Hospital Social Workers Experiences with Ethics and Ethical Decision-Making

By Rachelle Ashcroft

A Thesis
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ABSTRACT

The purpose of this study was to explore the experiences of hospital social workers regarding the areas related to ethics and ethical decision-making. The focus of this study was to also explore social workers' perceptions of ethical issues encountered in practice and to gather participants' insights on the best mechanisms to assist in addressing ethical issues within the hospital environment.

Based on the purpose of the research and my own learning goals, a qualitative research approach was incorporated in this study. In-person interviews were conducted with ten hospital based social workers representing the various patient care areas in which they clinically practice.

The findings indicate that hospital social workers regularly encounter ethical related issues and routinely participate in ethical decision-making within their areas of practice. Social workers also provided insights into the necessary supports and skills required to effectively participate and address ethical issues.

Recommendations to enhance social workers participation with ethical issues include access to comprehensive ethics education and associated skill training. As well, social workers require forums to discuss difficulties encountered in clinical practice as well as learn from their peers. Increasing overall support for social workers will assist in preventing and reducing the experiences of stress, anxiety, and moral distress that can emerge when involved in the resolution of an ethical issue.

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Chapter 1

INTRODUCTION

1.1 Background

Social work is a profession with an underlying ethical foundation grounded in humanitarian and egalitarian principles. The ethical ideals of social work promote the characteristics of social work and the obligations of each individual member. Social work is a profession that traditionally assists people "to resolve problems in person-situation interactions"(Compton & Galloway, 1989, p.19) and social workers have the necessary skills required to enhance and assist in complex problem solving and ethical decision-making.

Social work has been a component of hospital care since approximately 1905 (Doucet et al., 2000). Although there has been an evolution of the role of hospital social work over the years, social workers have consistently maintained the skills to effectively assess and intervene in individual's psychosocial issues that arise due to illness and/or injury. Hospital social work is not only guided by an ethical foundation but also has a significant role in identifying and addressing ethical issues. Exploration of the hospital social worker's experience with ethics and ethical issues will provide rich information and a better understanding of how ethics impacts the practice of clinical hospital social workers.

The incentive to pursue this study is influenced by the years that I've spent in a clinical social work role in health care. Throughout my social work clinical practice within a hospital setting, I have encountered numerous ethical issues, dilemmas and

events that have been a significant part of clinical practice. Although the necessary communication and conflict resolution skills required to effectively address ethical issues is imbedded in the practice of social work, I am unclear of the experiences of other social workers when confronted with ethical issues within the hospital environment. My own experience has ignited a curiosity of the current practice of social workers as it relates to ethics.

1.2 Learning Goals

My personal learning goals in pursuing this research project were three-fold:

(i) To explore hospital social workers' experiences with ethics and ethical issues. Social workers practicing within a health care setting will frequently confront ethical issues. Unfortunately, the existing research and literature in the area of social work and ethics is minimal. I am also undertaking this research to add to the body of knowledge in this area, as greater expansion in the literature regarding social work and ethics would be beneficial. Literature provides professionals with a reference source to educate themselves about the current and emerging trends and issues. There is minimal representation from social work in the literature in the areas of ethics and ethical decision-making; thus, social workers currently have to rely on other professions for the bulk of information in this area, particularly in the area of bioethics.

(ii) My own professional goals and interest regarding the topic of social work and ethics also led me to undertake this study. Academically and professionally, I sought to increase my awareness of the issues related to social work and ethics.

This will provide me with the opportunity to expand knowledge related to social work and ethics within a health care setting.

(iii) To gain practical experience performing social research using qualitative methodology. The intention was to collect qualitative data from clinical social workers practicing within a hospital environment relating to their experiences with ethics and ethical issues. Undertaking this study would enable me to hone my research skills in this area.

1.3 Purpose of Study

The purpose of this research study was to explore the experiences of hospital social workers regarding the areas related to ethics and ethical decision-making. The major objectives of this research study were:

(i) to explore hospital social workers' knowledge base regarding ethics,

(ii) to examine hospital based social workers' perceptions of ethical issues encountered in clinical practice,

(iii) to ascertain social workers' thoughts on the role of social work in ethical decision-making within a hospital setting,

(iv) to gather participants' insights on the best mechanisms to assist in addressing ethical issues within the hospital environment.

