9)
Have participants offer solutions to problems identified	-	56%	44%	(9)
Have participants plan the implementation of the professional review process	11%	33%	56%	(9)
Have participants plan the next stages of the professional review process, beyond the audit	44%	44%	11%	(9)

*One participant did not return the questionnaire, and another left employment at Hillside Hospital prior to completing this evaluation or engaging in professional review.

effective in involving staff in planning for the implementation of the professional review system. The responses may be an accurate reflection of the amount of attention given in the training to the first three objectives in relation to the last three which appear on the list in Table 9. Greater emphasis was given to the practice of audits and to the development of the participants' technical skills for review.

A training program of longer duration might adjust this imbalance. Although the participants had asked for additional training sessions because they felt unprepared to begin review, the variability in the quality of social work and the quality of recording was another value cited.

NOTES

1. The relationship between increased communication and higher levels of information feedback and socialization was posited by J. Hage in Communication and Organizational Control.

2. The content of the Training Program package is in Appendix 3. The material was used to illustrate various quality assurance programs and to provide factual information on professional review and the PSRO legislation that might be referred to at a later time by participants. The audit instrument and its accompanying instructional manual which were designed by the Interdivisional Quality Assurance Committee the previous year were included.

3. The social service records used were selected from among those made available by the other hospital divisions of the medical center for the Interdivisional Quality Assurance Committee's use. Copies of all records are in Appendix 4. All identifying data in the records have been altered for inclusion in the Appendix.

4. A copy of the staff memorandum is in Appendix 5.

5. A copy of the group's final report is in Appendix 6.

6. The questionnaire used for participants' evaluation of the training program is in Appendix 7.

CHAPTER VII

THE EFFECT OF THE TRAINING PROGRAM ON SOCIAL WORKERS' ATTITUDES AND PARTICIPATION IN PROFESSIONAL REVIEW

The participants' evaluation of the training program, in which they concluded that the program had been effective in preparing them to engage in professional review, was only one measure of the value of the program. In addition, the attitudes of the participants were again measured, following the training program, to determine if participants were more or less positive or negative in their attitudes toward professional review or remained unchanged in their opinions of it.

Research Design

In order to obtain a valid measure of any change in attitudes, the project used a before-after research design with randomized subject in the experimental group (training program) and in the two control groups (orientation program and no program). The design was selected to allow for greater confidence in the effect of the training program on any differences between staff attitudes before and after the training, and between staff who had and who had not participated in the training program. The design used is illustrated in Figure 2.¹

For the first control group, social work staff were selected to attend an orientation session on professional review prior to their en-

Figure 2

BEFORE-AFTER RESEARCH DESIGN

	Y_b	X	Y_a (Training Program)
R	Y_b	(X)	Y_a (Orientation Program)
	Y_b		Y_a

gaging in review for one month with the same social service records that the participants in the training program would be using in their month review. The randomly selected social workers were notified by the Director of the Hillside Hospital Department of Social Work Services of their selection as the second group of professional reviewers and of the orientation session which they were to attend in order to prepare themselves as reviewers.

The same leader of the training program conducted the two hour orientation session. An introduction to professional review was given and the group practices reviewing one social service record, using the audit instrument. There was no opportunity for group discussion or for a growing appreciation of professional review and recognition of the limitations of it. The participants were not given the chance to share their reactions or to shape some of the decisions that would affect them. Instead of the process experienced by the participants in the training program, this group of staff was simply told about mandated professional review and of the job of the reviewer.

The experience of the orientation group was thought to be similar to the circumstances under which social work staff might be selected and prepared for professional review if the kind of approach and training program described in this project were not used. It was likely that

Departments and administrators, less aware of possible staff reaction or negativism and anticipating staff support and cooperation, would see the need for only an orientation session and a "how-to" session.

A comparison between changes in attitudes among staff in the training program and in the orientation program was considered important. The impact of the training program would have greater meaning if the participants' attitudes were compared to those who were also required to engage in professional review but failed to have the same "treatment". It was anticipated, for example, that not only would the participants in the training program be more positive or less negative about professional review after their experience but that participants in the orientation program would be more negative and less positive about professional review following their experience.

Critical to an understanding of the effect of the training program was an understanding of the possible attitude changes that may have occurred without either program. It was possible that during the six month period between the before and after attitude survey, social work staff would have become more familiar with professional review and more accepting of its beginning in the near future. On the other hand, during that time the staff might have become more anxious and fearful, and consequently more resistant. It is within this context that the influence of the training program can perhaps best be appreciated. An increase in negativism or positivism, or no change at all, among training program participants is more significant when compared to attitudes of the staff in general (no program) and to those who were briefly introduced to professional review prior to engaging in it.

Thus the use of a second control group, all social work staff who participated in neither training program and did not engage in professional review, made it possible to see if history and maturation, events that may have occurred between the pretest and posttest, affected staff and could account for any changes in attitude. The additional control group allows for increased confidence that differences found can be attributed to the training program and not to a normal course of events, to the testing itself, or to staff having become sensitive to either the study instruments or the "correct" responses.

From among the fifth line social workers at Hillside Hospital, fifteen had been randomly selected to be in the training program and twelve were randomly selected to be in the orientation program. The remaining half of the staff received neither program and were not asked to participate in professional review but completed the attitude study at the same times as the participants of both programs. Taking into consideration the staff who were selected but did not actually participate in the programs, and the staff who did not respond to either the pre or post-test, a total of thirty-five social workers were involved in this project and in the analysis of the data. Table 10 summarizes the number of subjects involved.

The total response rate on the after test was 76% for an N of thirty-five. Of the training program participants, 90% responded; 86% of the orientation program participants responded; and, only 67% of the no-program participants responded to the post-test.

Participants in the training program were given the same summated rating and semantic differential scales after the program as before.

TABLE 10
PARTICIPANTS IN PROGRAMS AND STUDY

Number of Staff	Training Program	Orientation Program	No Program	Total
Pre-test	10 ^a	7	29	46
Post-test	9	6	20 ^b	35

^aAlthough there were eleven in the training program, one did not return the pre or post-test questionnaires.

^bOne respondent did not complete the semantic differential scales, therefore N=19 in the analysis of the semantic differential data.

The post-test was distributed following the program's tenth and final session which took place after a month in which participants engaged in professional review. A period of six months intervened between the pre and post-tests. To lessen participants' association of the post-test with the training program, the questionnaires were sent directly to residences and the request for staff cooperation did not refer to the training program. The fact that the training program had been evaluated previously undoubtedly helped to disassociate the two. In a cover letter, it was being asked to complete the same questionnaires and they were asked to answer items according to their feelings and reactions at this time without attempting to recall previous answers. No explanation was given for why they were being asked to repeat the study. The questionnaires and letters were sent to all other staff, as well as the participants in the orientation program, at the same time.

Data from the summated rating and the semantic differential scales were first analyzed by use of descriptive statistics for gross compari-

sons among the three groups and between the pre and post-tests. Measures of central tendency and variability provided a simple and efficient profile for comparison. Statistical tests of significance (of differences and of relationship) between before and after scores were considered not suitable with this sample and data. Therefore, the data were analyzed, secondly, with nonparametric statistical tests which were deemed more appropriate.² Nonparametric tests are freer of assumptions about the characteristic or the form of the distributions of the populations of research samples. They can be used with research data as presented in this study where small sample sizes are small and the variables are measured in an ordinal scale. In addition to avoiding violating the parametric assumptions due to the sample size and type of measurement, the nonparametric tests are somewhat easier to use.

Nonparametric tests of significance that use signs, ranks, and frequencies were applied to the data. The Sign Test and the Wilcoxon Matched-Pairs Signed-Ranks Test were useful in establishing the difference between two conditions. The Spearman Rank Correlation Coefficient was useful in establishing the association between two conditions. Each helped to differentiate statistically significant from non-significant findings.

Less useful were the Median Test and tests of analysis of variance by ranks. Both the Kruskal Wallis One-Way Analysis and the Friedman Two-Way Analysis of Variance By Ranks were applied.

Changes in the Attitudes of
Participants and Non-participants
in the Training and Orientation Programs

In the first analysis, it appeared as though the total number of social workers who change their attitudes toward professional review between the before and after tests was negligible. As Table 11 indicates, very few staff showed any change in attitudes as measured by the rating scale. A change by a training program participant was in the positive direction. Participants in the orientation program became more negative. No attitude change was shown by staff who were non-participants.

TABLE 11
 POSITIVE AND NEGATIVE ATTITUDES
 TOWARD PROFESSIONAL REVIEW,
 PRE AND POST TEST SCORES ON RATING SCALE

Staff Attitudes	Training Program		Orientation Program		No Program	
	Before	After	Before	After	Before	After
Positive*	(6) _{67%}	(7) _{88%}	(5) _{83%}	(3) _{50%}	(14) _{70%}	(14) _{70%}
Negative*	(3) _{33%}	(2) _{22%}	(1) _{17%}	(3) _{50%}	(6) _{30%}	(6) _{30%}
Total	(9) _{100%}	(9) _{100%}	(6) _{100%}	(6) _{100%}	(20) _{100%}	(20) _{100%}

*Positive attitudes include scores above the mid point of the rating scale (155); negative attitudes include scores at or below 155.

Table 12 indicates a similar pattern for participants in the training and orientation program when attitudes were measured with the semantic differential scales. The only change in attitude in a positive direc-

tion occurred with a participant in the training program; a participant in the orientation program changed attitude but was less positive.

In contrast to the data from the rating scale, these findings indicate that non-participants held favorable or positive attitudes at the time of the after test than at the before test. This decrease in the numbers of social workers with favorable attitudes was found with each of the three concepts thought to be an essential component of attitudes toward professional review.

TABLE 12
POSITIVE ATTITUDES TOWARD PROFESSIONAL REVIEW,
PRE AND POST TEST SCORES ON
SEMANTIC DIFFERENTIAL SCALES

Concept	Training Program		Orientation Program		No Program	
	Before	After	Before	After	Before	After
Professional Review	(6) _{67%}	(6) _{67%}	(5) _{83%}	(5) _{83%}	(17) _{89%}	(14) _{74%}
Having to Audit and Evaluate Colleagues	(6) _{67%}	(7) _{88%}	(6) _{100%}	(6) _{100%}	(18) _{95%}	(15) _{79%}
Being Audited and Evaluated by Colleagues	(6) _{67%}	(6) _{67%}	(6) _{100%}	(5) _{83%}	(15) _{79%}	(13) _{68%}
Total	(9)	(9)	(6)	(6)	(19)	(19)

The meaning of professional review to participants and non-participants is more clearly seen when the mean scores of the before and after

tests on the three concepts are compared. Table 13 summarizes these data.

The least amount of change appears to be in the meaning of the concept, "professional review". But the unchanged means conceal differences in the range and distribution of scores in the before and after tests. The effect of the training program was to change the attitudes of its most negative participants and to bring their scores closer to the mean. But at the same time, the program changed that attitudes of some of its most positive participants, bringing their scores closer to the mean as well. The mean was maintained by movement of the lower and higher before test scores, with the result of a more normal distribution of all scores.

TABLE 13
MEANING OF PROFESSIONAL REVIEW*
MEAN SCORES ON PRE AND POST SEMANTIC DIFFERENTIAL TESTS

Concept	Training Program		Orientation Program		No Program	
	Before	After	Before	After	Before	After
Professional Review	45.1	45.3	47.0	46.8	51.8	51.8
Having to Audit and Evaluate Colleagues	45.4	46.4	46.3	49.0	51.3	48.2
Being Audited and Evaluated by Colleagues	41.8	43.0	46.2	45.5	47.2	44.2
Total	(9)	(9)	(6)	(6)	(19)	(19)

*Based on ten scales.

The effect of the orientation program was similar to that of the training program in changing the attitudes of its more negative participants. Unlike the training program, participants in the orientation session showed a slight, general downward shift in the negative direction in after test scores which was offset by one much more positive score.

The effect of no program was quite the opposite. The range and distribution of after test scores was larger than the range of before test scores. There were more positive (high) scores and more negative (low) scores in the after test, and both lower and higher scores were reached.

Participants in the training program were the only staff who showed more favorable attitudes about the concept, "being audited and evaluated by colleagues". Much of the lower score for participants in the orientation program can be attributed to lower activity factor scores, indicating staff was more anxious and tense about being audited at the time of the after test. Non-participants showed no change in either their activity or potency factor scores. Their lower scores are a result of much lower evaluative factor scores; non-participants expressed a greater dislike towards being reviewed by peers on the after test than on the before test. Considering that this was the one concept which all staff had been most negative toward, the fact is that only the training program had an influence on attitudes to being reviewed.

Although the participants in the training program showed a slightly more favorable attitude toward the concept, "having to audit and evaluate colleagues", the participants in the orientation program showed the

greatest increase in positive attitudes. The brief orientation session apparently gave the participants enough of a taste of professional review to like it, as indicated by their higher evaluative factor scores on the after test. They also showed less anxiety about having to review whereas the training program participants were slightly more anxious at the time of the after test.

Although an analysis of the total number of social workers with positive or negative attitudes toward professional review at the time of the after test in comparison to the time of the before test seemed to show negligible changes, a closer examination of the numbers of staff that actually showed an increase or decrease in their scores indicates considerable change. Table 14 summarizes the data of the direction and magnitude of change from the before to the after test, and as measured by the rating scale.

The greatest change in a positive direction occurred among the training program participants; 78% were more favorable toward professional review at the time of the after test than at the before test. The most change in a negative direction occurred among the orientation program participants, half of whom were more negative and half of whom were more positive toward professional review on the after test. The non-participants were more likely to express positive than negative attitudes on the after test.

A similar analysis of the direction and magnitude of change in the scores of the semantic differential scale provides a slightly different picture. These scores indicate that most non-participants showed a decrease, that is, more negative attitudes on each of the concepts: 74%

of the non-participants showed a decrease in their scores on the concept, "professional review"; 68% showed a decrease in their scores on the concept, "having to audit and evaluate colleagues"; and 63% showed a decrease in their scores on the concept, "being audited and evaluated by colleagues". Participants in neither the training nor orientation programs showed as much decrease in their scores. In fact, the number of participants in both programs who showed an increase in scores was greater than or the same as the number who showed a decrease.

To what extent, if any, did the frequency of positive and negative scores in the after test differ significantly from the frequency of scores in the before test in the training group, the orientation group, or in the group of non-participants? In order to answer this question, the data were analyzed further with nonparametric statistical tests.

TABLE 14
DIRECTION AND MAGNITUDE OF CHANGE
IN RATING SCALE SCORES

Change in Scores	Training Program	Orientation Program	No Program
More than 21	(2) 22%	(1) 17%	(2) 10%
Increase			
From 1 to 20	(5) 56%	(2) 33%	(10) 50%
From 1 to 20	(2) 22%	(2) 33%	(5) 25%
Decrease			
More than 21	-	(1) 17%	(3) 15%
Total	(9) 100%	(6) 100%	(20) 100%

No statistical difference was found between the before and after scores for the participants in the training program or the participants in

the orientation program when the Sign Test, which uses information only of the direction of difference between scores, was applied. The more efficient test that combines the sign of the test with the relative size of the difference between scores, the Wilcoxon Matched-Pairs Signed-Ranks Test, also showed no statistical difference. As a result, it is necessary to conclude that there was no difference between the before and after scores for the participants in either program. There were as many with favorable and unfavorable attitudes toward professional review after the programs as before. The training program and the orientation program, therefore, had no systematic effect on the attitudes of the participants.³

But what, if any, is the systematic effect of no program on the attitudes of social work staff? Without any program, with no orientation or training and participation in professional review, we would expect to find as many with favorable and unfavorable attitudes toward professional review at the time of the after test as at the time of the before test. The application of the Sign Test and the Wilcoxon Matched-Pairs Signed-Ranks Test to the data from the semantic differential scales enabled us to reject this null hypothesis.⁴ It was possible to conclude that the scores differ significantly between the before and after tests, and that the after test scores show significantly more negative attitudes toward professional review than the before test scores. As Table 15 indicates, however, this conclusion can be drawn only in relation to two of the three concepts used in the semantic differential scales: "professional review" and "being audited and evaluated by colleagues". We cannot conclude that the absence of a program has an effect on attitudes related to "having to audit and evaluate colleagues."

TABLE 15
SIGN TEST AND WILCOXON MATCHED-PAIRS SIGNED TANKS TEST
OF SEMANTIC DIFFERENTIAL SCALES FOR
SOCIAL WORKERS WITH NO PROGRAM

		Professional Review	Having to Audit and Evaluate Colleagues	Being Audited and Evaluated by Colleagues
<u>Sign Test</u>	N	18	18	17
	x(positive)	4	6	5
	p	.015	.119	.072
	α	.05	-	-
<u>Wilcoxon Test</u>	N	18	18	17
	T(positive)	20	43.5	30
	α	.01 ^a	-	.025 ^a
	α	.005 ^b	-	.05 ^b

^aOne-tailed test; ^bTwo-tailed test.

The Spearman Rank Correlation Coefficient (ρ) Test was also applied to the data to determine the extent to which the scores on the after test were associated with the scores on the before test for each group of program participants and the non-participants. We were interested in seeing if the relationship between the two sets of scores, those obtained in the before and after tests, differed from zero only by chance. The results are summarized in Table 16.

The after scores on the rating scale for all social workers, those who were participants in the training and orientation programs and those

TABLE 16
SPEARMAN RANK CORRELATION
OF BEFORE AND AFTER TEST SCORES
ON RATING SCALE AND SEMANTIC DIFFERENTIAL SCALES

Scales	Training Program	Orientation Program	No Program
	rho α	rho α	rho α
Rating Scale	.79 .01 ^a	.20 .01 ^a	.79 .001 ^b
Professional Review	.65 .05 ^a	.54	.74 .001 ^b
Having to Audit and Evaluate Colleagues	.74 .05 ^a	.24	.53 .01 ^a
Being Audited and Evaluated by Colleagues	.56	.73	.80 .001 ^b

^aOne-tailed test; ^bTwo-tailed test.

who participated in no program, correlated significantly with the before test scores. The correlation, however, between the before and after scores of the participants in the orientation program is very weak. On each of the three semantic differential scales, the correlation between the before and after scores of those in the orientation program was not significant. The scores of the training program participants were significant on all but one of the semantic differential concepts, "being audited and evaluated by colleagues". The relationship between the before and after scores on this concept is not strong for those in the training program. Only the scores of the non-participants are correlated significantly for each of the scales.

These findings suggest that participants in the training program were likely to maintain the same attitudes before and after the program and the experience with professional review. Non-participants were also likely to maintain the same attitude throughout that period. It cannot be attributed to chance alone that the training program participants and the non-participants had after test scores that were so highly correlated to their before test scores. However, the very low correlation between before and after scores on the rating scale for orientation program participants, and the absence of statistically significant correlated scores on the semantic differential scales, suggest that the differences in the before and after scores that were found were a result of chance. We cannot attribute to the orientation program responsibility for the association between the participants' scores on the before and after tests.

Summary

The data suggest, that, to some extent, the participants in the training program were more favorably inclined towards professional review after the program and after they had engaged in professional review. The participants were generally more positive about professional review, and about reviewing colleagues and being reviewed. The program seems to have been especially effective in changing the most negative attitudes of participants to more positive attitudes. The program also seems to have prevented an increase in negative attitudes among staff, a phenomenon much more closely associated with those who did not experience the training program. Although the extent of the attitude change among staff was not statistically significant, the fact that some change did occur

should not be dismissed. And, statistically significant correlations between the participants' before and after scores point to the program's effect on participants' attitudes.