1.4 Research Questions

(i) Are hospital social workers in this setting aware of ethics and potential ethical issues?

(ii) What types of ethical issues have hospital social workers encountered in practice?

(iii) What role do hospital social workers play in ethical decision-making?

(iv) What do hospital social workers see as the best approaches for addressing ethical issues within the hospital setting?

My hope is that this research will contribute to and enhance the body of literature that currently exists in ethics, as well as illuminate the need for ongoing research specific to ethics and social work.

Chapter 2

LITERATURE REVIEW

Examination of the topic of 'social work and ethics in a hospital health care setting' requires exploration of several concepts. These concepts include the role of hospital social work, social work and ethics, bioethics, social work and bioethics, as well as ethical decision-making.

2.1 Role of Hospital Social Work

Historically, social work practice has been focused with helping people to "resolve problems in person-situation interactions"(Compton & Galloway, 1989, p.19). Health is the foundation of human well being and one's quality of life, with hospitals centrally placed in the health care system. Health problems and solutions are increasingly linked to social and environmental factors; thus, the social work role continues to become more essential and central to the health care system. Social workers maintain a significant presence within the health care system including a variety of positions located within the hospital setting.

Social work practice within the hospital setting was initiated in the period between approximately 1905 & 1920 (Doucet et al., 2000) with the expansion of social work in the 1920's to meet the need of preventative health care programs. In the 1940's and 1950's the education of social workers expanded to include a psychoanalytical approach and was further influenced in the 1960's with an emphasis on social action as a result of the influence of the civil rights movement (Doucet et al, 2000). The 1970's and 1980's saw a slight shift in the social work profession in that attention on inward and self-evaluation was then promoted. It is during this period that the social work profession

gathered data, developed a variety of theoretical approaches and skills, and seemed to progress to specialization (Doucet et al, 2000). It is this evolution that facilitated the profession in obtaining a status of independence.

Social work has the training, knowledge base and essential skills required to understand the complex psychosocial and economic needs that emerge as a result of, and may contribute to, illness and injury. Social work can effectively assess and intervene in the imposed changes and adjustments that are demanded of a patient and his/her family when health issues arise. As well, it is the hospital social worker that can assess the interpersonal and intrinsic resources that are required for treatment and assist with the adjustments through counseling and referral (Ross, 1993). This is evident as Davidson states, "...hospital social work has developed a fund of knowledge and has influenced patient care by promoting recognition of the psychosocial components of health care"(Davidson, 1990, p.233).

Hospital based social work services encompasses a continuum of strategies including referrals to community resources, pre-admission and discharge planning, risk screening whereby possible difficulties because of the medical condition are identified and counseling. As well, psychosocial evaluation, health education, case consultation with hospital staff and community organizations, program consultation, planning activities and research also comprise strategies of the hospital based social worker (DuBois and Krogsrud Miley, 1996).

Four dominant characteristics of the medical social worker have been identified by Larouche & Flaherty(2000), these being the social worker as: advocate, counselor, crisis intervener and collaborator. The identified role of the medical social worker as

advocate is to defend the inherent rights of the patient by promoting treatment that improves quality of life in combination with respecting the person's autonomy. As counselor, the medical social worker assesses the psychosocial facets of the person and his/her family while promoting or strengthening their coping behavior when faced with life and health threatening situations. The role of crisis intervener is identified as one in which the medical social worker assists patients and their families cope with the trauma of the health situation. As well, the medical social worker as collaborator works cooperatively with the patient, family, the medical institution, other health care professionals, and various representatives of other professions to facilitate decision-making, conflict resolution and instruction. According to Larouche & Flaherty (2000), the four identified characteristics of the medical social worker function closely together and overlap one another with the ideal medical social worker as "integrator" maintaining a combination of all of the stated role characteristics.