The orientation program seems to have had an effect on its participants, but somewhat different than the training program. As many of the orientation program participants became more positive as became more negative about professional review after the program and after they had engaged in professional review. Increased positive attitudes seemed to be related to doing the review. Increased negative attitudes seemed to be related to being reviewed. While the extent of the attitude change among orientation program participants was also not statistically significant, that change did occur among participants should be recognized. What is less clear is whether the orientation program was responsible for those changes. The lack of a statistically significant correlation between any of the before and after scores raises the possibility that any increase in negative or positive scores among participants might have been independent of the orientation program.

Perhaps the most important and dramatic finding from the data was the effect of no program on the attitudes of social work staff. Each analysis consistently pointed to the increased negativism about professional review in general and to engaging in it among the non-participants during the six month period. The absence of any program apparently contributes to changes in attitudes in the direction of less favorable and more negative toward professional review. Without a program, staff grows increasingly against professional review. Both the extent of the attitude change and the relationship between the non-participants' before and after test scores were statistically significant, confirming the

consequences of no program.

The findings clearly indicate the need for some program for social work staff to deal with their attitudes toward professional review. Without any program, staff is likely to become increasingly negative. Both the training program and the orientation program helped to prevent the growing negativism. The training program was somewhat more effective in that it not only prevented more negative attitudes but it also produced more positive attitudes.

Social Workers' Attitudes Toward
Critical Aspects of Professional Review
Before and After Training and Orientation Programs

Two of the items on the rating scale thought to be sensitive measures of favorable or unfavorable attitudes toward professional review are those that ask staff to respond to the idea of getting out of having to engage in professional review and to the idea of being evaluated by colleagues. Staff response to these items, in mean scores, before and after participation in the training and orientation programs, is shown in Table 17 along with the scores of other items considered to be critical aspects of professional review. Participants in both programs are less eager to get out of reviewing colleagues and are less resentful of being reviewed by their colleagues. Although both groups were less negative toward doing the review and being reviewed, neither group was really positive toward engaging in professional review even after the programs. Non-participants, however, showed no more and no less eagerness to review or willingness to be reviewed on the after test than on the before test.

The training program participants were more positive about the value

TABLE 17

MEAN SCORES ON SELECTED ITEMS OF RATING SCALE ON BEFORE AND AFTER TESTS

Item	Training Program		Orientation Program		No Program	
	Before	After	Before	After	Before	After
If I could, I would just as soon get out of having to do audits	4.0	4.4	4.2	4.7	4.9	4.9
I would resent being evaluated by some of the social workers here	4.0	5.0	4.5	5.0	3.9	3.8
The social work profession will be better off with professional review	4.6	6.3	6.8	6.8	6.5	6.2
My own interests would be better served without professional review	5.2	5.2	7.2	5.7	6.2	5.9
These audits are not going to tell us anything we don't already know	4.3	5.6	6.5	5.5	6.0	6.7
The clients will get the most out of professional review	4.8	5.2	6.0	6.7	5.6	5.6
Evaluations are bound to be uncritical	6.0	6.6	7.2	6.3	6.5	6.4
Most people will just pretend that they are auditing	6.1	5.9	5.3	6.3	6.2	5.8
Peer evaluations can hardly ever be objective	6.3	6.2	6.5	5.7	5.4	6.0
On the whole, professional reviewers will be honest	6.1	6.8	6.0	6.3	6.1	6.0
Professional review is just too impractical	5.5	5.4	6.2	6.0	6.3	6.1
The idea of professional review is OK, but it just won't work	4.9	4.7	5.5	5.7	6.3	6.0
I'm confident that the results will be put to good use	5.2	5.7	5.3	5.7	5.1	5.7
It's perfectly alright to judge the quality of service by what workers record	3.4	3.0	3.5	4.2	3.9	3.3
It's not fair to evaluate social work practice from case recordings	4.1	3.3	3.8	4.5	3.9	4.5
Anyone can fix his recordings so that his work will look good	4.8	4.5	5.0	5.6	4.1	5.0
It isn't easy to tell your colleague what you think of his work	3.4	3.8	3.3	4.0	3.0	3.2
I'd rather not know who I am reviewing	3.4	3.0	3.5	4.2	3.9	3.3
I wouldn't be surprised if my colleagues take offense with my evaluations	5.2	5.2	3.7	4.5	3.7	4.2
These kinds of evaluations can dampen staff morale	5.2	5.6	5.8	5.5	4.6	4.2
I wouldn't want my colleagues to know I evaluated them	5.8	5.4	5.5	4.8	5.2	5.2
It will be hard to keep a pleasant disposition while this is going on	3.4	3.8	3.0	3.8	3.7	3.5

of professional review after their experience than before. They were more likely to believe that professional review had value for the social work profession, for clients, and for the new information it would provide, after the training program. Their feelings about its value for themselves remained unchanged. The orientation program participants, on the other hand, showed more negative attitudes about the value of professional review for themselves and in providing additional information. Although they were more positive about its value for clients, their feelings about its value for the profession remained unchanged. Non-participants were more positive on the after test than on the before test on only one of the items related to the value of professional review--whether the audits would tell anything that is not already known. This change suggests that the influence of the orientation program on the same item was especially strong in creating an unfavorable impression.

The training program participants gained increased confidence in the feasibility of professional review in three areas; the reviewers would be critical and honest, and the result would be put to good use. The orientation program participants gained increased confidence in four areas related to feasibility; like training program participants, they believed the results would be put to good use and that reviewers would be honest. Unlike training program participants, they thought reviewers would take their responsibility seriously and not pretend they were reviewing, and that the professional review system could work. Non-participants gained confidence in only one area; that the results would be put to good use. The fact that all three staff groups showed about the same increase in mean scores on this item suggests that external factors or circumstances unrelated to the programs might have contributed to the

change in attitude related to this item.

The attitude about the use of records for review was less favorable among training program participants after the program than before. In fact, this experience resulted in the participants' initial negativism about the fairness of evaluating social work practice from case recordings becoming even more negative. In contrast, the orientation program participants became more favorable about the use of records and expressed an increased positive attitude about the likelihood of recording being "fixed" by workers. Even non-participants showed a tendency toward more favorable attitudes about the use of records at the time of the after test. This would suggest that the training program was most dysfunctional in this area.

The greatest change in attitudes about the possible effect of professional review on colleague relations and work norms occurred among the orientation program participants who were more favorable after the program than before. The training program participants were more favorable towards half of the items in this area at the time of the after test. However, as with the attitudes about the use of records, the changes were not large and no initially negative attitudes were replaced with positive attitudes.

Summary

Once again, the findings clearly indicate that social work staff who do not participate in any kind of orientation or training program grow increasingly negative about professional review in time. Both training program and orientation program participants were less negative about the critical aspects of professional review than non-participants in the

after test. Although the findings are not statistically significant,⁵ participants in the orientation program are more likely to become more favorable about the key aspects of professional review than either training program participants or non-participants. As Table 18 indicates, about two-thirds of the orientation program participants had more positive attitudes after the program than before whereas only half of the training program participants and one-third of the non-participants had more positive attitudes.

The training program did not have the kind of effect on the attitudes of social work staff as had been anticipated. Much to our surprise, the orientation program which was introduced as a comparison group and as a typical model of what might be used in place of the training program, seemed to be more effective in influencing staff attitudes toward professional review.

TABLE 18
CHANGE IN MEAN SCORES OF SELECTED ITEMS
OF RATING SCALE ON BEFORE AND AFTER TESTS

Change in Mean Scores	Training Program	Orientation Program	No Program
More positive	11 50%	14 64%	7 32%
Remained the same	2 9%	1 4%	3 14%
More negative	9 41%	7 32%	12 54%
Total	22 100%	22 100%	22 100%

Comparison Between
Training and Orientation Program Participants'
Engagement in Professional Review

Another means for assessing the effect of the training program was to determine the differences in the way participants of the training program engaged in professional review in comparison to the participants in the orientation program. Our initial assumption had been that there would be some difference in staff's willingness to review which would be reflected in how the review were carried out.

To examine the influence of the training program on professional review, the participants of both program were required to review six social work case records during the month following the ninth session of the training program and the one session of the orientation program. Recently closed social work records were randomly selected for review and were deposited in the office of the Director of Social Work Services where they could easily be borrowed for review. Participants were notified that as of a given date the records were available to them. Each participant was expected to make his own arrangements to pick up the record, review it, and return it.

Six indicators of possible difference in the way participants engaged in professional review were used; the number of records reviewed, the period in which the reviews were completed, the number of errors, the extent of response agreement, and the number of recommendations and comments related to "qualifications". Although all are gross measures, each is a fairly precise and efficient indicator of the way professional review is approached and carried out. Numerous errors or failure to note recommendations and comments would most likely be indicative of a less than serious approach to review, and less investment and commitment

in review than might otherwise be shown.

At the end of the period in which participants were required to review the six social work case records, (extended from the original plan of four weeks to six weeks), five of the ten participants in the training program had reviewed the six records and only one participant of the seven in the orientation program had reviewed as many as four records. The likelihood of carrying out the mandate to review was greater among training program participants than orientation program participants. Those who reviewed no or few records were not necessarily staff with least favorable attitudes toward professional review or those whose attitudes became more negative as a result of their experience with professional review and with the program in which they participated. Similarly, those who reviewed many records were not necessarily staff with more positive attitudes toward professional review or those whose attitudes became more favorable following either of the programs. Regardless of attitude or degree of attitude change, the training program participants were more likely to fulfill the mandate to engage in professional review than the participants in the orientation program.

Not only was the total number of records reviewed by staff influenced by the training program, but the speed in which the review was started was also affected by participation in the training program. Participants in both programs were asked to log in the date that they borrowed and returned each of the six records for review. By the second week of review, more than half, seven, of the training program participants had taken records and were engaged in the review of them. Only one participant in the orientation program was as involved in that time. It was not until the fourth week of review that four of the seven orientation program par-

ticipants were engaged in the review. A memo to staff inquiring about any problems they might be having which would account for their failure to review was sent during the fourth week. As a result, several more records were reviewed the following week. A few participants responded to the memo and indicated that there were no problems; they had not yet gotten around to doing it. This casualness about the responsibility to review, and the subsequent lapse in the time before it was actually done, was representative of only the orientation program participants.

A comparison between the way the two groups reviewed could be done only on four of the records, and each was reviewed by a different number of participants in the training and orientation programs.⁶ The proportion of errors made by the participants in each group, on the same records, was no different. Errors were defined as failures by the reviewers to complete any of the summary ratings on the first page of the audit instrument as well as omissions of answers to any of the audit questions. For example, when a reviewer's response required that the reviewer write-in a comment, a failure to do so was considered an error.

The participants in both groups also commented to the same extent in the area of "qualifications" found on the first page of the audit instrument. The qualifications that were noted by the participants were similar. The training program participants, however, were much more likely to add an overall recommendation than the orientation program participants. They wrote recommendations in 39% of the time in which they could do so whereas the orientation program participants did so only 20% of the time.

The likelihood of obtaining agreement among reviewer ratings was greater with training program participants than orientation program par-

ticipants. The training program participants more frequently rated the records, on the summary ratings, in the same way that did the orientation program participants, although the training group did not attain 100% agreement.

The major difference between the way in which the professional review was carried out by the program's participants rested in getting started, but differences were also found in how the records were actually reviewed. The training program participants reviewed more records in the allotted time--half of them reviewed the number of records that they had been required to review--and the quality of their review was as high, if not higher, than that of the orientation program participants despite the quantity. The training program participants acted more responsibly toward the mandate to engage in professional review as individuals and as professionals than did the participants in the orientation program.

NOTES

1. For a discussion of general designs of research and the before-after design see, F.N. Kerlinger, Foundations of Behavioral Research, Part Four, pp. 275-355.

2. For a discussion of nonparametric statistical tests see, Ibid., pp. 257-272; Sidney Siegel, Nonparametric Statistics For The Behavioral Sciences (New York: McGraw-Hill, 1956); and Morris Zelditch, A Basic Course in Social Statistics (New York: Henry, Holt, 1959).

3. Both tests were applied to the data from the summated rating scale and the semantic differential scales. The Median Test, the Krusdal-Wallis One-Way Analysis of Variance By Ranks, and the Friedman Two-Way Analysis of Variance By Ranks were also applied to the data. The results were not statistically significant at the .05 level.

Although we chose to interpret the lack of statistical significance as a rejection of the null hypothesis, it is possible that there are other explanations for the results. More importantly perhaps is the question of whether the decision to use $\alpha = .05$ as our level of significance was correct. For this kind of study, it may have been too high and a lower level may have been more acceptable. It also may have been more meaningful to report the significant levels of all the results or to use confidence intervals. It should also be pointed out, in this context, that question has been raised by researchers as to the value of applying tests of significance if acceptance or rejection of the null hypothesis becomes the primary basis for interpretation of data.

4. The application of these tests to the scores of the non-participants on the rating scale did not show similarly significant results.

5. The findings were not significant at the .05 level with the Chi-square Test, the Sign Test, or the Wilcoxon Matched-Pairs Signed Ranks Test.

6. Case record A was reviewed by 7 training program participants and 4 orientation program participants; B was reviewed by 7 training program and 5 orientation program participants; C was reviewed by 9 training program and 3 orientation program participants; and D was reviewed by 8 training program and 3 orientation program participants.

CHAPTER VIII

A DISCUSSION OF THE PROJECT AND ITS IMPLICATIONS

The training program that was designed and conducted to prepare social work staff at Hillside Hospital to engage in professional review was successful in achieving some of its objectives. The project demonstrated that staff attitudes toward professional review can be influenced as can the way staff engages in professional review. Training, that deliberately involves staff in a process in which they participate in defining their role and in shaping the policies and procedures that will affect them and, at the same time, are encouraged and enabled to assert professional autonomy in relation to professional review, contributes to more favorable attitudes toward professional review and to more responsibility in the way the review is carried out.

The professional social work staff who participated in the training were encouraged and helped to engage in professional review. Possible staff negativism or resistance was effectively neutralized and prevented from being dysfunctional. The program was somewhat more effective in producing more favorable attitudes toward professional review, among staff whose initial attitudes were most negative. It was also more effective in preventing staff from becoming increasingly negative toward professional review. How can we account for the results of the training program and its being less effective than anticipated and having less of

an impact on its participants than expected?

In trying to explain the results of the training program, it should be kept in mind that we do not know what the influence has been of the unique aspects of Hillside Hospital: a unionized social work staff, a multidisciplinary setting with several disciplines engaged in professional review, and a broad range of hospital services, especially in and out patient, where social workers are located. One explanation to be considered was the possibility that other factors, seemingly unrelated to professional review, might be responsible for the staff's attitudes and the likelihood of their changing. These factors might also account for the minimal effect of the training program. In an attempt to consider possible factors, we specified four conditions which could have an effect on staff attitudes and the likelihood of their changing: professional orientation, change orientation, agency orientation, and social work experience. Several measures of each were obtained through a brief questionnaire given to staff along with the after test.¹ We hypothesized that if any one of these factors was closely associated with positive or negative attitudes and with attitude change in either a positive or negative direction, it could be sufficiently powerful to wipe out any effect of the training program itself.

None of these factors proved to be significant in explaining the attitudes of staff or the likelihood of more or less favorable attitudes at the time of the after test. The relationships previously found between these factors and the direction of attitude change were noted, (change in a positive direction was more closely related to greater agency orientation, to greater change orientation, to greater professional orientation, and to more social work experience), it was not

possible to attribute the findings on the effect of the programs and no program to any of these factors. It is possible that there are other factors that were not taken into consideration that may explain the findings.

One might question the program's duration, its scope and breadth, and ask whether enough content had been included, or whether there had been sufficient time for the development of the group and the process considered so vital to the program's success. The participants themselves had asked for more training sessions; as a group they voiced their feelings of not yet being ready to start reviewing colleagues. But might they not have expressed the same feelings regardless of the duration of the training and as the time for them to engage in the review drew near?

A few more hours or sessions would have provided a greater opportunity for an appreciation of professional review and for professional development. On the other hand, additional sessions would have furthered the opportunity for understanding the difficulties with and limitations of professional review. The process of raising questions and voicing doubts, and dealing with them may help the individual come to grips with his concerns but it does not change the reality that has triggered the questions and doubts in the first place.

Would new or additional content, or some other sequencing of it, have made a difference? The core of this kind of training must be the practice of professional review. There is little leeway for major changes in content. In a more recent training program, based on this model, some changes were made in the selection of case records for practice. Case records from the participants' hospital social work de-

partment were used in the early sessions and throughout the training. In addition, greater emphasis was placed on practicing review in teams rather than individually. These kinds of changes serve to make the training experience and professional review much more real for the participants. But among the effects of such changes is the likelihood that the participants would be more anxious and thus feel even less prepared than the Hillside Hospital staff felt.

There is a certain amount of risk in a training program such as this, as with all efforts to actively involve professional staff. If staff is involved in a meaningful way, they are likely to be exposed to the problems and weaknesses of the program as well as to its good points. This may very well describe what happened with this project. The strongest evidence of it can be seen in the effect of the one orientation session which was to have been the model of what should not be done. Participants in the orientation program simply did not have the chance to see the limitations of professional review just as they did not see the value of it. They were not attuned to the difficulties that they might encounter as reviewers or to the possible consequences and dysfunctional aspects of the professional review system. Their interest was piqued, and then translated into positive attitudes which were not offset, as expected, by their resentment or by the thought of reviewing colleagues after only a briefing.

But if the training program was less than successful in its effect on staff attitudes, it seems to have been quite effective in influencing the staff's sense of commitment to professional review. If we can say that actions speak louder than words (or attitudes), then the training program participants did convey strong positive feelings about profes-

sional review in the way they took on the responsibility for review. Perhaps it was the message that the department or the social work profession cared about their experience with professional review that helped to motivate them to actually engage in it. Or, perhaps the process itself instilled among participants a feeling or responsibility for a system which they had come to view as theirs. Both were deliberately woven into the training program. The absence of both resulted in the orientation program participants' failure to actively begin to engage in professional review because there was no stimulation of personal or professional involvement in the system. We had predicted that a non-committed staff, regardless of how positive their attitudes were, might go along with the review, but proceed in a way that could undermine its effectiveness. In a very real sense, that is what we observed with the orientation program participants.

In our attempt to explain the results of the project, two points, related to the research component of the project, should be noted. Although we can be fairly confident in our findings because of the before-after research design used, one might question the validity and reliability of the instruments used and the timing of the after test.²

As a first attempt to study professional staff attitudes toward professional review, the instruments were developed and used without a thorough test of their validity and reliability. It is possible that the instruments are not really measuring attitudes toward professional review at all and therefore could not be expected to detect change in attitudes. It is also possible that the instruments are measuring more than just attitudes toward professional review and that whatever else is being measured is masking any change in attitudes. Because it is not

possible to be sure of the instruments' accuracy or to know for certain that what is being measured are attitudes toward professional review, there can always be some doubt about the findings from the data.

Another issue is raised by our decision to conduct the post-test after the participants had been engaged in professional review for one month instead of immediately following the training and orientation programs. In deciding that we were interested in assessing the effect on attitudes of the interaction of the programs with the actual experience of doing professional review, we forfeited the opportunity to see if indeed there was any change in attitude following either program. Any such change may have been further influenced by the participants' experience with the review. It was therefore not possible to tease out the effect of the professional review experience from the effect of the programs on staff attitudes. And although the conclusions drawn refer to the effect of the two programs, the reference is really a short hand expression for the programs plus the one month experience with professional review.

To gauge staff attitudes toward professional review six months after the initial test does not necessarily mean that any changes in attitudes would have taken place by then or that any changes found would be the same if measured again six months later. Six months was considered to be the shortest time in which it was realistic to conduct the two tests. It was also thought to be valuable to have the post test follow closely on the staff's experience with the review and with the programs when the influence of both on attitudes would probably be greatest. This decision leaves open the possibility that the effect of the program would have been substantially different, and in the anticipated direc-

tion, if the assessment was done another time. Since we do not know at what point the program's effect on attitudes would be greatest, the conclusions that are drawn must have that limitation.

The most important question raised by this project is not do we need a program to prepare social work staff for professional review but what kind of program is best. The project has clearly demonstrated the hazards of no program. Staff who participated in neither the training nor the orientation program grew more negative toward professional review during the six month period under study. There is no reason to anticipate that the negativism would not continue to develop in time unless deliberate actions were taken to overcome it. There are likely to be no advantages to having an uninformed or uninvolved staff.

What are the practical implications of this project? Can a case be made for the use of the training program, an obviously more expensive approach? Would not the orientation program, or some modification of it, be adequate?

An orientation program may be a viable alternative to no program for social work staff and be as effective as the training program described here in preparing staff to engage in professional review. With a highly "professional", energetic, and dedicated social work staff who are favorably inclined toward professional review in the first place, a ten week training experience based upon a peer group process and staff involvement in shaping the professional review system will not necessarily make staff much more favorable toward professional review nor much more skillful in the way they review.

A better use of resources might be to set up a series of two orientation sessions for small groups of staff in which there is an oppor-

tunity to practice a review, to raise questions and voice doubt, and to develop some sense of commitment to professional review. There are at least two exceptions to the effectiveness of the orientation program approach than can be surmised from the experience with this project:

1. If the staff is not at the level that we have vaguely described as "professional, energetic, and dedicated", or if the staff is already negative or anxious, then the training program is likely to be more useful and effective than the orientation sessions.

2. If the staff's attitudes toward professional review are not of concern or of interest, but what is important is having the staff take on the responsibility for professional review and carrying it out with maximum autonomy and only minimal administrative intervention, then the training program is likely to be more useful and effective than the orientation sessions.

This project was planned and designed in the broader context of professional control and professional accountability, and in our concern with the effect of the training program, we must not lose sight of the larger concerns.

Mandated professional review was viewed as a possible mechanism that would regulate and control professionals more effectively than informal peer control, and would serve to balance the organizational need for bureaucratic control and the professional need for autonomy and self regulation. For the social work profession, mandated professional review was considered as a possible alternative to the traditional and current method of bureaucratic and professional control--supervision--and one that was in keeping with the profession's emphases on developing

the autonomous practitioner and on increasing professionalization. It was to help professional review get off to a promising start that this project was undertaken. Predicting where major problems may lie, and identifying staff attitudes and reactions as one possible source, we attempted to neutralize or lessen the potential problems through a training program.

Our experience with the project leads to optimism about the prospects of professional review for social work. Social workers apparently will take on the responsibility for monitoring and evaluating colleagues through the review of case recordings. Although they do not especially like it, or believe it is fair, staff will make a serious effort to critically and objectively assess the practice of colleagues and offer helpful recommendations. The reviews are carried out in the spirit of education and professional development; they are not done with the intent to catch or to punish colleagues. It is likely that the greater the link between professional review and continuing education, the greater the acceptance of professional review as consistent with professional autonomy and control.

Although social workers find it is often difficult to review records, and realize that their judgments are easily subject to bias, they try to overcome the difficulties and the biases rather than give up on review. Staff seems to find it easier to review when they know less about the situation of the case from their own direct experience and when there are administrative reasons or systems problems that can be used to explain the poor quality that is found. It is also easier to review when the immediate consequences of the review findings are not known or not clear. The use of standards and criteria for evaluation,

the visibility of practice, and the appraisal of performance are all taken in stride by social workers. What is not acceptable, however, is the professionals' responsibility for the exercise of authority in relation to the reviews. Social workers do not wish to be part of what happens as a result of their reviews. In defining the boundaries of their role as reviewers, they have chosen not to participate in the planning for corrective action. While cognizant of their serving as a link between evaluations and (corrective) action, the professional reviewers will resist going beyond the limits they have set. We do not yet know the consequences of professional review being closely linked to the exercise of authority, an area for further study.

We have only begun to see what might be done to strengthen the professional review system if it is to be used with social workers. It seems likely that an effective system will require administrative support. Administrators will not be able to relinquish their responsibility because of a professional review system. One might say that it is because of a clearly defined administrative role, related to the exercise of authority, that it will be possible for professional review to work. Administrators will have to act on the findings of the reviewers, not only to deal with individual practitioners who may continue to receive poor ratings, but to make necessary changes in the policies and procedures that influence the way service is delivered and place constraints upon optimal practice. In effect, a partnership between the professional staff and the administrative staff will be established and each partner must fulfill his responsibility for the system to be successful.

The suggestions that an administrative-professional partnership might be essential for effective professional review may sound more like

a note of pessimism than optimism. But there is too little experience with professional review, and too little information at this time in the very early stages of beginning professional review to believe other than the outlook is promising. There is every reason to believe that the establishment of professional review systems can lead to increased accountability among social workers. The system exerts a kind of pressure on professionals to strive toward the standards of quality that have been identified by their peers.

Our experience with the project leads to optimism about the use of training for professional review and suggests several considerations in attempting to establish professional review systems. The greater the number of staff who are involved in doing the review, even at the practice stage, the more effective is the system likely to be. The experience of doing the reviews has considerable impact upon those who are reviewing. The staff who practiced reviewing or engaged in professional review reported that their own practice and the recording of it had improved.

The anticipation of the establishment of the system also has a positive effect on workers' practice and the recording of it. Staff should therefore be kept informed of the plans for the system and of the standards and criteria with which they will be expected to comply as each is being developed in order to take advantage of the effects of anticipation.

The tendency for staff to look out for one another, and to make sure that no one will inadvertently be injured by the system should be incorporated into the planning for the professional review system by in-

volving staff in the deliberations. There are so many aspects of a review system that can be overlooked that it can be refreshing as well as valuable to have as many concerns and ideas as possible taken into consideration. Staff concerns have been thoughtful and insightful and are essential for planning.

Because the validity of evaluating the quality of professional practice from case recordings will always be questionable, it is incumbent upon departments and administrators to develop and use more than one method for assessing the quality of practice and service. Reliance on only a professional review system is neither valid nor practical. The results of the review will be most meaningful, and the effectiveness of the system will be greatest, when professional review is used in conjunction with other approaches to quality assurance.

Regardless of how positive staff might be towards professional review, or how strong their sense of commitment to its success might be, without the provision of adequate resources and staff compensation (including the allotment of staff time), it may not be possible to have an effective professional review system.

Professional review may be more readily acceptable when it is seen as linked to continuing education and staff development as opposed to a system of rewards and punishments. The extent to which that link will lead to less effective professional review, and a system reminiscent of informal peer control, is not known.

NOTES

1. The questionnaire is in Appendix 8.
2. For a discussion of validity and reliability see, F.N. Kerlinger, Foundations of Behavioral Research, pp. 429-462.

APPENDIX 1

QUESTIONNAIRES -

SOCIAL WORKERS' ATTITUDES TOWARD PROFESSIONAL REVIEW

YOU WILL FIND LISTED BELOW A NUMBER OF STATEMENTS ABOUT PROFESSIONAL REVIEW. THERE IS NO GENERAL AGREEMENT ABOUT THESE STATEMENTS; PEOPLE DIFFER WIDELY IN THE WAY THEY FEEL ABOUT EACH ITEM. THERE ARE NO RIGHT ANSWERS. THE PURPOSE OF THIS PART IS TO SEE HOW YOU FEEL ABOUT EACH ITEM. I WOULD LIKE YOUR HONEST OPINION ON EACH OF THESE STATEMENTS. READ EACH ITEM CAREFULLY AND CHECK THE PHRASE THAT BEST EXPRESSES YOUR FEELING ABOUT THE STATEMENT.

Wherever possible, let your own personal experience determine your answer. Do not spend much time on any item. If in doubt, check the phrase that seems most nearly to express your present feeling about the statement. WORK RAPIDLY. Please be sure to answer every item.

	STRONGLY AGREE	MODERATELY AGREE	SLIGHTLY AGREE	AGREE	UNDECIDED	DISAGREE	SLIGHTLY DISAGREE	MODERATELY DISAGREE	STRONGLY DISAGREE
1. The idea of professional review is OK, but it just won't work	_____	_____	_____	_____	_____	_____	_____	_____	_____
2. The clients will get the most out of professional review	_____	_____	_____	_____	_____	_____	_____	_____	_____
3. Anyone can fix his recordings so that his work will look good	_____	_____	_____	_____	_____	_____	_____	_____	_____
4. No one cares much about the results anyway	_____	_____	_____	_____	_____	_____	_____	_____	_____
5. Evaluations are bound to be uncritical.....	_____	_____	_____	_____	_____	_____	_____	_____	_____
6. We are doing this only because we have to	_____	_____	_____	_____	_____	_____	_____	_____	_____
7. On the whole, professional reviewers will be honest	_____	_____	_____	_____	_____	_____	_____	_____	_____
8. I'm confident that the results will be put to good use	_____	_____	_____	_____	_____	_____	_____	_____	_____
9. Most people will just pretend that they are auditing	_____	_____	_____	_____	_____	_____	_____	_____	_____
10. These audits are not going to tell us anything we don't already know	_____	_____	_____	_____	_____	_____	_____	_____	_____
11. Peer evaluations can hardly ever be objective	_____	_____	_____	_____	_____	_____	_____	_____	_____
12. I don't see it as my responsibility to be my "brothers' keeper".....	_____	_____	_____	_____	_____	_____	_____	_____	_____
13. I wouldn't want my colleagues to know I evaluated them	_____	_____	_____	_____	_____	_____	_____	_____	_____
14. These kinds of evaluations can dampen staff morale	_____	_____	_____	_____	_____	_____	_____	_____	_____

[illegible]

IN THIS PART, WE ARE INTERESTED IN KNOWING THE MEANINGS OF CERTAIN THINGS TO VARIOUS PEOPLE BY HAVING THEM JUDGE AGAINST A SERIES OF DESCRIPTIVE SCALES. IN DOING THIS EXERCISE, PLEASE MAKE YOUR JUDGMENTS ON THE BASIS OF WHAT THESE THINGS MEAN TO YOU. YOU WILL FIND A DIFFERENT CONCEPT TO BE JUDGED ON EACH OF THE 3 PAGES AND BENEATH IT A SET OF SCALES. YOU ARE TO RATE THE CONCEPT ON EACH OF THESE SCALES IN ORDER.

HERE IS HOW YOU ARE TO USE THESE SCALES:

If you feel that the concept at the top of the page is very closely related to one end of the scale, you should place your check mark as follows:

fair X: ____: ____: ____: ____: ____: ____ unfair

or

fair ____: ____: ____: ____: ____: ____: ____ unfair

If you feel that the concept is quite closely related to one or the other end of the scale (but not extremely), you should place your check as follows:

strong ____: X: ____: ____: ____: ____: ____ weak

or

strong ____: ____: ____: ____: ____: X: ____ weak

If the concept seems only slightly related to one side as opposed to the other side (but is not really neutral), then you should check as follows:

active ____: ____: X: ____: ____: ____: ____ passive

or

active ____: ____: ____: ____: X: ____: ____ passive

The direction toward which you check, of course, depends upon which of the two ends of the scale seem most characteristic of the thing you're judging.

If you consider the concept to be neutral on the scale, both sides of the scale equally associated with the concept, or if the scale is completely irrelevant, unrelated to the concept, then you should place your check mark in the middle space:

safe ____: ____: ____: X: ____: ____: ____ unsafe

IMPORTANT

1. Place your check marks in the middle of the spaces, not on the dotted boundaries
2. Be sure you check every scale for every concept - do not omit any
3. Never put more than one check mark on a single scale

Sometimes you may feel as though you've had the same item before. This will not be the case, so do not look back and forth throughout the items. Do not try to remember how you checked similar items earlier on. Make each item a separate and independent judgment. Work at a fairly high speed. Do not worry or puzzle over individual items. It is your first impressions, the immediate "feelings" about the items, that we want. On the other hand, please do not be careless, because we want your true impressions.

HAVING YOUR WORK AND PRACTICE AUDITED AND EVALUATED BY COLLEAGUES

positive ____: ____: ____: ____: ____: ____: ____ negative

relaxed ____: ____: ____: ____: ____: ____: ____ tense

honest ____: ____: ____: ____: ____: ____: ____ dishonest

worthless ____: ____: ____: ____: ____: ____: ____ valuable

severe ____: ____: ____: ____: ____: ____: ____ lenient

good ____: ____: ____: ____: ____: ____: ____ bad

fearful ____: ____: ____: ____: ____: ____: ____ courageous

dirty ____: ____: ____: ____: ____: ____: ____ clean

optimistic ____: ____: ____: ____: ____: ____: ____ pessimistic

anxious ____: ____: ____: ____: ____: ____: ____ calm

powerless ____: ____: ____: ____: ____: ____: ____ powerful

fair ____: ____: ____: ____: ____: ____: ____ unfair

YOUR HAVING TO AUDIT AND EVALUATE THE WORK OF YOUR COLLEAGUES

positive ____: ____: ____: ____: ____: ____: ____ negative
relaxed ____: ____: ____: ____: ____: ____: ____ tense
honest ____: ____: ____: ____: ____: ____: ____ dishonest
worthless ____: ____: ____: ____: ____: ____: ____ valuable
severe ____: ____: ____: ____: ____: ____: ____ lenient
good ____: ____: ____: ____: ____: ____: ____ bad
fearful ____: ____: ____: ____: ____: ____: ____ courageous
dirty ____: ____: ____: ____: ____: ____: ____ clean
optimistic ____: ____: ____: ____: ____: ____: ____ pessimistic
anxious ____: ____: ____: ____: ____: ____: ____ calm
powerless ____: ____: ____: ____: ____: ____: ____ powerful
fair ____: ____: ____: ____: ____: ____: ____ unfair

YOU WILL FIND LISTED BELOW A LIST OF NINE STATEMENTS ABOUT PROFESSIONAL REVIEW. SIMPLY INDICATE THE POSITION MOST ACCEPTABLE TO YOU BY PLACING A #1 ALONGSIDE IT; INDICATE THE POSITION MOST OBJECTIONABLE TO YOU BY PLACING A #2 ALONGSIDE IT; AND INDICATE ANY OTHERS THAT ARE ACCEPTABLE OR MAY BE OBJECTIONABLE BY WRITING ALONGSIDE THEM "acceptable" or " objectionable."

- _____ A. The establishment of professional review is absolutely essential from all angles in the Department's interests.
- _____ B. On the whole, the interests of the Department will be served best by the establishment of professional review.
- _____ C. It seems that the Department's interests would be better served if professional review is established.
- _____ D. Although it is hard to decide, it is possible that the Department's interests may be better served if professional review is established.
- _____ E. From the point of view of the Department, it is hard to decide whether professional review would be advantageous or disadvantageous.
- _____ F. Although it is hard to decide, it is probable that the Department's interests may be better served without professional review.
- _____ G. It seems that the Department's interests would be better served without professional review.
- _____ H. On the whole, the interests of the Department will be served best without professional review.
- _____ I. The establishment of professional review is completely detrimental from all angles to the Department's interests.

YOU WILL FIND LISTED BELOW A LIST OF NINE STATEMENTS ABOUT PROFESSIONAL REVIEW. SIMPLY INDICATE THE POSITION MOST ACCEPTABLE TO YOU BY PLACING A #1 ALONGSIDE IT; INDICATE THE POSITION MOST OBJECTIONABLE TO YOU BY PLACING A #2 ALONGSIDE IT; AND INDICATE ANY OTHERS THAT ARE ACCEPTABLE OR MAY BE OBJECTIONABLE BY WRITING ALONGSIDE THEM "acceptable" or "objectionable."

- _____ A. The establishment of professional review is absolutely essential from all angles in my own interests.
- _____ B. On the whole, my own interests will be served best by the establishment of professional review.
- _____ C. It seems that my own interests would be better served if professional review is established.
- _____ D. Although it is hard to decide, it is possible that my own interests may be better served if professional review is established.
- _____ E. From my own point of view, it is hard to decide whether professional review would be advantageous or disadvantageous.
- _____ F. Although it is hard to decide, it is probable that my own interests may be better served without professional review.
- _____ G. It seems that my own interests would be better served without professional review.
- _____ H. On the whole, my own interests will be served best without professional review.
- _____ I. The establishment of professional review is completely detrimental from all angles to my own interests.

YOU WILL FIND LISTED BELOW A LIST OF NINE STATEMENTS ABOUT PROFESSIONAL REVIEW. SIMPLY INDICATE THE POSITION MOST ACCEPTABLE TO YOU BY PLACING A #1 ALONGSIDE IT; INDICATE THE POSITION MOST OBJECTIONABLE TO YOU BY PLACING A #2 ALONGSIDE IT; AND INDICATE ANY OTHERS THAT ARE ACCEPTABLE OR MAY BE OBJECTIONABLE BY WRITING ALONGSIDE THEM "acceptable" or "objectionable."

- _____ A. The establishment of professional review is absolutely essential from all angles in the profession's interests.
- _____ B. On the whole, the interests of the profession will be served best by the establishment of professional review.
- _____ C. It seems that the profession's interests would be better served if professional review is established.
- _____ D. Although it is hard to decide, it is possible that the profession's interests may be better served if professional review is established.
- _____ E. From the point of view of the profession, it is hard to decide whether professional review would be advantageous or disadvantageous.
- _____ F. Although it is hard to decide, it is probable that the profession's interests may be better served without professional review.
- _____ G. It seems that the profession's interest would be better served without professional review.
- _____ H. On the whole, the interests of the profession will be served best without professional review.
- _____ I. The establishment of professional review is completely detrimental from all angles to the profession's interests.

YOU WILL FIND LISTED BELOW A LIST OF NINE STATEMENTS ABOUT PROFESSIONAL REVIEW. SIMPLY INDICATE THE POSITION MOST ACCEPTABLE TO YOU BY PLACING A #1 ALONGSIDE IT, INDICATE THE POSITION MOST OBJECTIONABLE TO YOU BY PLACING A #2 ALONGSIDE IT; AND INDICATE ANY OTHERS THAT ARE ACCEPTABLE OR MAY BE OBJECTIONABLE BY WRITING ALONGSIDE THEM "acceptable" or "objectionable."

- _____ A. The establishment of professional review is absolutely essential from all angles in the patients' interests.
- _____ B. On the whole, the interests of patients will be served best by the establishment of professional review.
- _____ C. It seems that patients' interests would be better served if professional review is established.
- _____ D. Although it is hard to decide, it is possible that patients' interests may be better served if professional review is established.
- _____ E. From the point of view of patients, it is hard to decide whether professional review would be advantageous or disadvantageous.
- _____ F. Although it is hard to decide, it is probable that patients' interests may be better served without professional review.
- _____ G. It seems that patients' interests would be better served without professional review.
- _____ H. On the whole, the interests of patients will be served best without professional review.
- _____ I. The establishment of professional review is completely detrimental from all angles to patients' interests.

YOU WILL FIND LISTED BELOW A LIST OF NINE STATEMENTS ABOUT PROFESSIONAL REVIEW. SIMPLY INDICATE THE POSITION MOST ACCEPTABLE TO YOU BY PLACING A #1 ALONGSIDE IT; INDICATE THE POSITION MOST OBJECTIONABLE TO YOU BY PLACING A #2 ALONGSIDE IT; AND INDICATE ANY OTHERS THAT ARE ACCEPTABLE OR MAY BE OBJECTIONABLE BY WRITING ALONGSIDE THEM "acceptable" or "objectionable."