Although the previous role characteristics of the hospital social worker have been identified, it is interesting that the literature also identifies difficulties arising from the ambiguity in and the lack of clearly defined roles of the hospital social worker. Egan & Kudushin (1995) evaluated perceptions of social workers and nurses regarding the role of the social worker in the acute care hospital and found that there were clear disagreements between the two professions regarding the role of social workers. The primary disagreement centered on the extent to which various tasks associated with psychosocial issues were regarded as the sole domain of social work or were considered areas for collaboration. Perceptions differed regarding what profession was responsible for the assessment and intervention in emotional and social problems of patients and families.

Ultimately, the lack of role definition can contribute to problems in collaboration because roles may overlap, with professionals possibly competing in areas that are not clearly assigned to one discipline. This overlapping of roles can be a distinct source of conflict; however, within the hospital setting the roles of health team members overlap considerably. Role blurring and the overlap of roles occur when expectations of role performance are not clearly defined (Egan & Kadushin, 1995). The likelihood of interdisciplinary conflict as a result of the ambiguity with roles supports the importance of educating social work students in skills of team building and multi-disciplinary collaboration. As well, the overlapping and duplication of functions may have consequences in the cost conscious hospital organization with the possibility of elimination of the non-essential personnel as a cost saving mechanism.

Robb (2003), Sulman et al (2001) propose adaptive solutions for social work to minimize the role overlap and duplication especially as other professions may be competing for social work roles. The suggestions comprise the following: create key roles on multidisciplinary teams, create pre-admission high-risk screening tools and improve discharge planning outcomes, use solution focused intervention which can be measured and develop community partnership for improved discharge and effective interface with the community.

There are a variety of difficulties that can emerge for social workers practicing within a medical setting that maintains different perspectives than those inherent to the social work profession. "Medicine...while accepting technical and scientific advances, is not noted for acceptance of social change or structural change. The social worker is thus in the position of having to demonstrate the value of their profession..."(Doucet et al.,

2000, 86). This reflects a further need for role clarity and minimization of overlap to ensure that social work maintains the most effective involvement given the various interpersonal, structural and political difficulties or conflicts that may be encountered.

As identified by Canadian author Faith (1999), there is also increasing concern about the future of social work's role within a context of changing political and economic policy in combination with the decline of the welfare state. Essentially, in many settings including health care "social work's role has been significantly narrowed, conforming in nature to organizational change and procedural protocol"(Faith, 1999, p.3). Although the 1980's proved to be a period of expansion for hospital social work, the early 1990's included changes to social work departments such as decentralization with some social work departments even having been eliminated (Ross, 1993). The social work role has a multitude of influencing forces including the fact that "services offered are frequently altered, eliminated, or added to meet the fluctuating perceptions of market demand"(Ross, 1993, p.243).

As well, Ross also states that "employees who create no revenue...whose cost saving value is unmeasured; and whose role is misunderstood, challenged, or underrated are valued least in this environment"(Ross, 1993, p.243). Interestingly, there is emerging evidence that empowering clients and addressing their psychosocial needs can be health and cost effective. Health status, quality of life and even functional status are often better correlated with psychosocial factors than physical disease severity (Keefler et al, 2000).

The nature of the social work role within the hospital setting has a variety of complex forces shaping the social work function. The social work role is essential and

crucial to overall care provided to persons within a hospital setting as well as providing a unique perspective to health care on all levels.

2.2 Social Work and Ethics

Values are the foundation to social work practice with social work being a value-based profession that incorporates "a constellation of preferences concerning what merits doing and how it should be done"(Levy, 1976, p.234). Essentially, values are the implicit and explicit ideas about what we cherish as ideal while defining norms and guidelines for behavior. The underlying values of the social work profession reflect fundamental beliefs about the nature of people, change and qualities that have intrinsic worth. Equality, social justice, rightful access to resources and liberation of self-powers comprise some of the inherent social work values that guide the profession on a variety of levels.

It is the professional values that are seen as the source of accountability and evaluation of professionals' actions. Linzer (1999) conceives that values in social work can be considered along three dimensions. Firstly, as preferred conceptions of people whereby people are inherently good, possess worth, dignity and have the ability for change. Secondly, as preferred outcomes for people materializing in the form of self-actualization, meaningful relationships, healthy family and satisfying basic human needs.