- _____ A. The establishment of professional review is absolutely essential from all angles in the interests of quality of social service rendered.
- _____ B. On the whole, the interests of quality of social service rendered will be served best by the establishment of professional review.
- _____ C. It seems that the interests of quality of social service rendered would be better served if professional review is established.
- _____ D. Although it is hard to decide, it is possible that the interests of quality of social service rendered may be better served if professional review is established.
- _____ E. From the point of view of quality of social service rendered, it is hard to decide whether professional review would be advantageous or disadvantageous.
- _____ F. Although it is hard to decide, it is probable that the interests of quality of social service rendered may be better served without professional review.
- _____ G. It seems that the interests of quality of social service rendered would be better served without professional review.
- _____ H. On the whole, the interests of quality of social service rendered will be served best without professional review.
- _____ I. The establishment of professional review is completely detrimental from all angles to the interests of quality of social service rendered.

APPENDIX 2**LETTER ACCOMPANYING ATTITUDE QUESTIONNAIRES**

LONG ISLAND JEWISH-HILLSIDE MEDICAL CENTER

Memorandum

TO: Social Work Staff
FROM: Gary Rosenberg, Ph.D.
RE: PARTICIPATION IN QAP RELATED STUDY

Because the department is ready to begin its quality assurance program, we have agreed to participate in a study of social work staff attitudes about quality assurance and professional review that is being conducted by Roz Chernesky who worked with us on the Functional Analysis Review and with the QAp staff committee.

The study is part of a larger project and is in no way related to our own quality assurance program. The questionnaires that you are being asked to complete are to be used only by Roz in her own research work. You can be identified by a number just in case she finds it necessary to get in touch with you about some additional information.

Please make every effort to complete the set of questionnaires and return them, by mail directly to her by October . While this date gives you a very short time to do them, they won't take long and it is urgent that she gets them back by then. I am sure the results of her study will be shared with the Department in the future. In the meantime, we both thank you for your cooperation.

127 West 77th Street
New York, New York 10024

September 1, 1975

Dear Social Worker,

As you may know, social work departments in health institutions and in medical settings will be developing procedures by which the quality of service provided to patients can be monitored and evaluated on an ongoing and systematic basis. This interest in quality assurance is in part a response to federal legislation that mandates the establishment of Professional Standards Review Organizations (PSROs) through which physician and non-physician health care practitioners must assume responsibility for the review and evaluation of health services under Medicare, Medicaid and Maternal and Child Health Programs to assure that health care under these programs will be necessary and consistent with professionally recognized standards of care. The commitment of social work professionals and departments to render effective and efficient health care services has been further encouragement to the development of systems for the continuous self evaluation of the quality of care to clients.

In nearly all instances, the system developed will be based upon the Professional Review Process whereby professionals, actively engaged in practice, will be required to evaluate the quality of care rendered by colleagues to determine whether it is in accordance with prescribed standards of professional practice and service

This means that you will be asked and expected to audit how your colleagues handled their cases as reflected in their case recordings. At the same time, your colleagues will be asked and expected to evaluate your work and practice as reflected in your case recordings. The details of how you will go about this will of course be determined by your department as it develops its Professional Review program.

I am interested in learning the opinions of social workers on Professional Review and I have selected the social work department in your hospital as one of the few to survey staff opinion. I believe it is important for social workers who will be directly involved in Professional Review to have an opportunity to express their views.

I would greatly appreciate your taking the time to respond to each of the three enclosed questionnaires (blue, pink and gold.) Although each is concerned with Professional Review, you will see that they differ in their form. I think you will find them interesting to do and they should take no more than 30 minutes.

Please answer every item on each questionnaire and do not work cooperatively with your colleagues. You may wish to comment on the questionnaires and about any problems with doing them. Your comments would be appreciated, especially since the questionnaires are still being revised.

An addressed, stamped envelope is enclosed for the return of the questionnaires. I hope you will be able to do them as soon as possible; it is necessary to have your responses by September. I would be pleased to share the results of the survey with you when the study of professional opinions on Professional Review is completed.

Thank you for your interest and cooperation.

Sincerely,

Roslyn H. Chernesky, ACSW

COMMENTS:

APPENDIX 3

TRAINING PROGRAM PACKAGE AND MATERIALS

PROFESSIONAL REVIEW

Professional review is the process by which professionals actively engaged in practice monitor and evaluate the quality of care rendered by colleagues to determine whether it is in accordance with professionally recognized standards of care. The process includes both the appraisal of quality of care or service delivered by a department or agency through its staff and the assessment of care practiced by individual professionals.

The major purposes of individual professional review, or practitioner review, are to

- 1) assist the individual practitioner in improving the quality of his practice, particularly in what may be identified as weak areas;
- 2) offer constructive feedback on performance of individual practitioners;
- 3) make known to the practitioner how significantly his practice deviates from accepted professional standards and/or departmental performance.

The major purposes of departmental professional review, or social work audit, are to

- 1) evaluate at regular intervals the quality of care delivered by staff in order to determine the extent of consistency to established standards of practice;
- 2) determine the strengths and weaknesses of service, and identify factors contributing to them in order to improve service;
- 3) provide evidence for recommendations for new or altered policies and procedures to improve care;
- 4) identify those areas where practice patterns indicate more knowledge is needed.

A SUMMARY OF PROFESSIONAL REVIEW

1. Professional review is mandated through the provisions of the 1972 Amendments to the Social Security Act (Public Law 92-603) which authorizes the establishment of independent, non profit professional associations, called Professional Standards Review Organizations (PSROs), "to promote the effective, efficient, and economical delivery of health care services of proper quality". The PSROs are to be review mechanisms through which practicing physicians and non-physician health care practitioners can assume full responsibility for the ongoing review and evaluation of health services covered under the Medicare, Medicaid and Maternal and Child Health Programs and thereby for assuring that health care under these programs will be necessary and consistent with "professionally recognized standards of care."
2. PSROs and statewide PSR Councils are now being organized within specific geographic regions for this purpose. The organizations will develop plans for involvement of health care professionals "in the planning and conduct of peer review and in the development and/or adoption and/or modification of criteria and standards, and in the selection of norms for care provided by their peers." Health care institutions can design and implement their own review and control mechanisms for quality care which will, if effective, comply with PSRO expectations and be approved.
3. Although the legislation does not specifically state that social work is to be included at this time, the social work profession and many social work departments in health settings are preparing to participate at the national, state and regional levels of PSRO and within health care institutions. Among the reasons for social work's participation are its desire to aid in better health service delivery and to guarantee that quality standards of social services and social work practice are established by the social work profession.
4. Professional review will, in general, be based upon an audit of patient records (medical audit.) Staff will appraise the quality of service rendered as it is reflected in social work recordings found in patient records. As such, it is an evaluation of process.
5. Standards used will, in general, be normative, having been determined by what a representative body of social work professionals considered to be the dimensions of good social work practice.
6. Professional review and medical audit are just two aspects of quality assurance. A comprehensive quality assurance program would have additional mechanisms for evaluating service rendered each providing another view of the care provided.

THE PROFESSIONAL REVIEW PROCESS

Scheme A.

1. Professional reviewers are appointed by the department or agency.
2. Using an audit instrument, reviewers audit case records selected for them.
3. If review team is used, agreement upon audit results is achieved.
4. Upon completion of audit, results are compiled, tallied or scored, using designated form. This may be a numerical scoring method or a summary reporting method.
5. Results are forwarded directly to designated recipients. These may be administrators, supervisors or workers who have been audited
6. Reviewers repeat process according to designated schedule - e.g. once or several times a week or month- and until replaced by new reviewers.

Scheme B.

1. Professional reviewers are appointed by the department or agency.
2. Serving as a committee, the reviewers
 - a) identify cases to be audited by determining the basis for audit selection - e.g. random, one kind of social service problem, one service area;
 - b) examine audit results to identify areas of sub-standard care or problems and to determine probable cause(s);
 - c) differentiate between individual practitioner deficiency and group patterns of inadequate practice;
 - d) develop solutions to the problems or recommend remedial action to be taken;
 - e) take steps to implement remedial actions;
 - f) reevaluate cases in which problems were identified after suitable interval to determine if action brought about improvement;
 - g) redesign audit instrument as necessary;
 - h) revise review procedures as necessary.

GLOSSARY OF SELECTED TERMS

ACCOUNTABILITY is one form of evaluation in which a department, agency or profession periodically reports on how well it is doing to the publics to which it is responsible - general public, funders, clients - on their terms. It includes statistical records and time studies.

CRITERIA are the specified elements or the dimensions of care and the values that are considered appropriate or relevant to be the basis for assessing care; sometimes referred to as standards.

EMPIRICAL STANDARDS are derived from actual practice and rest on demonstrably attainable levels of care. They are used to compare care in one setting with that in another, or with statistical averages and ranges obtained from a larger number of similar setting.

EXPLICIT CRITERIA refer to the degree to which the standards and procedures for evaluation have been formalized; are characterized by prior, explicit and formal specification of criteria and procedures to be used in the valuation. Professional judgment is used but limited by instruction to what aspects are to be considered.

EXTERNAL AUDIT is a review carried out by one or more examiners who are independent of the hospital or the setting in which the care is delivered.

IMPLICIT CRITERIA refer to the degree to which the standards and procedures for evaluation have been formalized; indicates that the examiner is the expert and that he compares and judges the case as though it were his own.

INTERNAL AUDIT is review conducted by one or more committees of the staff in the setting in which the care is delivered.

MEASUREMENT SCALE consists of the number of divisions of quality used to classify care; categories such as "excellent," "good," "fair," or "poor" and "optimal" or "less than optimal." Numerical scores may also be used.

MEDICAL AUDIT (RECORD AUDIT, CHART REVIEW) is one approach to the evaluation of quality of patient care as reflected in medical records. A sample of all records or a sample of records of a particular kind of case selected for examination. The records can be individually examined or examined by teams of expert raters or the raters can prepare a checklist for use by less skilled personnel. In each case, the examination serves to see if standards are met. This is the most popular method of obtaining information for the evaluation of process.

NORMATIVE STANDARDS are derived, in principle, from the sources that legitimately set the standards of knowledge and practice in the service system. In practice, they are set by standard textbooks or publications, panels or committees of professionals, highly qualified practitioners who serve as judges, or a research staff in consultation with qualified practitioners. Normative standards can be set very high and represent the "best" care that can be provided, or they can be set at a more modest level signifying "acceptable" or "adequate" care. In any event, they stem from a body of legitimate knowledge and values of what is good rather than from specific examples of actual practice and are determined by consensus.

OUTCOME EVALUATION or APPRAISAL is one type of evaluation which appraises what happens to the patient as a result of service or treatment. Outcomes may be either intermediate or final and include such measures as mortality or survival, level of functioning, improvement or change, patient satisfaction, patient understanding of his disease, and patient compliance with instructions. While outcome evaluation is the most important aspect of evaluation, it remains one of the most difficult to measure.

PATIENT SERVICES EVALUATION is one approach to assuring the quality of patient care by evaluating each department's service according to predetermined standards for acceptance. The kind of criteria include such items as courtesy of receptionist, the time it takes for the telephone to be answered, waiting room conditions, availability of medical charts. This is a form of structural evaluation.

PEER REVIEW is generally used interchangeably with professional review. A distinction between the two can be made. Professional review implies that members of a profession judge their colleagues regardless of status in the profession or in the organization. Peer review implies that members of a profession holding a specific status or rank judge only those colleagues who hold the same status or rank. Thus a peer review team in a social work department auditing line workers would not have supervisors on it.

PROCESS EVALUATION or APPRAISAL is one type of evaluation of services actually provided to patients. An appraisal is made of the service rendered or treatment given to a patient. Process evaluation is based on the assumption that there is a generally accepted method of practice or treatment, that it is known what good treatment or practice consists of, and then examines whether this treatment was appropriately applied. Examples include medical audit and direct observation of staff activities.

PROFESSIONAL REVIEW is the process by which professionals actively engaged in practice appraise the quality of care rendered by colleagues to determine whether it is in accordance with professionally recognized standards of care. There are two types of professional review: individual professional review which involves evaluation of quality of care by an individual practitioner; and, agency review in which general patterns of care provided to patients within an agency are examined.

PSRO (PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS) are review mechanisms mandated by the 1972 Social Security Amendments (P.L.92-603) through which physicians and nonphysician health care practitioners must assume responsibility for the review and evaluation of health services under Medicare, Medicaid and Maternal and Child Health Programs to assure that health care under these programs will be necessary and consistent with professionally recognized standards of care.

QUALITY ASSURANCE PROGRAMS include a range of ongoing and systematic attempts to assure and to improve the quality of service provided. They are based upon ongoing monitoring and evaluation of patient care and services. Some programs appraise process, others appraise outcome or structure. Some are programs of review by outside bodies (insurance companies or the federal government), others are internal reviews. All are attempts to see if prescribed standards are met and to identify the need for corrective action if service does not meet the standards. Quality assurance programs may take a variety of forms and differ in their design. All, however, must address five program components: i) the establishment of standards of quality; ii) the examination of the care rendered or service provided; iii) a comparison of results with anticipated outcomes based on criteria; iv) corrective action to remedy identified shortcomings; and v) reassessment of outcomes after corrective actions have taken place.

STANDARDS represent the desired level of compliance with criteria in the assessment of care. There are two types of standards; normative and empirical. Standards can be differentiated by their selectivity and inclusiveness, in the choice of dimensions to be assessed, by the extent of their specificity and directiveness, and by the level of strictness or permissiveness. Standards sometimes refer to criteria.

STRUCTURAL EVALUATION or APPRAISAL is one type of evaluation of quality of care that focuses upon the capacity to provide services - eg. the preparation of an individual professional, the adequacy of a facility or organization to provide specific services at a stated level of quality. It consists of examination of the presence of the tools necessary to provide care - eg. the number of staff or offices. This type of evaluation has been carried on for many years as part of the accreditation mechanism for hospitals. The Patient Services Evaluation is one kind of structural evaluation.

UTILIZATION REVIEW is a term used for the retrospective review of admissions, duration of stay and professional services furnished with regard to their medical necessity and the appropriate and efficient use of facilities and services.

SELECTING A TOPIC FOR AUDIT*

An audit topic is a specific category that is selected for review.

The topic for an audit can be:

- a diagnosis (medical or psychiatric)
- a social service problem
- a treatment plan
- a departmental program
- a hospital service
- the length of time a case is open
- a designated worker

A topic should generally not be considered for audit unless several of the following conditions can be satisfied:

- occurs with high frequency
- role of social work intervention is clear
- significant chance for a problem in the absence of social work intervention or because of inadequate intervention
- generally agreed upon practices in handling the topic
- special interest in this topic (often a result of a "hunch" or concern, a feeling that a problem might exist, or because it is generally known to be a problem elsewhere and therefore may be a problem in this setting)

Ideally, the focus of an audit topic should be one in which it is likely to reveal at least one problem in patient care or is likely to affect patient functioning and therefore will be most fruitful for improving patient care.

In order to select a topic for audit, the following questions should be asked:

- Is there reason to suspect that there may be a problem anywhere within this audit topic?
- What are the major effects to the patient and his functioning that could occur around this audit topic?
- Are any of these problems or effects preventable?
- Is it likely that more than a limited number of patients and practitioners would be involved with this topic?

*Although the selection of an audit topic may be done on a random basis, e.g. every 20th case, every case closed on a specific day or date, all cases on one service on one day, and the like, it may be desirable to deliberately select an audit topic.

SELECTING A PATIENT SAMPLE

After an audit topic is selected, it is helpful to limit the kinds of patients or charts to be involved in the audit, since the standards for care may differ with different populations.

The patient sample or chart sample is that population to which the audit topic is designated as applicable.

The parameters that can be used in defining and selecting any one patient or chart sample are:

- age
- sex
- mode of treatment
- length of treatment
- initial or returning patient

Differentiating patient samples also allows for comparisons at the time of review.

SETTING AN EXPECTED PERFORMANCE LEVEL

The degree to which it is expected that the standards of care will be met should be established prior to the audit. This is the Expected Performance Level. It represents the percent of time it is felt that the standard should be met in the review and serve as an indicator of when the level falls below or above.

An Expected Performance Level is helpful for the following reasons

- it insures that all those doing the audit and those whose performance will be audited know the degree to which it is expected to be met
- it provides an objective way to determine when action to improve patient care must be taken
- it indicates the worth of the standard; if the Expected Performance Level is set at 75%, it may not be a useful standard

IDENTIFYING A PERFORMANCE DEFICIENCY

Two kinds of performance gaps may be identified in an audit: performance discrepancies and performance deficiencies.

All performance that falls below the Expected Performance Level is considered performance discrepancies.

Performance deficiency refers only to those discrepancies which can be accounted for by the actual care provided and not by the choice of criterion or expected performance level.

STEP	PROCEDURE	
1	Identify all performance discrepancies that fall <u>below</u> the Expected Performance Level.	
2	Choose one performance discrepancy on which to begin working.	
3	Ask if that performance discrepancy can be explained because uncontrollable variables were operating, causing performance to look worse than it really was.	
	IF	THEN
	The answer is Yes	You do <u>not</u> have a performance deficiency that can be remedied by any action you take: 1. Do <u>not</u> attempt further analysis. 2. Record in the committee minutes why you will not take action including a list of the uncontrollable variables at work.
	The answer is No	Go on to STEP 4
4	Ask if that performance discrepancy can be explained because of defects in the criterion - e.g., it is not measurable or clear enough to allow for reliable abstraction.	
	IF	THEN
	The answer is Yes	1. Restate the criterion in measurable, clear terms. 2. Recalculate the Actual Performance Level. 3. Document this in the committee minutes.
	The answer is No	Go on to STEP 5
5	Ask if major developments in the body of medical knowledge have invalidated what was formerly considered a valid criterion.	
	IF	THEN
	The answer is Yes	1. Delete the no longer valid criterion from the Audit. 2. Document in the committee minutes this deletion, including what body of medical knowledge has changed.
	The answer is No	Go on to STEP 6
6	Ask if the expected performance level is unrealistic given the hospital's capabilities and lowering the performance level will <u>not</u> in any way interfere with desirable patient outcomes.	
	IF	THEN
	The answer is Yes	1. Change the expected performance level to one that is realistic. 2. Record in the committee minutes why the change was made.
	The answer is No	You have a performance <u>deficiency</u> which must be corrected.
7	THEN Repeat STEPS 3 through 6 for each performance discrepancy that falls below the expected performance level.	

PROBLEM ANALYSIS

For the one performance deficiency selected as critical, a list of possible explanations for the performance deficiency will be developed.

Some of the questions to be considered in developing a list of possible explanations for a performance deficiency are:

1. Some of the causes of the performance deficiency may be attributable to gaps in health care provider skills/knowledge. Consider the following questions in order to further explore concerns related to skills/knowledge deficiencies:
 - Which health care providers are presently contributing to or responsible for this performance deficiency?
 - What kind of skills should they be equipped with and using?
 - How often is the skill put to use?
 - Was the skill known and used in the past?
 - Under what circumstances (if any) is the skill utilized correctly? Under what circumstances is it not?
 - Is feedback received when the skill is used so that self-correction can go on?
 - Are the persons currently contributing to or responsible for the performance discrepancy over-trained for the job?
2. Some of the causes of the performance deficiency may be attributable to obstacles in the environment. Consider the following questions in order to further explore concerns related to environmental obstacles:
 - Are there high personnel turnovers?
 - Are there adequate physical facilities, tools, supplies for carrying out the expected performance?
 - Is there a clear-cut chain of command? (Responsibilities and authorities spelled out.)
 - Are work flow patterns defined?
 - Is there evidence of coordination of skills, supplies and personnel?
 - Are there defined communication channels?
3. Some of the causes of the performance deficiency may be attributable to motivational/incentive problems. Consider the following questions in order to further explore concerns related to motivational/incentive deficiencies:
 - Is carrying out the expected performance actually punishing? What form does the punishment take and why?
 - Is it more rewarding to do other than what is expected?
 - Does it even matter whether or not the expected behavior is carried out? Who cares?

Data needed to substantiate whether or not the possible explanations for the performance deficiency are good explanations will be determined.

Ways of collecting that data will be determined.

Fact-finding efforts using a data source will allow for a revised list of the possible problem explanations in order to produce a list of the most probable explanations for or causes of a performance deficiency.

EVALUATING PERFORMANCE DEFICIENCIES

From the audit, performance deficiencies will be distinguished from performance discrepancies. Deficiencies will be evaluated according to their importance and one considered critical will be selected for remedial action planning.

Guidelines to be used in evaluating the importance of performance deficiencies are:

- The existence of this performance deficiency has serious implications for patient functioning and for patient care outcomes, either long or short range.
- The existence of this performance deficiency appears to be at the heart of many other problems in delivering patient care.
- The existence of this performance deficiency appears to be symptomatic or closely related to other problems in providing good patient care.
- The existence of this performance deficiency was known and felt by workers, department or medical center even before the audit.
- The existence of this performance deficiency appears to reflect group patterns of inadequate practice rather than idiosyncratic practice.

REMEDIAL ACTION PLANNING

A series of corrective objectives which will describe the type of performance needed to correct the performance deficiency will be developed.

For each corrective objective identified as what is needed to ameliorate the performance deficiency, several remedial strategies will be identified.

Possible remedial strategies will be evaluated in order to determine the most effective and efficient action.

Plans will be made to follow through on the remedial strategy selected for achieving the corrective objective and thereby helping to alleviate the performance deficiency.

Level at Intake: ☒
 Level at Follow-up: *

FIGURE 1
Sample Clinical Guide: Crisis Intervention Center

Level at Intake: 29.4
 Goal Attainment Score
 (Level at Follow-up): 62.2
 Goal Attainment Change
 Score: +32.8

PROGRAM EVALUATION PROJECT

GOAL ATTAINMENT FOLLOW-UP GUIDE

Check whether or not the scale has been mutually negotiated between patient and CIC interviewer. SCALE ATTAINMENT LEVELS	SCALE HEADINGS AND SCALE WEIGHTS				
	Yes ☒ No _____	Yes _____ No ☒	Yes _____ No ☒	Yes ☒ No _____	Yes ☒ No _____
	SCALE 1: Education (w ₁ =20)	SCALE 2: Suicide (w ₂ =30)	SCALE 3: Manipulation (w ₃ =25)	SCALE 4: Drug Abuse (w ₄ =30)	SCALE 5: Dependency on CIC (w ₅ =10)
a. most unfavorable treatment outcome thought likely (-2)	Patient has made no attempt to enroll in high school. ☒	Patient has committed suicide.	Patient makes rounds of community service agencies demanding medication, and refuses other forms of treatment. ☒	Patient reports addiction to "hard narcotics" (heroin, morphine).	Patient has contacted CIC by telephone or in person at least seven times since his first visit.
b. less than expected success with treatment (-1)	Patient has enrolled in high school, but at time of follow-up has dropped out.	Patient has acted on at least one suicidal impulse since her first contact with the CIC, but has not succeeded. ☒	Patient no longer visits CIC with demands for medication but continues with other community agencies and still refuses other forms of treatment.	Patient has used "hard narcotics," but is not addicted, and/or uses hallucinogens (LSD, Pot) more than four times a month. ☒	Patient has contacted CIC 5-6 times since intake. ☒
c. expected level of treatment success (0)	Patient has enrolled, and is in school at follow-up, but is attending class sporadically (misses an average of more than a third of her classes during a week).	Patient reports she has had at least four suicidal impulses since her first contact with the CIC but has not acted on any of them.	Patient no longer attempts to manipulate for drugs at community service agencies, but will not accept another form of treatment.	Patient has not used "hard narcotics" during follow-up period, and uses hallucinogens between 1-4 times a month. *	Patient has contacted CIC 3-4 times since intake.
d. more than expected success with treatment (+1)	Patient has enrolled, is in school at follow-up, and is attending classes consistently, but has no vocational goals. *	 *	Patient accepts non-medication treatment at some community agency. *	Patient uses hallucinogens less than once a month.	
e. best anticipated success with treatment (+2)	Patient has enrolled, is in school at follow-up, is attending classes consistently, and has some vocational	Patient reports she has had no suicidal impulses since her first contact with the CIC.	Patient accepts non-medication treatment, and by own report shows signs of improvement.	At time of follow-up, patient is not using any illegal drugs.	Patient has not contacted CIC since intake. *

Department Evaluation Report

Dates: 11/30/73 Times: 11:00 A.M.

<u>Attributes</u>	<u>Acceptable</u>	<u>Not Acceptable*</u>
1. Employee Attitude	✓	
2. Waiting & Process Time	✓	
3. Appointment Time	✓	
4. Adequate Waiting Space		✓
5. Rooms out of order	✓	
6. Exam Room check	✓	
7. X-Ray Film Availability	✓	
8. Time out on loan		✓
9. Folder Content	✓	
10. Report Time	✓	
TOTALS		

Quality Rating = $\frac{\text{No. Acceptable}}{\text{No. Acceptable \& No. Not Acceptable}} = \frac{8}{10} = 80\%$

*Reasons for unacceptable rating (verify with appropriate Supervisor)

4 - Three patients standing in waiting area due to lack of seats.
Waiting room very crowded and difficult to move around in.

8 - one folder out on loan for 27 days
patient name: James Smith
number: 049-32-9374

Critical Observations

Corridor floor too highly waxed - very slippery -
potentially very dangerous to patients and staff.

Please return this form immediately upon completion to:
Quality Engineer - Management Science Dept., 3349 Steuben Ave.

Auditor: W.J. Jones

Figure 24

Quality Assurance Manual

Attributes	Radiology	Acceptance Criteria																										
1. Employee Attitude	1. Proceed to the Radiology in-patient waiting area and exam rooms. Observe x-ray technicians, receptionists and nurses performing their jobs for a few minutes. Reject if any of these people are not helpful, informative, understanding, courteous, friendly, pleasant, responsive to crises, assisting with movement of patients, etc.																											
2. Waiting and Process Time	2. Locate the patient board on the wall next to the in-patient coordinator in the above waiting room. If before noon select one Barium Enema (B.E.), one Gastro Intestinal (G.I.) and one Intra-venous pyleogram (I.V.P.) slip from the patient board. If after 12 o'clock noon select one skull, one chest and one spine instead. Determine how far each of these three patients has progressed with his exam and reject if any of the patients have not met the time line described below. All times are measured cumulatively from the moment the patient entered the department (punched on front of slip).																											
	a. Initial waiting time	<table><tr><th>D.E.</th><th>G.I.</th><th>I.V.P.</th><th>Skull</th><th>Chest</th><th>Spine</th></tr><tr><td>15 min. max</td><td>15</td><td>15</td><td>10</td><td>10</td><td>10</td></tr><tr><td>b. Waiting time plus total exam time until ready to be taken back (a+b)</td><td>65 min. max</td><td>75</td><td>75</td><td>30</td><td>15</td><td>30</td></tr><tr><td>c. Initial waiting, exam time, plus waiting time to re-turn to R. (these times are cumulative)</td><td>70 min. max.</td><td>80</td><td>80</td><td>35</td><td>20</td><td>35</td></tr></table>	D.E.	G.I.	I.V.P.	Skull	Chest	Spine	15 min. max	15	15	10	10	10	b. Waiting time plus total exam time until ready to be taken back (a+b)	65 min. max	75	75	30	15	30	c. Initial waiting, exam time, plus waiting time to re-turn to R. (these times are cumulative)	70 min. max.	80	80	35	20	35
D.E.	G.I.	I.V.P.	Skull	Chest	Spine																							
15 min. max	15	15	10	10	10																							
b. Waiting time plus total exam time until ready to be taken back (a+b)	65 min. max	75	75	30	15	30																						
c. Initial waiting, exam time, plus waiting time to re-turn to R. (these times are cumulative)	70 min. max.	80	80	35	20	35																						
3. Appointment Time	3. Using the same patients (providing they are in-patients as in 2 above, locate the x-ray request form for each patient. Reject if the following times since receipt of request by X-ray Dept. (stamped on front of request) have been exceeded: G.I., B.E., I.V.P. - 3 days Chest, skull, spine - 24 hours																											
4. Adequate Waiting Space	4. Observe both the in-patient and out-patient waiting areas. Reject if there are no seats available and people are standing as a result in either of the waiting areas.																											
5. Rooms out of order	5. Ask the floor supervisor if there are any exam rooms out of order due to equipment breakdown. Reject if any rooms are out of order and record the number of each such room.																											

12/75

DEPARTMENT OF SOCIAL WORK SERVICES
LONG ISLAND JEWISH-HILLSIDE MEDICAL CENTER
PROFESSIONAL REVIEW AUDIT

Case (patient) Identification _____

Basis for Audit Selection _____

Status of Case at time of Audit

Closed _____

Open _____

Unknown _____

Length of time Case has been a Social Work Service Case
_____Social worker (s) on Case _____

Date of Audit _____

Auditor (s) _____

Audit Recommendations _____

REFERRAL (REQUEST FOR SERVICE)

To determine whether the case should have been taken on and/or continued as a social work case beyond the initial interview or screening. To determine whether a need for social work service is indicated, especially with self referrals or where mandatory social work coverage exists.

- | | <u>YES</u> | <u>NO</u> | |
|--|------------|-----------|-----|
| 1. Is the date of referral to Social Work Services or date of initial contact stated? | ___ | ___ | 1. |
| 2. Is the source of referral or how the client got to Social Work Services clearly stated? | ___ | ___ | 2. |
| 3. Should the referral source have been contacted? | ___ | ___ | 3. |
| 3a. If YES, was the referral source contacted or | ___ | ___ | 3a. |
| 3b. Is it understood why it was not contacted? | ___ | ___ | 3b. |
| 4. Is the reason for referral (request for service) clearly stated? | ___ | ___ | 4. |
| 4a. If NO, is the reason implied or inferred? | ___ | ___ | 4a. |
| 5. Does the reason for referral or request for service fall within the realm of social work service? | ___ | ___ | 5. |
| 5a. If NO, is it understood why this case was taken on or continued beyond the initial interview or screening? | ___ | ___ | 5a. |
| 5b. If YES, is the reason valid? | ___ | ___ | 5b. |

DEPARTMENT OF SOCIAL WORK SERVICES
LONG ISLAND JEWISH-HILLSIDE MEDICAL CENTER
PROFESSIONAL REVIEW AUDIT

SUMMARY REPORT

Case (patient) Identification _____

Basis for Audit Selection _____

Status of Case at time of Audit

Closed _____

Open _____

Unknown _____

Length of time Case has been a Social Work Service Case

Social worker (s) on Case _____

Date of Audit _____

Auditor (s) _____

Audit Recommendations _____

Attributes	Better than Average	Acceptable	Unacceptable	QUALIFICATIONS
PSYCHO-SOCIAL HISTORY				
ASSESSMENT				
PROBLEM SELECTION				
GOAL FORMULATION				
TREATMENT PLAN				
SOCIAL WORK INTERVENTION				
RECORDING				
OUTCOME				
	Totals			

Quality Rating

PSYCHO-SOCIAL HISTORY
(INFORMATION GATHERING)

To determine if necessary information, relevant to request for service is presented; to determine whether the information is sufficient and complete so that the worker has the kind of knowledge about the patient's need and situation which would aid in the evaluation, care and planning in relation to the patient; to determine if unnecessary or extraneous information has been gathered.

	<u>YES</u>	<u>NO</u>	
6. Is there a social history?	___	___	6.
7. Has the psycho-social information essential to this case been presented? (e.g. demographic characteristics, family composition, economic status, living arrangements, patient's relationships, patient's perception of presenting problem, past history of the problem, etc.)	___	___	7.
8. Should any of the information presented been verified or documented?	___	___	8
8a. If YES, was documentation made?	___	___	8a.
8b. If YES, was documentation adequate?	___	___	8b.
8c. If NO, was an adequate explanation given?	___	___	8c.
9. Is there any information that is missing from the psycho-social history that should have been presented?	___	___	9
9a. If YES, what information? _____			9a.
10. Is there any information presented that was unnecessary?	___	___	10.
10a. If YES, what information? _____			10a.
11. Is it understood whether the patient was previously known to the hospital division's social work department?	___	___	11.
12. Is it understood whether the patient was known to other agencies?	___	___	12
13. Should any agencies or departments have been contacted or should any records have been requested?	___	___	13.
13a.. If YES, were appropriate contacts or requests made?	___	___	13.
13b. If NO, what records should have been requested or what contacts whould have been made? _____			13b.
14. HOW WOULD YOU JUDGE THE OVERALL QUALITY OF THE PSYCHO-SOCIAL HISTORY?			
_____ Better than average			
_____ Acceptable			
_____ Unacceptable			
	___	___	14

ASSESSMENT (EVALUATION)

To determine whether the data on patient and his problem (s) are identified, analyzed and evaluated with understanding and insight, and with the application of behavior and practice theories in order for the worker to arrive at a sound professional judgment for goal (s) and treatment plan to be formulated.

	<u>YES</u>	<u>NO</u>	
15. Is there some assessment? (If NONE, skip to Problems)	___	___	15.
16. Does the assessment indicate an integration of data?	___	___	16.
17. Does the assessment indicate an understanding of data?	___	___	17.
18. Has a differential diagnosis been made?	___	___	18.
19. Does the assessment lead systematically and directly to problem formulation, goals and treatment?	___	___	19.
20. Are there significant gaps in this assessment?	___	___	20.
20a. If YES, what should have been included in the assessment?	_____		20a.
21. Does the assessment give evidence that this case falls within the realm of social work service?	___	___	21.
21a. If NO, explain _____	_____		21a.
22. HOW WOULD YOU JUDGE THE OVERALL QUALITY OF THE ASSESSMENT?			
_____ Better than average			
_____ Acceptable			
_____ Unacceptable			22.

PROBLEM

To evaluate the delineation of the problem (s) and selection for social work intervention. Problem is defined here as the unmet need, the state of affairs which brought about concern to the patient or others, the condition about which something should be done.

	<u>YES</u>	<u>NO</u>	
23. Are the patient's problems clearly stated?	___	___	23.
24. Are the problems related to the request for service or referral?	___	___	24.
24a. If NO, was an adequate explanation for the difference given?	___	___	24a.
25. Are there potential problems that have not been noted or explained?	___	___	25.
25a. If YES, what are they? _____	_____		25a.
26. Is it understood which problems will be the focus of social work intervention?	___	___	26.
27. Have the appropriate problems been selected for social work intervention?	___	___	27.
28. What other problems, if any, should have been selected?	_____		28.
29. HOW WOULD YOU JUDGE THE OVERALL QUALITY OF THE PROBLEM SELECTION?			
_____ Better than average			
_____ Acceptable			
_____ Unacceptable			29.

GOALS

To evaluate the goals that are formulated. Goals are defined as the desired results, the hoped for outcome of the treatment plan, the state of affairs the worker hopes to achieve.

	<u>YES</u>	<u>NO</u>	
30. Are the goals (or goal) stated?	___	___	30.
30a. If NO, are they implied:	___	___	30a.
(If NONE, skip to Treatment Plan)			
31. Are short range (immediate) goals specified?	___	___	31.
31a. If NO, should there have been short range goals?	___	___	31a.
31b. If YES, what are they? _____			31b.
32. Are long range (long term) goals specified?	___	___	32.
32a. If NO, should there have been long range goals?	___	___	32a.
32b. If YES, what are they? _____			32b.
33. If the case was referred, are the goals related to the referral?	___	___	33.
33a. If NO, is an adequate explanation given?	___	___	33a.
34. If there is an assessment, do the goals follow logically from the assessment?	___	___	34.
34a. If NO, what goals would have followed logically? _____			34a.
35. Were the goals mutually agreed upon by worker and patient (or family)?	___	___	35.
35a. If NO, was an adequate explanation given?	___	___	35a.
36. Are the goals feasible (attainable)?	___	___	36.
36a. If NO, why not? _____			36a.
37. If there is more than one goal, are priorities amongst goals clear?	___	___	37.
37a. If YES, are the priorities appropriate?	___	___	37a.
38. HOW WOULD YOU JUDGE THE OVERALL QUALITY OF THE GOAL FORMULATION?			
_____ Better than average			
_____ Acceptable			
_____ Unacceptable	___	___	38.

TREATMENT PLAN

TO determine if an appropriate treatment plan was selected, one that addresses the problem and the goals, and takes into account the realities of the patient's situation, the social worker's role and responsibility, the agency's function, and external (environmental) constraints.

	<u>YES</u>	<u>NO</u>	
39. Is there a treatment plan?	___	___	39.
40. If there was a reassessment, does the treatment plan take it into account?	___	___	40.
41. Does the treatment plan take into account the patient's situation?	___	___	41.
41a. If NO, specify _____			41a.
42. Does the treatment plan take into account social work's parameters?	___	___	42.
42a. If NO, specify _____			42a.
43. Does the treatment plan take into account the agency's function?	___	___	43.
43a. If NO, specify _____			43a.
44. Does the treatment plan take into account external (environmental) constraints?	___	___	44.
44a. If NO, specify _____			44a.
45. Has the patient (or surrogate) been involved in the development of the treatment plan?	___	___	45.
45a. If NO, should the patient have been involved?	___	___	45a.
45b. If YES, was an adequate explanation given for his exclusion?	___	___	45b.
46. Was the treatment plan mutually agreed upon by worker and patient or family?	___	___	46.
46a. If NO, was an adequate explanation given?	___	___	46a.
47. Have changes been made in the treatment plan?	___	___	47.
47a. If YES, are adequate reasons for the change given?	___	___	47a.
48. Should alternative plans have been developed?	___	___	48.
48a. If YES, are the alternative plans appropriate?	___	___	48a.
49. Is the treatment plan sufficiently clear so that anyone picking up the case would be able to implement it?	___	___	49.
50. Have the aspects of the treatment plan that should be followed by other disciplines been identified?	___	___	50.
51. HOW WOULD YOU JUDGE THE OVERALL QUALITY OF THE TREATMENT PLAN?			
	_____	Better than average	
	_____	Acceptable	
	_____	Unacceptable	
			51.

SOCIAL WORK ACTIVITY (INTERVENTION)

	<u>YES</u>	<u>NO</u>	
52. Are there progress notes describing social work activity on the case? (If NONE, skip to conclusion note)	___	___	52.
53. Do the progress notes present an easily understood flow of sequential recording?	___	___	53.
54. Are the progress notes dated for each entry?	___	___	54.
55. Where appropriate, are the notes signed for each entry?	___	___	55.
56. Is the frequency of progress notes timely in order to be useful?	___	___	56.
57. Are the progress notes sufficiently clear so that anyone picking up the case would be able to understand the social work activities?	___	___	57.
58. Are the progress notes helpful to other providers?	___	___	58.
59. Are the progress notes legible?	___	___	59.
60. HOW WOULD YOU JUDGE THE OVERALL QUALITY OF THE RECORDING?			
___ Better than average			
___ Acceptable			
___ Unacceptable			60.
61. If there is a treatment plan, does the social work activity follow from the treatment plan?	___	___	61.
62. If involvement with the health care team was called for, does the social work activity indicate involvement with the team?	___	___	62.
63. If involvement with the patient's family was called for, does the social work activity indicate involvement with the family?	___	___	63.
64. Does the social work activity give the impression of thoughtful service?	___	___	64.
64a. If NO, specify _____			64a.
65. Does the social work activity give the impression of appropriate service?	___	___	65.
65a. If NO, specify _____			65a.
66. Is there a closing note?	___	___	66.
67. Is the note dated and, where applicable, signed?	___	___	67.
68. Is there a conclusion note summarizing the work between client and worker?	___	___	68.
69. Does the conclusion note indicate progress made?	___	___	69.
70. Does the conclusion note state whether the case was referred, transferred or closed?	___	___	70.
71. Does the conclusion note state why the case was referred, transferred or closed?	___	___	71.
72. Does the conclusion note indicate whether there was a need or lack of need for follow-up?	___	___	72.
73. If there is a NEED FOR FOLLOW-UP, are the follow-up plans appropriate?	___	___	73.
74. If there is a NEED FOR FOLLOW-UP, were the follow-up plans carried out?	___	___	74.
75. Should this case have been terminated?	___	___	75a.
referred?	___	___	75b.
transferred?	___	___	75c.
continued for follow-up?	___	___	75d.