Finally, as preferred instrumentalities for working with people such as with respecting privacy, showing empathy, maintaining confidentiality and offering support. These dimensions, however, indicate solely the social workers' values with no inclusion of the client values. According to DuBois and Krogsrud Miley (1996), ethical behavior is ultimately based on an interpretation of the application of values; however, interpretation

can differ resulting with possible disagreement about what constitutes ethical behavior or appropriate actions. Essentially, ethics is a generic concept for various ways of understanding and examining moral life. Kugelman (1992) describes professional ethics as a 'system of norms'.

Codes of ethics outline expectations of conduct for professionals and can serve several functions such as: guiding decision-making, assessing competence, regulating behavior, and providing a standard by which to evaluate the profession (DuBois and Krogsrud Miley, 1996). As described by Faith, "the basis of most, if not all, professional codes is Primum non nocere...First do no harm"(Faith, 1999, p.4). This concept is closely related to the principle of nonmaleficence which "asserts an obligation not to inflict harm intentionally"(Beauchamp & Childress, 1994, p.189).

According to Reamer (1998), codes of ethics are designed to address problems of 'moral hazard' or instances when a profession's self interest may conflict with public interest. As well, it includes professional courtesy whereby rules are established to guide how professionals should behave to maintain professional integrity, and also issues that concern professionals' duty to serve the public interest. Codes of ethics are not only used to encourage ethical behavior on the part of the professional but also to perform a controlling function by seeking to prevent unethical behavior.

Ultimately, a code of ethics is a significant form of a profession's formal mechanism of control (Ife, 2001). Codes of ethics impose limitations on the behavior of the more powerful persons within a society. "Thus codes of ethics are about controlling the excesses of the powerful, and historically it has been the poor and disadvantaged who have called for such constraints, and for rules through which the powerful can be held to

account"(Ife, 2001, p.110). In contemporary society, it is indeed the various professionals who are perceived to be powerful thus requiring a standard of practice to adhere to ensure that the abuse of power is constrained. This control measure is also iterated by Levy who states, "Principles of social work ethics are designed to prevent social workers...from exploiting those they are suppose to serve or are in a professional position to affect"(Levy, 1993, p.20).

Social work has developed a comprehensive set of ethical standards that have evolved and undergone revisions over time to reflect societal changes as well as changes in social work itself. The first social work code of ethics was published in 1920 and since then, many different social work organizations have developed their own codes. The ethical standards for the social work profession appear in a variety of forms including the Canadian Association of Social Workers Code of Ethics (C.A.S.W., 1994).

Inherent within most social work code of ethics, including the Canadian Association of Social Workers Code of Ethics, are the principles that every individual has intrinsic worth, dignity, as well as the right for self-determination and individuality. These principles are parallel with the previously identified social work values that underlie the code of ethics as well as the philosophy that the foundation of the social work profession is humanitarian and egalitarian ideals (C.A.S.W., 1994).

The social work profession is supposed to be informed and guided by principles outlined in the profession's code of ethics, such as those contained in the Canadian Association of Social Workers Code of Ethics. "If a conflict arises in professional practice, the standards declared in this Code take precedence....In all cases, the social worker must act in a manner consistent with this Code"(C.A.S.W., 1994). However,

evidence within the literature identifies the difficulty that social workers...experience in interpreting and adhering to principles outlined in professional code of ethics (Huber, 1994; Holland & Kilpatrick, 1991; Faith, 1999; Bernard & Jara, 1985; Pope & Vasquez, 1991). In Holland & Kilpatrick's study, not one social worker offered the professional code of ethics as a resource for assisting to deal with complex ethical issues (Holland & Kilpatrick, 1991).

Adhering to social work values and ethical principles can be difficult for a variety of reasons, especially given the enormity of forces within one's daily practice. For example, determining what is meant by 'best interests' for a client is a very subjective matter that may have different interpretations by different social workers and other colleagues. As well, "organizational constraints can often impede the social worker's ability to adhere to social work ethical ideals thus creating ethical dilemmas in daily practice"(Faith, 1998, p.9). In addition to ethical dilemmas, moral distress "arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action"(Jameton, 1984, p.6).