OUTCOME (RESULTS)

To gauge effectiveness of social work intervention where possible and to determine factors that contributed to results.

	<u>YES</u>	<u>NO</u>	
76. Was the treatment plan implemented?	___	___	76.
IF THE TREATMENT PLAN WAS IMPLEMENTED			
77. Are the results indicated?	___	___	77.
77a. If YES, are the results related to social work intervention?	___	___	77a.
77b. If NO, is it clear why social work intervention was not responsible for the results?	___	___	77b.
IF THE TREATMENT PLAN WAS <u>NOT</u> IMPLEMENTED			
78. Are reasons given for why the plan was not implemented?	___	___	78.
78a. If YES, are the reasons adequate?	___	___	78a.
78b. If NO, is it clear why the treatment plan was not implemented?	___	___	78b.
79. Were the goals achieved?	___	___	79.
80. Are there goals that were not achieved?	___	___	80.
81. For the GOALS THAT WERE ACHIEVED, which of the following might account for their achievement?			
a. quality of assessment	___	___	81a.
b. problem formulation	___	___	81b.
c. selection of problems for focus of social work intervention	___	___	81c.
d. goal formulation	___	___	81d.
e. treatment plan	___	___	81e.
f. external circumstances (beyond worker's control)	___	___	81f.
g. patient's participation or cooperation	___	___	81g.
h. quality of intervention	___	___	81h.
82. FOR THE GOALS THAT WERE <u>NOT</u> ACHIEVED, which of the following might account for their not being achieved?			
a. quality of assessment	___	___	82a.
b. problem formulation	___	___	82b.
c. selection of problems for focus of social work intervention	___	___	82c.
d. goal formulation	___	___	82d.
e. treatment plan	___	___	82e.
f. external circumstances (beyond worker's control)	___	___	82f.
g. patient's participation or cooperation	___	___	82g.
h. quality of intervention	___	___	82h.
83. HOW WOULD YOU JUDGE THE OVERALL QUALITY OF OUTCOME?			
_____ Better than average			
_____ Acceptable			
_____ Unacceptable			
	___	___	83.

DEPARTMENT OF SOCIAL WORK SERVICES
LONG ISLAND JEWISH - HILLSIDE MEDICAL CENTER
QUALITY ASSURANCE AUDIT

Instruction Manual

REFERRAL (REQUEST FOR SERVICE)

1. The date of referral to Social Work Services should be stated in all cases. This date may be different from, and should not be confused with, the initial date of recording. It cannot be assumed that the initial date of recording is the same date of referral. Therefore, the referral date must be cited in the narrative.
2. The source of referral - how the client got to Social Work Services - should be stated in all cases. If the case is self-referred or one of mandatory coverage, this should be noted. Reviewers will not always be familiar with the policies and procedures of every service.
3. At times, it may be necessary to confirm with the referral source that the service was in fact requested or the reason for referral. The reviewer must judge whether this case is one in which the referral source should have been contacted
4. and, if it is, then whether contact was made. In stances where there was a need to contact but contact was not made,
5. the reviewer must judge whether there was an adequate explanation for the failure to do so (e.g. time, unable to locate source.)
6. There should be an understanding of why the case was referred. A clearly stated reason for referral is preferred but an
7. implied or inferred reason will be acceptable. However, the reviewer should not have to search out or guess the reason; implication or inference is acceptable only in instances in which there is no doubt in the mind of the reviewer.
8. It is assumed here that all requests for service are not necessarily appropriate for Social Work Services. The item is intended to identify instances in which social work service is rendered unnecessarily. The reviewer must judge whether the reason for referral or request for service indicated the
9. need for social work service. If no need was indicated, it
10. must be clear and acceptable to the reviewer why the case was continued beyond the initial interview or screening.

PSYCO-SOCIAL HISTORY

11. It is assumed here that a social history of some kind should and will always be present. The quality of the social history, however, may differ considerably. Therefore it would be only in the most unusual circumstances that the response would be NO.
12. The reviewer must determine what information is essential to the case and then must judge whether that information has been presented. The quantity of information is not important here; in fact, as the latter questions point out, too much information is as critical as too little information. The question should be answered in light of what information is deemed necessary for the worker to evaluate and plan for this case. If the reviewer believes that nonessential material has been presented or that essential material is missing, the response would be NO.
13. Under some circumstances, information collected should be verified or documented (e.g. prior hospitalization, receiving SSI, being evicted from apartment.) The reviewer must decide whether there was a need for any documentation and whether it was obtained.
14. When documentation was considered necessary and
15. there is no indication that it was sought, the reviewer
16. must be satisfied with the worker's reason for not having done so.
17. If the reviewer believes that essential information is missing
18. from the psycho-social history, he is obligated to list that information.
19. Similarly, if the reviewer believes that unnecessary information was collected and presented in the psycho-social history,
20. he is obligated to list that information.
21. Whether the patient has been previously seen by the Social Work Department in that hospital division or whether the
22. patient has been known to other agencies should be noted. The reviewer should not wonder if this is the first time that this case has been served by the Department or by other agencies; the worker should clarify that information.
23. The reviewer must determine if agencies or departments known to the patient should have been contacted, and whether appropriate contacts were made.
- 24.
25. Rating the overall quality of the pscho-social history should relate to the previous answers. However, it should not be a summing of the YES and NO answers. Rather, the rating should be the reviewer's overall impression based on his best professional judgment.

ASSESSMENT

26. Although every case should have some assessment, it is possible that the assessment will not be evident or clear. A YES answer should be given if the worker has interpreted the information that is presented, attached meaning to the items of information (rather than merely reporting them), or has related the information in a narrative form that conveys an understanding of the data and their implications. Length of the assessment, whether it is placed in a separate section with or without a heading, are not criteria used for judging the presence or lack of an assessment.
27. An adequate assessment will reflect the worker's having organized and integrated data and will convey an understanding of what the discrete pieces of information mean. Integration and understanding are not to be thought of as the same thing although the two tend to coincide. When an assessment appears to be inadequate or limiting, the reviewer must differentiate between the two and specify which (or both) is lacking.
- 28.
29. The assessment is expected to reflect an individualized, not a "canned" approach. The patient should come across to the reviewer as a "person."
30. Integration and understanding of the information are not sufficient for an adequate assessment. The assessment should also logically connect the information to the problem formulation and treatment plan.
31. The reviewer is obligated to comment on any significant gaps in the assessment, e.g. information the worker has not fully understood or information that the worker omitted from the analysis.
- 32.
33. Once again the reviewer is being asked to judge whether this case is a valid social work service case. Whereas the reviewer's first determination was made based upon information given about the reason for referral or the request for service,
34. the judgment at this time should be based upon the worker's assessment. If the reviewer does not believe that this is a valid case, explanation must be given (e.g. beyond scope of the agency, belongs more appropriately to nursing.)
35. Rating the overall quality of the assessment should relate to the previous answers. However, it should not be a summing of the YES and NO answers. Rather, the rating should be the reviewer's overall impression based on his best professional judgment.

PROBLEM

36. Where the Problem-Oriented-Record is used, it is likely that the problems will be clearly stated. It is expected that even when the POR is not used, the problems will also be clearly stated. This may not be the case. The reviewer should not have to search out the problems; they should be easily discernible. The question does not ask whether the problems are apparent but rather if they are clearly stated.
37. It is likely that the problems presented will be the same as or closely related to the request for service or the reason for referral. This does not necessarily have to be
38. the situation. Should there be a difference between the problems identified and the initial reason for service, this fact and the reason for it should be adequately explained by the worker. The reviewer should not have to try and figure out what caused the discrepancy.
39. At times the reviewer may feel that certain problems have been overlooked by the worker; the worker may have failed to pick up or follow through on certain problem indicators. In these situations, the reviewer is obligated to specify
40. what the problems are.
41. More than one problem may have been identified by the worker. The record should clearly indicate which of the problems
42. is the focus of social work intervention.
43. The reviewer must judge whether the appropriate problems were selected for intervention and, if not, which of the
44. other problems identified by the worker (or added by the reviewer) should have been the focus.
45. Rating the overall quality of the problem formulation should relate to the previous answers. However, it should not be a summing of the YES and NO answers. Rather, the rating should be the reviewer's overall impression based on his best professional judgment.

GOALS

46. Goals are defined here as the desired results, the hoped for outcome of the treatment plan, or the state of affairs the worker hopes to achieve. In some cases the goals may not be stated as such
47. but will be implied or inferred. While this will be considered acceptable, the reviewer must be able to determine the goals without difficulty.
48. Short range goals are usually the immediate focus of the worker's attention but the goals may not be specified as such.
49. It is expected that all cases will have short range goals. If the reviewer is unsure of the goals of the worker, he is obligated to
- 50.
51. Long range goals are not appropriate in all cases. However,
52. if the reviewer believes there should be long range goals and
53. the worker has not specified them, the reviewer must state the:
54. If the goals are unrelated to the initial request for service and/or reason for referral, the worker must give a satisfactory explanation for the discrepancy.
- 55.
56. Assuming there is some assessment, it is expected that the goal would follow from it. If they do not, the reviewer must indicate what goals would have been a logical conclusion.
- 57.
58. It is expected that the goals formulated would have been mutually agreed upon by the worker and the patient. In many instances if this were the case, mutuality may not be explicit. As long as the reviewer does not pick up any indications otherwise, it can be assumed that they have been mutually agreed upon. There may be indications however that the worker's goals and the patient's are at variance.
59. In these instances, the worker is expected to acknowledge the difference as well as the goal(s) toward which treatment is directed. Although the worker may have provided an explanation, the reviewer must judge if it is satisfactory.
60. It is expected that the goals will not be formulated in a vacuum, without regard to the realities of the situation. The reviewer must judge whether the goals seem feasible
61. If the reviewer believes that the goals could not be attained, he should indicate why.
62. Frequently more than one goal may be formulated and it is likely that not all can be pursued simultaneously. The worker is expected to state the priorities amongs goals and the reviewer must judge if they are appropriate.
63. Rating the overall quality of the goal formulation should relate to the previous answers. However, it should not be a summing of the YES and NO answers. Rather, the rating should be the reviewer's overall impression based on his best professional judgment.

TREATMENT PLAN

65. It is expected that there will be a treatment plan in every case unless assessment indicates an inappropriate request for service or the patient declines service.
66. At times, there may be a difference between what might be
67. termed the initial treatment plan and the ongoing treatment plan. If the worker has not differentiated between the two,
68. where applicable, the reviewer should note that.
69. If the treatment plan does not seem to take into account the
70. patient's situation (e.g. ability, motivation, state, status, etc.), the reviewer should explain how it failed.
71. If the treatment plan does not seem to take into account the
72. scope and limitations of social work's responsibility and parameters, the reviewer should explain how it failed.
73. If the treatment plan does not seem to take into account the
74. limitations and the functions of the agency, the reviewer should explain how it failed.
75. If the treatment plan does not seem to take into account the
76. external realities (e.g. not public housing vacancies, waiting lists to receive service, patient cannot travel to agency, etc.), the worker should explain how it failed.
77. It is expected that the treatment plan will have been developed
78. by the worker along with the patient. If the patient has not been involved, the record should note the reason for the
79. patient's non-participation which the reviewer will judge if satisfactory.
80. It is expected that the treatment plan will have been
81. mutually agreed upon by worker and patient. If there appears to be some indication of difference, the worker must explain
82. in the record why the difference exists.
82. It is possible that somewhere along the way the treatment
83. plan may change. If this occurs, the worker must give an adequate reason for the change.
84. At times, it is appropriate to have several or alternative
85. plans ready. The reviewer should judge whether alternative
86. plans were needed and formulated. If they were developed, the reviewer should judge whether they were appropriate.
87. The treatment plan is expected to be sufficiently clear so
88. that anyone picking up the case would be able to implement it.
88. At times the treatment plan will require participation and
89. cooperation of other disciplines or agencies. The worker should specify which aspects of the treatment plan are to be followed by others.
89. Rating the overall quality of the treatment plan should relate
90. to the previous answers. However, it should not be a summing of the YES and NO answers. Rather, the rating should be the reviewer's overall impression based on his best professional ju

SOCIAL WORK INTERVENTION

- 90-99. All cases must have progress notes. The reviewer must judge whether the recordings are adequate. The items in this section are self-explanatory.
100. What the social worker does, and therefore records, should follow from the treatment plan (which flows from problem identification, assessment, and goal formulation.)
101. Communication between and among members of the health care team (especially with inpatient cases) is essential. The reviewer should be able to ascertain from the record that the worker has communicated and/or obtained necessary information from relevant others (whether in person or in writing.)
102. In some cases, there may be the need for the social worker's involvement with the patient's family. The reviewer should be able to ascertain whether the worker has been so involved.
103. What the worker does, and therefore records, should give the impression of thoughtful and appropriate service. This is where the worker's relationship with the patient, for example, can come across. If the reviewer does not get
104. the impression of thoughtful and appropriate service, he must specify why.
105. If a case is audited after it has been closed, there should
106. be a closing note, dated and, where applicable, signed.
107. A conclusion note, in which the worker summarizes his work,
108. progress made, and how the case was ended, must appear in
109. all cases. At times it may be incorporated in the closing note.
110. The summary should also explain why the case was ended in the way it was.
111. The conclusion note should also indicate whether follow-up was considered necessary and arranged for.
112. If there is a need for follow-up, the reviewer should judge whether the plans are appropriate.
113. If there is a need for follow-up, the reviewer should determine whether the plans were carried out.
114. The reviewer should indicate how he thinks the case should have been ended, regardless of what the worker decided or did

OUTCOME

115. The record should indicate if the treatment plan was implemented. If implementation is not made clear by the worker, the reviewer must judge based upon the information provided.
116. The record should indicate the end results.
117. If the results are indicated, the reviewer must judge whether they were brought about by the social work intervention.
118. If the reviewer judges that the results were brought about independent of or coincidental to social work intervention, the reviewer must indicate whether the cause of the results is clear.
119. Reasons should be given for why the plan was not implemented.
120. The reviewer must judge whether the reasons given are adequate.
121. If the reviewer judges that the reasons are inadequate, the
122. The record should indicate if the goals were achieved. If the information is not made clear by the worker, the reviewer must make this judgment.
- 123-130. The reviewer must judge and indicate all of the factors that he considers might explain why the goals were achieved.
- 131-137. The reviewer must judge and indicate all of the factors that he considers might explain why the goals were not achieved if this were the case.
137. Rating of the overall quality of the outcome should relate to the previous answers.

APPENDIX 4**SOCIAL SERVICE CASE RECORDS**

MRS. F.

PRESENTING PROBLEM: Mrs. F. is a white Jewish woman who is seeking help in coping with her family. She is "at her wits end," as to how to handle her son's marijuana abuse, cannot get cooperation from her husband who she describes as "impossible", and feels that all the family's problems and dysfunctional patterns of behavior "fall on my head." She has sought help many times and hopes counseling will be successful now.

DEVELOPMENTAL HISTORY: Mrs. F. was born in Brooklyn, the youngest of 5 daughters of Anna and Abraham N. Although Jewish, the family was not observant and patient had no religious education. The family was always poor, Mr. N. changing jobs frequently. Patient reports constant quarreling between parents over money. She reports that she and her sisters got along well and she still has good relations with them. All the children left high school before graduation in order to help support themselves and their parents. Mrs. F. left Jefferson High School in 11th grade where she was enrolled in a commercial course. Starting as a factory worker, she rose to the position of assistant bookkeeper in the garment industry and worked until she became pregnant with her first child.

MARITAL HISTORY: Mrs. F. met her husband Albert when she was 21 at a dance. He was then dating her sister who was separated from her husband. When her sister decided to return to her husband, Mrs. F. says she was a great consolation to Albert and 2 years later they were married. She stated this was her big mistake as her husband "has strange ways", is a "momma's boy" and very difficult to get along with, e.g. he would lock himself in his room if anyone visited, would not allow Mrs. F's sisters and their families in the house, would not allow anyone to eat at the house, in fact, would "count food" regularly. She also states he is very bigoted and intolerant of anyone but Jews, "twists reality" and always has to be right. In 1953 the couple separated for 1½ years, but returned together. During that time, Mrs. F. lived with his mother. When I wondered why she would have maintained her marital relationship, Mrs. F. says she cannot understand it herself. "Even the kids say, 'Why don't you get divorced?'" In addition to the above-mentioned problems, Mr. F. has never been a good provider, has had many jobs, the longest -- 10 years as a cutter in a dress factory. He is currently working at this job, but it is seasonal and he is usually laid off from January 1 to the end of April. He makes no attempt to find temporary employment as unemployment insurance is more profitable.

When I inquired if Mrs. F. had considered employment she became quite angry saying she absolutely would not work to help her husband. "I don't see why I should work while he sits around the house doing nothing for

months every year." The family has moved 7 or 8 times in the last 20 years, but have been living in the same apartment in a four family house for 10 years. Mrs. F. says this is the longest she has ever lived in one place.

PARENTAL HISTORY: Mrs. F. has 3 children, Steven 20, Allen 18 and Judy 14 -- all living at home. Her son Steve was arrested 3 years ago for possession of marijuana and probated to Far Rockaway Youth Center for one year. Although she describes his childhood as normal, he was friendless and alone most of his early adolescent years. His school performance was poor and he wanted to drop out of high school, but he did "barely graduate" from Far Rockaway High School. She claims her husband always insisted he go to college and it was only when Steven's guidance counselor intervened that Mr. F. "let the kid alone." Once the pressure about college was removed Steven agreed to remain at Far Rockaway High School. Mrs. F. describes him as abusive, doing anything against the law, staying out till all hours of the night and not being "normal". When I inquired into his "lawless" behavior, Mrs. F. admitted it concerned only refusal to stop marijuana abuse and her fears that if caught as a second offender, he'll go to jail. Steven has been employed since graduation at the N.Y. Mercantile Exchange. Mrs. F. is not sure exactly what his job is. His salary is \$130 weekly. Allen, 18, graduated from Far Rockaway High School in June 1974. He was not a good student, 70 average, but plans to enter Queensboro Community College in September. Mrs. F. is very angry about this decision because she wanted him to go to college in Brooklyn because of ease of public transportation. He has a summer job at Dun & Bradstreet which he enjoys. Mrs. F. is worried that he will begin abusing marijuana and be like Steven.

Judy is a retarded child but educable and is in a special class at U.H.S. 202. Mrs. F. reports they were unaware of her mental status until kindergarten when Judy's teacher advised testing. Mrs. F. reports "you wouldn't know she's retarded if you met her, she's so beautiful." Mrs. F. claims her husband has never accepted Judy's problem. At the same time, she states she's never told her relatives about it, it's hard enough if she knows.

Toward the end of the interview Mrs. F. remarked that "one thing about my boys, they are ambitious." When I asked her if she was aware that this was the first positive thing she had said about any member of her family, her response was "what did I say bad?" I restated the question and she thought a moment and then agreed that perhaps she did take an overly negative view and "look for problems".

PREVIOUS TREATMENT HISTORY: Mrs. F. reports 2 years of treatment at Jewish Community Services in Brooklyn, about 2 years at Jewish Community Services in Far Rockaway, but "I think they gave up on us." She says

Steven and her husband were also seen in Far Rockaway but that her husband denied any problems and went only to help Steven. When Steven reported his refusal to give up marijuana use, she called A.S.A. who referred her to Project Chameleon.

IMPRESSIONS: Mrs. F. is obese, but neatly dressed woman. She talks very rapidly and exhibits a great deal of anxiety, hostility and aggression which she seems to use as a defense against her underlying dependency needs. She avoids her own behavior problems and projects onto her husband and children. She attempts to be very controlling in the therapeutic situation as well as at home. She still attempts to be the decision maker for the entire family and seems to receive gratification from the abuse she receives. She views therapy as a means of "getting things off my chest" rather than a way of modifying her own behavior. She repeatedly asked me what she should do, e.g. get divorced, throw Steven out, etc., and not only is unable to make decisions about her own life, but is unable to allow her sons any freedom to learn from their failures as well as their successes.

PROGRESS NOTES:

7-29-74: Mrs. F. began the session with a replay of complaints about her husband and Steven. She tried to avoid any discussion of herself or ways in which her actions could alleviate some of her problems. Mrs. F. would like the sessions with me to allow her to ventilate her frustrations while doing nothing to change her patterns of behavior. Rather than relying on herself, she prefers to have decisions made for her which she hopes will give her some "peace". The main focus of our interview was trying to have Mrs. F. accept a contract to work on her strengths and possible courses of action.

Mrs. F. is not too comfortable when confronted with this approach but admits that 12 years of prior therapy have changed nothing and perhaps she does have to begin looking at herself and alternatives on her part, rather than attempting to change Steven and her husband through working with me.

8-13-74: The focus of the interview was on getting Mrs. F. to take a first step in allowing Steven to be responsible for his actions. During the first half of the session, I explored areas that might provide a point of entry. Mrs. F. and I agreed this would be letting Steven, not her, see that he got up in time for work.

The records of the family's prior treatment and my own observations indicate that no amount of encouragement and support in the direction of allowing Steven to grow up will succeed without concrete, clearly stated procedures. Mrs. F. and I role played the morning with Steven and she promised to make a real attempt to resist reminding him to get up and to work on time. Her confidence in her own ability to succeed is minimal, but her trust and thankfulness that at last someone has given her concrete direction may make it possible for her.

8-22-74: Mrs. F. reported that she has not awakened Steven since our last session. Rather than being gratified, she stated it wouldn't last and anyway Allen was waking Steven. I pointed out to her that she seemed to be looking for reasons to go back to waking him, thereby keeping him dependent on her.

Mrs. F. cannot accept this interpretation as yet, and attributes her infantilizing of her children to her own upbringing. In this way, she is much like Steven and this too, was pointed out to her. She states she will continue not to wake Steven, and try to take changing her behavior toward him one step at a time.

8-29-74: The focus of the interview was once again Mrs. F.'s efforts to let Steven be responsible for himself. She has been following through thus far and was able to reflect upon how she treats Judy and Allen.

She reports that she has already told Judy that she is going to give her an alarm clock and that she, too, will be expected to be responsible for getting up in the morning for school. Mrs. F. seems to have made movement in the area of allowing her children some autonomy. She seems encouraged that she can change, if very slowly, and is very positive in her feelings toward me as a result.

9-5-74: Mrs. F. reports that her sons have been getting up by themselves until today when she woke Steven. She rationalized this because she didn't hear his alarm go off.

Once again we focused on her need to infantilize her children and ways she could change this pattern.

9-11-74: Step one, the children awakening themselves, has been successful for over a week, and Mrs. F. has resisted her impulse to take over for them because "I think I'm afraid what you'll think."

Step two, is that Steven has one week to clean up the room he shares with Allen and choose what to keep or discard, or Mrs. F. will do it. Steven can no longer be allowed to abuse Allen by taking over the entire room.

9-19-74: Mrs. F. reports she will try to follow through on step 2, since Steven refuses. She states that she is surprised to find that since she is coming here and being firmer with Steven, that her relations with her husband have improved. I pointed out to her that this might be because she is agreeing more with her husband vis a vis Steven and not, as formerly, always on Steven's side. She agreed this might be so.

10-3-74: Mrs. F. reports she is following through with getting her sons' room in shape. She is delighted now at how "peaceful" mornings are and has begun to accept the possibility of further change.

She has also begun to realize that as she becomes more adequate as a mother and wife, Steven and her husband are beginning to change.

10-17-74: Although progress is slow, Mrs. F. is encouraged by her accomplishments so far. She states her children and husband are beginning to believe she will do as she says and take her more seriously.

10-31-74: Progress is slow but sure, and Mrs. F. is pleased that she has been able to assert herself as a mother. She is much less complaining and anxious and continues to make efforts to change.

11-7-74: Mrs. F. continues to bring up problem areas in her mothering role and is making genuine attempts to set limits and structure her home. She accepts as our mutual goal the necessity for her to be in control rather than her son, Steven.

11-21-74: Mrs. F. continues to make efforts to modify her own behavior, but is frustrated at her husband's inability to change or accept help. It is particularly difficult now when she is facing his 4 month layoff shortly.

12-19-74: Mrs. F. continues to regress as her husband's layoff approaches. I will continue supporting her efforts to cope with his bizarre behavior and the resultant effects upon her children.

12-26-74: Mrs. F. is trying to get back to asserting herself as a parent in order to bring some peace and order to her house. Her task for this week is to set limits on friends visiting her sons and taking over her home.

1-9-75: Mrs. F. and I reviewed our work together and agreed she had made some gains since beginning here. However, she is unable or unwilling to be consistent in coping with other family members. Rather, she threatens and then doesn't follow through, thus perpetuating the F's dysfunctional family system. Mrs. F. and I agreed she would use the period of my vacation to decide whether any further gains can be made by continuing here.

2-20-75: Mrs. F. had almost no complaints and was aware that she had reacted to anticipatory anxiety as her husband's layoff approached. Now that she has lived with it for a number of weeks, she was able to report that the gains she has made here have served her well.

At the moment, at least, she is reasonably content.

CHARLES

IDENTIFICATION: Charles B. is a twenty-three year old white, single man who is presently living with his mother and 9 year old brother in their home in Corona, New York. He is a tall, slightly overweight young man who presents himself as being depressed and insecure regarding future plans.

PRESENTING PROBLEM: Charles was referred to "Project Chameleon" by John Allen of the Detoxification Unit at South Shore Hospital. He was successfully detoxed from barbiturates and methadone there, and discharged on 1-10-75. He was placed on a waiting list for admission to Strauss Cottage. It was agreed that I would follow him in treatment while he waited for hospitalization. I arranged to see Charles 2-3 times a week.

Charles' major presenting problem was one of depression. There was a great deal of self-depreciation and guilt present, as well as some suicidal ideation. He was desperately trying to hang on until he received a date for hospitalization, which he believed would solve all his problems. His attempts to remain drug-free at this time were unsuccessful and he was soon readdicted to methadone.

FAMILY HISTORY: Charles lives with his mother, Margarita B., aged 49, who works full time as a saleswoman. He also has a 14 year old brother named Vincent. His father, Joseph, died in 1968 of a heart attack. Charles has never been married. There is also a 26 year old sister, Julia, who is married and lives in East Meadow. Charles seems to relate to his mother and other relatives on a childish, immature level, requiring much nurturance, but giving nothing in return.

EDUCATION: Charles attended P.S. 22 for elementary school and P.S. 97 for junior high school. He graduated from James Madison High School in 1969. He has also attended vocational courses in plumbing, welding, and printing.

EMPLOYMENT: Charles has held down 5 plumbing jobs in the past 5 years, the longest period of employment being 8 months. These jobs were held intermittently, and were usually lost because of his heavy drug abuse.

COURT HISTORY: Charles was first arrested at the age of 18 for car theft. He was arrested again in February 1974 for grand theft (car again), convicted, and sentenced to 3 years probation. His probation is dependent

on the condition that he is in a drug rehabilitation program, which includes methadone to abstinence, followed by an antagonist program.

PSYCHIATRIC HISTORY: Charles was seen on 2-5-75 by Dr. Rothman because of a suicidal gesture on 2-3-75. He diagnosed Charles as having an acute schizophrenic reaction with anxiety and depression. An earlier diagnosis, while he was on the Detox Unit, was borderline character neurosis with anxiety and depression.

DRUG HISTORY: Charles has had a history of drug and alcohol abuse since the age of 18. He has used alcohol for 9 years, and for the past 5 years has used barbiturates, methadone, and marijuana extensively. He has also used heroin, amphetamines, and cocaine. He was enrolled in a methadone to abstinence-antagonist program in the early part of 1974 at N.Y. Medical College, but stopped taking the antagonist, dropped out of treatment and became addicted to methadone again.

IMPRESSIONS: Charles is a 23 year old unmarried male, with a 2 year history of heroin addiction followed by a 3 year history of methadone maintenance. This drug history was concurrent with heavy use of alcohol and barbiturates.

Charles is aware of some strong unresolved feelings precipitated by an argument he had with his father prior to his death of a heart attack at the age of 41. After this time, he began using opiates on an increased level.

Charles was seen from 1-14-75 to 2-10-75 by me. While he was always cooperative during sessions, he appeared somewhat superficial in recognizing or working on problems. He admitted to suicidal ideation and periods of depression. Underneath the superficiality of awareness of his present state, seems to be feelings of depression and self-depreciation.

Treatment goals were first to maintain Charles in treatment until a bed opened up on Strauss, and later until a bed opened up in the Detox Unit. Both times he was unable to refrain from taking drugs.

Charles is obviously a person with immature personality development and weak ego strengths. He relates to this therapist on an infantile level, requiring constant support and nurturance.

The treatment plan is for him to be detoxified again and held on the Unit until a bed opens up in Strauss Cottage. He is eager to return to the warm, supportive climate of the Detox Unit, and hopes the staff will continue taking care of him. His extreme dependency needs and inability to

control or refrain from drug abuse for any length of time add up to a poor prognosis for Charles.

PROGRESS NOTES:

1-14-75: Charles appeared quite anxious and uptight for this first session. There is still no opening on Strauss and Charles is finding it very difficult to resist taking drugs while home.

He vacillates between wanting to return to Detox or remain home until he can go to Strauss. He is having difficulties with sleeping and keeping himself occupied. At the end of the session, he agreed to stay home and try to stick it out as long as possible.

1-17-75: Charles was anxious and upset today and finding it very difficult to stay off drugs while not in the hospital. He states that friends constantly call and want him to go out and take drugs with them. He has been unable to sleep and admits to copping two tuinolols on 1-16. He did not want to get high and therefore only got 2 pills to help him sleep. He is extremely ambivalent about either returning to detox or staying home until there is a bed in Strauss.

A meeting took place with Charles, myself, and Dr. Rothman to explore his ambivalence, and he decided to remain home. Dr. Rothman wrote him a prescription for 4 sleeping pills to tide him over until our next appointment on 1-21-75.

1-21-75: Charles was in much improved spirits today. With the aid of sleeping pills, he is feeling more relaxed and is able to sleep. He states he has not taken drugs. He has resisted his former friend's attempts to see him and spends most of his time reading. He seems to have gained a great deal of confidence in himself in being able to remain drug free. We discussed some of his questions and anxieties regarding his admission to Strauss and hope he will not have to wait much longer. Our next appointment is on 1-23. Another meeting was arranged with Dr. Rothman to continue the sleeping medications, as the previous prescription was for 4 pills, which ran out last night.

1-24-75: Charles is still maintaining himself while waiting for admission to Strauss Cottage. He states he has remained drug-free, but realized he needs further help which he hopes to find in Strauss. He continues taking Elavil and sleeping pills prescribed by Dr. Rothman.

1-27-75: Charles had a good weekend and celebrated his mother's fiftieth birthday with his family. He remains in good spirits. He is impatient to enter Strauss, but also seems to have gained in self-confidence and ego esteem during the wait, as he has proved himself able to stay off drugs.

1-28-75: Ms. Goldin from Hillside called today to say a bed would be available for Charles on 1-29. She also called his home and told his mother, in Charles' absence. I tried to contact him later in the day, but he wasn't home. His mother said he will be at Strauss on 1-29 at 9:00 a.m. for admission.

2-5-75: Charles came in on time for the interview. He appeared to be drugged and when I approached him with this, he admitted to taking about 60 mg. methadone a day, and about 80 mg. of valium per day. He feels he needs this medication in order to maintain himself while waiting for a bed in our Detox Unit.

He still refuses to accept any other detox program and says he will wait until a bed is available. After some exploration and discussion, Charles admitted that if there is an emergency and he just can't wait to get in here, he will accept a referral elsewhere.

Another appointment was set up for 2-10. He refused the appointment time for 2-7, saying he planned to be busy that day.

2-7-75: I spoke to Mrs. B. on this date to discuss her worries about Charles and whether he can remain at home while taking such a large amount of drugs. She agreed with me that if he acts up again, she will take him to Triboro or Bernstein for detoxification.

2-10-75: I met with Charles on this date and was relieved to tell him that a bed had opened up on Detox and he would be admitted at 1:00 p.m. today. He was quite pleased to hear this and feels that he will make it this time.

This case has been transferred to the Detox Unit.

CLOSING STATEMENT: Charles B. was referred to Project Chameleon on 1-10-75 while he was still on the Detox Unit. I arranged to continue counseling him until his admission to Strauss, which was imminent. We met two to three times a week until a bed was available on Strauss on 1-29. He went to the admission stoned and revealed he had been taking 80 mg. of methadone per day since discharged from Detox. They sent him home and he requested re-admission to detox at South Shore, but there was no bed.

I worked with Charles on a daily basis as he insisted on waiting for a bed in the hospital. He slashed his wrists on 2-3-75 in an effort to get into detox quicker. He was taking 80 mg. of methadone daily and 80-100 mg. of valium.

Therapy was concentrated in the area of daily functioning during this waiting period, as Charles refused detoxification at any other facility. A bed was available on Detox on 2-10-75, and Charles was immediately admitted.

MRS. C.

9-16-74 Referral: Patient referred by physician in Central Medical Clinic for help with personal planning. She suffers from asthma since age 16. Her attacks have recently increased in frequency, and patient feels it is because of emotional strain at home.

Social Situation: Mrs. C. looks many years younger than her actual age, and she is articulate and very clear mentally. She was anxious to make a good impression, and at first tended to deny all problems. She gives the impression of a woman quite eaten away by disappointment and without much joy or satisfaction in her life now. There is a mildly paranoid flavor to her, but her history reflects a stable manner of functioning.

Mrs. C. has been married for 39 years, and has no children. Her husband, William, is now 67, and retired from his job with the Parks Department. Patient stopped work two years ago -- she had worked for 22 years doing alterations on men's clothing in a good shop on Madison Avenue. Now she is home all the time, and this appears part of her problem. Living with the C's is his mother, Natalie, who is 87, ill and senile. In addition to caring for, and catering to her, William spends a lot of time caring for his elderly, senile aunt in Manhattan. Patient undoubtedly resents his involvement with these relatives, although she added that "darling Willy" is the best husband in the world. Still she does have her differences with him -- she said he greatly resents her illness (asthma) and complains about her attacks and need for medical attention all the time. This hurts her when he has so much patience with the many complaints of his mother and aunt.

Mrs. C. said she has friends down South who ask her to visit, and she is thinking of going to stay with them for a couple of months. She thought getting away from home might help her asthma, but she is worried about leaving her husband alone with all the home responsibilities. Also, in discussing this further with her, patient agreed it is no solution to her problem, as she will just return to the same situation. I asked how she occupies her time, and she said she has "loads of friends", but that her husband is rude to them, and she does not socialize as much as she would like. In other words, she is at loose ends. Mrs. C. did not pick up on my suggestion that she look into Day Centers for Senior Citizens. I did tell her about our group program in Mental Hygiene Clinic, and she said she will think about this, and let me know, as I will help her apply.

While she is certainly unhappy, I did not feel there is any emergency or urgency to this situation. Patient is not in depression, and she has remained with the same husband for 39 years and is not about to leave him now. I suggested she come to my office next time she comes to the hospital, to let me know how things are going with her, and she said she will do this. I'm not sure she will.

No service requested at this time. CASE IS CLOSED.

Social Worker, 10-3-74

MR. W.

9-5-74 Mr. W., a 52 year old man, was referred on Ward rounds on 3 North. He was admitted with a diagnosis of cirrhosis of the liver.

Patient was seen on the Ward. He is single and lives in a 3½ room apartment in Jamaica. Mr. W. has been paying \$145 a month rent. He related that he has been supporting himself with the savings which his mother left him when she died two years ago. Patient has been working off and on but does not have a steady job. He worked as a steam fitter for 23 years. However, he is not receiving any benefits. Mr. W. stated that he never got in touch with his Union or his employer to see if he was covered for benefits. Mr. W. related that, according to the physician, he will not be able to return to work. We noticed that he had an extended stomach and learned from the physician that he has to return to the clinic for tapping of the fluid. We were also advised by the physician that the patient will not be able to return to work.

9-6-74 Mr. W. was seen again. He informed us that he will not have any problem returning to his previous work. He has paid his rent until September 14th. However, he does not have any financial resources to buy his food and other necessities. We discussed with him Social Security Disability and assistance through Welfare while he is awaiting his Social Security. Mr. W. requested that we have Mr. B. see him on the Ward.

9-9-74 We learned from the patient that he has not been seen by the Social Security representative. We contacted patient's sister and sister-in-law and advised them to go to the Social Security office to make application and were assured that the family will take care of this.

9-11-74 We visited Mr. W. again. He showed us the application which his sister-in-law brought from SSI for his signature. Patient signed the application. Later we saw Mr. B. from the Social Security office and asked him to take the application to the Social Security office. The application was given to Mr. B.

9-13-74 Mr. B. visited the patient on the Ward. He was concerned about patient's benefits from the Union and requested the patient to get a letter from the Union that he is not now eligible for any benefits. Mr. B. also informed us that he will not get any Social Security benefits for another three or four months. We gave the patient an application for DSS.

Patient's sister and sister-in-law came in the afternoon. We explained the procedure for application to DSS and advised them to take the patient to the DSS on Monday Sept. 16th early in the morning. The necessary letter regarding patient's hospitalization, a referral from Social Service, and also a referral letter from SSI were given to the patient. Patient was discharged in the afternoon and will return to GI Clinic on Sept. 26th. Case submitted for closing.

Social Worker

ANTHONYSOCIAL WORK INTAKE

SOURCE OF REFERRAL: This referral originated with Ms. Adams, Social Worker at St. Joseph's School, and came to Children & Family Service through Dr. B., PRYME Pediatrician, who referred it on 3-26-75.

PRESENTING PROBLEM: According to the referral the only problem is that Anthony is having difficulty learning to read as well as interpreting symbols in arithmetic. Mr. F., whose English comprehension was fair to good and whose English pronunciation was fair to poor, also indicated that these were the only problems that he felt his son had. Anthony has apparently been having difficulty learning to read for almost two years now and Mr. F. is eager to understand why he is having these difficulties.

PATIENT'S FUNCTIONING: Anthony, who prefers to be called Tony, is just finishing up second grade for the second time at St. Joseph's. Last year both the teacher and the family felt that most of Tony's problems were due to bilingualism but now neither the school nor the family believe that. Mr. F. noted that last year Tony was rather uncomfortable in the school and was frightened often, saying that children were blaming him for doing things he did not do. Mr. F. was called up to school a number of times last year and told that Tony had brought toys to school to play with instead of working. According to the report from Tony's teacher, he seems to particularly find symbols or symbol reading difficult. When writing he sometimes does not leave spaces between the words. He is only able to read some of the most simple words. The teacher notes that his eyes seem to shift swiftly across the page making it difficult for him to focus on one particular word. She feels Tony might have a problem focusing and tracking as well as visual perception and visual memory deficits. There are apparently no behavior problems.

At home Tony presents no problem to his parents. He often helps out his mother watching the smaller children and cleaning. He is always moving around, being still only when he is watching T.V. His father believes he has a short attention span. He never has to be disciplined at home.

Tony has no difficulty sleeping although he is sometimes afraid to go to sleep and might have bad dreams after he has seen horror pictures. He has no difficulty getting up in the morning and usually gets himself ready for school. There are no eating problems.

Tony gets along well with his siblings and with his friends, both older and younger, in the neighborhood.

DEVELOPMENTAL HISTORY: Ms. F. was 16 years old and her husband 27 when she gave birth to Tony. This was her first pregnancy and there were no problems with pregnancy, labor, or delivery. Tony was born in Santo Domingo and was described as an active infant. He began walking at 8 months old, talking at 12 months old, and there were no problems with weaning or toilet training. Medically, he was hospitalized once for 3 or 4 days at 2 years of age in the Bronx after getting a bean stuck in his left ear.

Tony went to kindergarten in the Bronx, apparently adjusted well to the school and liked going there. He went to first grade at P.S. 105 in Rockaway where he apparently had no problems. After the first grade Tony was transferred to St. Joseph's because his parents wanted a Catholic education for him.

FAMILY SITUATION: Mr. & Ms. F. came to the United States in 1967, moving to the Bronx. They moved to Rockaway in November of 1972. Mr. F. has family living in New Jersey. He indicated that he did not have any relatives living in Rockaway although he did speak about a grandmother of Tony's sometimes babysitting and Tony later mentioned that his uncle lived in the apartment above the family. Mr. F. worked in a grocery store in Brooklyn. He sometimes works 6 or 7 days a week and doesn't see his family much at those times. Ms. F. works at a nursing home. Mr. F. was not completely aware of what she did, but thought it involved serving food. She works on different shifts at different times.

The next oldest child in the family, Roberto, was described by Mr. F. as being very intelligent. He is now in kindergarten and the family plans to send him to St. Joseph's school next year. Maria is four years old and developing normally and Janet, is 7 months old, and also is apparently developing normally.

When the both parents are working during the day they always get a babysitter to come to their home. There is no one consistent babysitter to watch the children.

INTERVIEW WITH PATIENT: Tony presented as a thin, alert, friendly child with a number of teeth missing. He separated from his father and came into the interviewing room without hesitation although he explained he was coming this morning to have his tooth pulled. He could not imagine why else he would come to PRYME but readily accepted the explanation that we were interested in finding out why he was having difficulty learning to read in school and seeing if we could be of help to him. Tony expressed himself well, occasionally speaking spontaneously, had a slight speech difficulty which might have been due to the missing teeth or the Spanish language influence, and seemed very interested in cooperating and wanting to please me. While there generally did not appear to be any problem with thinking or orientation, there were some questionable responses. For example when

asked who he would take to a desert island, Tony initially replied he would take a lamp, a magic lamp, which he then explained he would use to wish for a boat. When the question was repeated to him he indicated he would take his brother because his brother helps him. Tony's initial response was interesting not only from the fact that he picked an inanimate object at first, but also that he seemed to assume that he would want to get away from the island. Also, Tony did not know his birthdate, he did not know this month nor could he tell me the names of any but four months of the year, he was somewhat confused about the days of the week, being able to name only 6 out of the 7 after much prodding, and although he was able to correctly tell me his address, he did not know his phone number nor in what neighborhood, area, or city he lived. Although Tony knew that his stomach was in his abdomen, he was unable to identify what its function was. He knew that his chest contained his heart and indicated it was to keep him alive. He stated his brains were in his head and they were used to think. When questioned he also reported hearing his mother call him when he later found out she hadn't done so and hearing his brother talking to him sometimes when he finds later that his brother isn't there. Tony seemed to have a healthily active imagination, although he may become a little over-ideational at times.

While I did not get the impression of any severe emotional problems, Tony did seem to be somewhat anxious, insecure, fearful, and in need of attention. For example, when asked what animal he would most want to be he indicated a monkey because it looks funny and then went on to describe how his brother does things to look funny and how people seem to get a kick out of this. He would least want to be a wolf because he is afraid he might kill somebody and then he would get killed. When asked if he ever saw things that really weren't there, Tony explained that he once woke up at night and saw a man in his room. He was frightened, and thought the man was going to hit his brother. Another time in a dark room he thought he saw a mummy. He now knows these were both in his imagination. He also talked about being afraid of certain T.V. shows and being scared by a dream of a wolf coming to eat him up. Tony's drawing of small, heavily shaded figures both with lines underneath their feet, were further evidence of the anxiety and insecurity that Tony exhibited. Some of his comments about the figures were also interesting. He noted that the boy was angry when other boys beat him up and he was scared to fight back. He indicated the girl was happy because she was going back to her mother. He further indicated that he himself likes to be with his mother and father but that he does not have that much time with his father who has to work a lot. Again, referring to his drawing, but also probably to his own desire for more contact with others, he indicated that the boy is sad when his friend's mother says that he cannot play with her son.

Tony appears to perceive his family as having quite unclear boundaries. When asked to draw a picture of the members of his family doing something, he initially drew all the males in separate places doing their own thing, and ignoring the females entirely. He even added a man who he says is his uncle. He is not sure how this man is related to him. After drawing all the males, Tony stated "I can't think of the rest..." and when this statement

was reflected back to him he said, "Oh my mother, I forgot her." He then drew his mother pushing a wheelchair and told me his mother worked in a nursing home. Again Tony indicated that he could not think of the rest and when questioned further he added his sister. When reminded he had previously talked about two sisters he stated, "Oh, I forgot the baby, she doesn't do nothing but cry."

While it appeared to me that Tony did well on the Bender Gestalt cards for his age, he did have trouble writing words. He was not able to spell dog, bed, or bad by himself and when these words were spelled out for him he wrote bog for dog and gad for pad. When asked to look at the word dog and say the letters, Tony repeated verbally dog. Tony is right-handed, right-footed and right-eyed and knows right from left. Tony is very aware that he has a problem learning to read and in fact his second magic wish is to learn to read, although I felt to some extent that this was one way he had of trying to please the interviewer. His other two wishes were for first a bike, and third a swimming pool.

IMPRESSIONS AND PLANS: Anthony is a rather likable child who it would seem, has learned to get gratification from behaving well and pleasing adults. The reason for his learning problems are quite unclear. While there seemed to be some evidence for perceptual difficulties, this seemed to be somewhat inconsistent. Another explanation might be what has been referred to as a failure to learn how to learn. However, it also seemed interesting and somewhat out of place that Tony did not know some very basic kinds of information. While Tony did not seem to exhibit any severe emotional problems, it is possible that he is minimizing the amount of anxiety, insecurity, and also sibling rivalry which he is feeling, all of which could interfere with his academic functioning. I would like a psychological evaluation scheduled to clarify the issues here.

In terms of treatment, I would at the present time lean toward trying a short term individual therapy for Tony using the flying start learning to learn kit as a means of trying to help Tony with his reading as well as offering the kind of individual attention that he seems to desire. Additionally, Tony may do very well in a group situation both to give him more peer contact as well as a balance for the large number of acting out children that we get for groups. In terms of his parents, if it was felt that they needed some type of counseling, I think it would have to be on a short term basis with possibly irregular appointments because of their work schedules.

Social Worker

APPENDIX 5

MEMORANDUM TO STAFF
FROM TRAINING PROGRAM PARTICIPANTS

DEPARTMENT OF SOCIAL WORK SERVICES
HILLSIDE DIVISION

December 5, 1975

To: Social Work Staff

From: Professional Review Training Committee
Peter Persoff, Henrietta Christian, Stu Gitlin, Sidney Sugarman, Randy Nemser, Jane Walvoord, Sydney Scheiner, Elizabeth Cramer, Jeff Pennell, Linda Ehrenfreund, Marge Koretzky

Re: Status of Quality Assurance Audit

We are the group of lineworkers who were randomly selected to participate in an eight week training program designed to prepare us to audit the quality of service of social work staff. Professional review has been mandated by HEW. Several disciplines within the hospital are designing audit procedures to monitor quality of service. The review will begin sometime early next year. (See attached "A Summary of Professional Review" for details). We have been meeting weekly with Mrs. Roz Chernesky, at Dr. Gary Rosenberg's request, around several interrelated tasks.

- 1) reviewing and refining the audit form which was developed last year by another staff task force.
- 2) applying the audit form to social work cases obtained from affiliated hospitals and agencies (not from Hillside) to assess its value and to reach consensus on the relevancy of the questions posed and their meaning.
- 3) training ourselves in the use of the audit form.
- 4) developing a plan for the implementation of Professional Review, i.e., the starting date, the number of people on the review committee, the method for selection of cases to be reviewed, ways of using the results obtained.

The Committee is aware that staff is interested in and concerned about this new procedure and is taking this into consideration in making plans. We welcome your suggestions. Please direct them to individual members or to Professional Review Training Committee, Dr. Rosenberg's office. The final audit form will shortly be available through your Administrative Supervisors.

A SUMMARY OF PROFESSIONAL REVIEW

1. Professional review is mandated through the provisions of the 1972 Amendments to the Social Security Act (Public Law 92-603) which authorizes the establishment of independent, nonprofit professional associations, called Professional Standards Review Organizations (PSROs), "to promote the effective, efficient, and economical delivery of health care services of proper quality." The PSROs are to be review mechanisms through which practicing physicians and non-physician health care practitioners can assume full responsibility for the ongoing review and evaluation of health services covered under the Medicare, Medicaid and Maternal and Child Health Programs and thereby for assuring that health care under these programs will be necessary and consistent with "professionally recognized standards of care."
2. PSROs and statewide PSR Councils are now being organized within specific geographic regions for this purpose. The organizations will develop plans for involvement of health care professionals "in the planning and conduct of peer review and in the development and/or adoption and/or modification of criteria and standards, and in the selection of norms for care provided by their peers." Health care institutions can design and implement their own review and control mechanisms for quality care which will, if effective, comply with PSRO expectations and be approved.
3. Although the legislation does not specifically state that social work is to be included at this time, the social work profession and many social work departments in health settings are preparing to participate at the national, state and regional levels of PSRO and within health care institutions. Among the reasons for social work's participation are its desire to aid in better health service delivery and to guarantee that quality standards of social services and social work practice are established by the social work profession.
4. Professional review will, in general, be based upon an audit of patient records (medical audit.) Staff will appraise the quality of service rendered as it is reflected in social work recordings found in patient records. As such, it is an evaluation of process.
5. Standards used will, in general, be normative, having been determined by what a representative body of social work professionals considered to be the dimensions of good social work practice.
6. Professional review and medical audit are just two aspects of quality assurance. A comprehensive quality assurance program would have additional mechanisms for evaluating service rendered, each providing another view of the care provided.

APPENDIX 6

FINAL REPORT OF
TRAINING GROUP PARTICIPANTS

TO: LIJ-HMC, Department of Social Work Services, QAP committee
Dr. Lurie
Dr. Rosenberg

FROM: Roslyn Chernesky

RE: Summary of Practice Audit Experience at Hillside Division

DATE: February 9, 1976

The Professional Review Training Group at the Hillside Division met on Thursday, February 5th, following a month's practice experience with professional review during which six records were individually audited. The purpose of the session was to discuss the experience and to make recommendations, where relevant, about the professional review process. The problems were identified and recommendations were made:

1. Use of the Audit Form.

While specific questions and the way they were worded continued to be problematic, (and are cited below), there were several more general problems that arose:

a. The section on formulation of goals was not relevant in cases where the POR was in use. The inpatient POR does not require identification of goals. Thus the audit form is inconsistent with POR recording requirements. The OPD, and especially, Project Outreach, may have POR recording requirements about goals. Rather than eliminate this section in the audit form to alleviate the discrepancy, it might be more appropriate to require goal formulation in all social work recording, including with the inpatient POR.

Even where POR was not in use, the goal section was not considered to be good. There are too many specific and unanswerable questions. Revision is recommended.

b. There is no summary question on judging the overall quality of the social work activity; the summary page asks for it but it was omitted from the body of the audit form.

c. The questions related to case termination, 70-75, are confusing as written. The intent was to have the worker indicate how the case was terminated (referred, transferred, closed) and to have the reviewer judge whether the decision seemed appropriate. Questions 70 and 75, thereby eliminating 72, 73, 74, would be sufficient for this purpose.

- d. The summary questions asking judgment of overall quality are not as useful as they could be because they offer only three choice categories. Because it is difficult to use the category, "unacceptable," there is a tendency to be lenient and use the "acceptable" category. It is recommended that 4 categories be used: poor, fair, good, excellent.
- e. Often the reviews required a qualification comment stating that the "acceptable" rating was given on the basis of the short term nature of the social work service. To specify this was felt to be necessary so that workers would understand that what is acceptable would differ depending on length of service. It is recommended that at least one question that addresses the length of the case be added so that it would not be necessary for the review to write the same qualifying comment wherever relevant.
- f. The problem section continues to be one that reviewers do not like to do. The section should be re-examined. For example, question #23 should read, "Are the patient's problems identified?"; #25 should be omitted; #27 needs to be reworded; #28 probably should be omitted.
- g. Questions 35 and 46 that ask about mutuality in the determination of treatment plan and goals were felt to be unanswerable. At the time, workers are not required to record that and it is not possible for the reviewer to detect it.
- h. Question #5 is not applicable to Hillside Division. Should it be felt to be relevant to a medical setting and therefore to be retained, the question should include, "where applicable."
- i. Question #8 should be eliminated; it adds no information that is not obtainable from #13, which states it more clearly.
- j. It is not possible to differentiate between questions #16 and #17; the two should be combined into one.
- k. Question #18 has a special meaning for Hillside Division social workers. As such it is inappropriate in the assessment section; if desired, it would more appropriately be placed following #69 in relation to the conclusion note.
- l. Question #50 should be eliminated; its intent is better met through #58.
- m. Question #79 should read, "Were any of the goals achieved?"
- n. Question #83, (and on the summary page) should be eliminated; there is yet no way to judge quality of outcome.
- o. Questions numbered with a's and b's continue to be confusing (e.g., 45, 13, 31, 77) and need to be renumbered.

2. Professional Review.

As anticipated, review of each record took about one hour; many took $1\frac{1}{2}$ hours while some took less than an hour. The audit form is especially demanding and to answer it completely and fairly much of the entire record must be read. Either the demands of the audit form must be toned down or reviewer must be supported in this job -- time must be allotted, schedules and workloads arranged. In addition to the time taken to actually do the audits, for many, travel time was also involved. Had this group engaged in team professional review, additional time for team review would have been necessary. Participants noted that not only did they resent the time required, but their team colleagues expressed resentment; there was a tendency to take time from team meetings for professional review.

APPENDIX 7**QUESTIONNAIRE -****PARTICIPANTS' EVALUATION OF TRAINING PROGRAM**

EVALUATION - PROFESSIONAL REVIEW TRAINING PROGRAM

1. To what extent do you think the Professional Review Training Program achieved its goals of:

a) increasing participants understanding of the professional review process;

Not at all Hardly Somewhat Quite a bit Very much

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b) preparing participants to do professional review;

Not at all Hardly Somewhat Quite a bit Very much

--	--	--	--	--

c) having participants identify problems or potential problems with the professional review process as it was designed;

Not at all Hardly Somewhat Quite a bit Very much

--	--	--	--	--

d) having participants offer solutions to those problems identified;

Not at all Hardly Somewhat Quite a bit Very much

--	--	--	--	--

e) having participants assist in the planning of the implementation of the professional review process;

Not at all Hardly Somewhat Quite a bit Very much

--	--	--	--	--

f) having participants assist in the planning of the next stages of the professional review process, beyond the audit itself.

Not at all Hardly Somewhat Quite a bit Very much

--	--	--	--	--

2. How prepared do you now feel to do professional review compared to how you felt prior to the training program?

Not at all Hardly Somewhat Quite a bit Very much

--	--	--	--	--

3. How necessary do you think a training program such as this one is for preparing staff to do professional review?

Not at all Hardly Somewhat Quite a bit Very much

--	--	--	--	--

4. What did you like best of the training program experience?

5. What did you like least of the training program experience?

6. What value, if any, do you think a training program such as this one has for staff?

7. What recommendations would you make about this training program for the future regarding:

- a) number of sessions _____

- b) length of sessions _____

- c) content _____

- d) sequence of content _____

- e) format _____

- f) leader _____

- g) participants (number, selection, etc.) _____

- h) case material _____

- i) training package and its distribution _____

- j) arrangements (time, location, etc.) _____

- k) other _____

8. Additional comments about the training program

APPENDIX 8

QUESTIONNAIRE -
SURVEY OF PARTICIPANTS

YOU WILL FIND LISTED BELOW QUESTIONS ABOUT YOURSELF. PLEASE ANSWER EACH ONE.

1. What is your age, at your last birthday? _____
2. What year did you graduate from social work school? _____
3. How many years were you employed as a social worker (paid) prior to graduate school? _____
4. How many years were you employed as a social worker (paid) since graduate school? _____
5. How long have you been employed at Hillside Hospital? _____
6. Do you expect to be working at Hillside Hospital five years from now? _____ 6a. If NOT, what do you expect to be doing? _____
7. If offered a position at another agency at this time, what would it have to offer you for you to leave Hillside Hospital? _____
8. Are you a CSW? _____
9. Are you an ACSW? _____
10. What professional associations, if any, do you belong to? _____
11. Have you taken any courses or advanced training since your MSW degree? _____ 10a. If YES, please specify. _____
12. How often have you attended social work workshops or conferences (outside LIJ-HMC) since graduation? _____
13. Where do you feel you get most of your professional stimulation? _____ Colleagues at Hillside Hospital
_____ Supervisor or Social Work Director _____ Professional books and journals _____ Professionals outside Hillside.
14. About how many times in the past year have you suggested to your supervisor a different or better way of doing something on your job? _____ Never had occasion to do so _____ Once or twice _____ About 3 to 5 times
_____ About 6 to 10 times _____ More than 10 times.
15. In your work experience, if someone tries to change the usual way of doing things, how does it generally turn out? _____ Usually turns out worse _____ Usually doesn't make much difference _____ Usually turns out better.

16. How involved do you feel in your job? ☐ Very little involved ☐ Slightly involved ☐ Moderately involved ☐ Strongly involved.
17. Would you say you work harder, less hard or about the same as other social workers at Hillside?
☐ Much harder than most others ☐ A little harder ☐ About the same ☐ A little less hard
☐ Much less hard.
18. About how often do you get together after work with some of your social work colleagues? ☐ Not at all
☐ Occasionally ☐ Frequently.
19. Would you say there is a discrepancy between professional standards and social work theory on the one hand and the actual social work performed by Hillside Hospital on the other?
☐ Yes, there is a considerable discrepancy between the two.
☐ No, there isn't any discrepancy.
☐ Yes, there is some but not very much of a discrepancy.
20. Do you ever feel that the administrative policies and procedures under which Hillside Hospital operates interfere with the professional service you can give to clients? ☐ Often feel that way ☐ Sometimes feel that way ☐ Seldom feel that way ☐ Never feel that way.
21. What do you think of the social work service offered at Hillside Hospital? ☐ It's one of the best around. ☐ It's a good service. ☐ It's not a very good service. ☐ It's one of the poorer services around.

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