Adequate education of social workers in the field of ethics is a necessity to ensure that in practice, social workers can recognize ethical issues and have a foundation to proceed in the resolution of such issue. Also, "in order for ...ethics to be properly understood and implemented in practice, language and ethics concepts must be promoted and used within professional work settings"(Faith, 1998, p.16). The education of social workers in ethics is essential to develop "ethical methodology, directions about how to think about what constitutes ethical actions and a process by which ethical ideals can be deliberated within demands of practice"(Brown, 1994, p.276). As is parallel with the

trends associated with bioethics, the bulk of social work's scholarship and literature on the subject of ethics has been published since the early 1980's (Reamer, 1999); however, as will be further discussed, little empirical research regarding social work and ethics is available in the literature.

Social workers can encounter a wide range of ethical dilemmas in direct and indirect professional practice. Possible ethical dilemmas that may emerge could include issues related to confidentiality and privacy, self-determination and paternalism, divided loyalties, professional boundaries, conflicts of interest as well as the relationship between professional and personal values (Reamer, 1999). Ethical dilemmas resulting from indirect social work practice includes issues pertaining to the allocation of limited resources, government and private-sector responsibility for social welfare, compliance with regulation and laws, as well as research and evaluation (Reamer, 1999).

Historically in social work practice, the aims and inherent challenge have been to overcome the various limitations and forms of oppression that people experience. As is evident with the parallel between the concepts of ethics with the intent of the social work profession, the profession of social work not only is guided by ethics but also has a significant role in the ethical arena.

2.3 Biomedical Ethics

Ethics is a study of moral conduct that inquires about the rightness or wrongness of various actions, character traits and social policies. As previously stated, values are the implicit and explicit ideas about what we cherish as ideal while defining norms and guidelines for behavior. Ethics then can be considered values put into action and behavior. Conflicts among competing values can ultimately lead to ethical dilemmas.

Bioethics is the application of general ethical principles and theories to the therapeutic practice and delivery of health care (Beauchamps & Childress, 1994). The inception of bioethics occurred in the 1970's, with the contemporary bioethics movement having grown to a major academic and service oriented profession. Interestingly, it is technology that has directly and inadvertently driven the bioethical agenda, with much of the progression in bioethics due to the explosion in technological advancement. "The impact of technology on our value systems is also seen in the fact that the development of new knowledge and techniques may blur, rather than sharpen, the very concepts that are central to our norms and values"(Arras & Steinboch, 1995, p.4). As well, little research had been conducted on ethics in any of the health related disciplines until the late 1980's, but an explosion of research occurred in the proceeding years (Jansson & Dodd, 1998).

There are a variety of approaches and influential theories significant to bioethics that is widely discussed throughout the literature (Beuchamp & Childress, 1994; Arras & Steinboch, 1998; Kluge, 1992; Garrett et al., 1998; Jonsen et al., 1998; Baylis et al., 1995; Thomas, 1983; Abramson, 1996). Several approaches to ethics include the normative approach that presents standards of right or good action. Normative ethics tends to be more embraced and seen as more relevant to social work because it is viewed to have immediate relevance to practice (Reamer, 1999). It is normative ethics that consists of attempts to apply ethical theories and principles to actual ethical situations and dilemmas (Reamer, 1999).

As well, there are non-normative approaches that have the objective to establish what the situation is factually or conceptually, not necessarily what the situation ought to be ethically. One non-normative example is descriptive ethics that reports what people

believe and how they act. This perspective is a factual investigation of moral behavior and beliefs. An additional non-normative approach is metaethics that involves the analysis of language, concepts and methods of reasoning in ethics.

The theoretical perspective that is utilized to explore topics in medical ethics can have a significant influence on the selection of problems that are recognized as well as the solutions that emerge. Utilitarianism, also known as consequentialism, refers to the theory that recognizes actions as being right or wrong according to their outcome. Within the utilitarianism school of thought, good consequences are those that produce happiness or pleasure and all individuals are considered equal; therefore, the impetus is to maximize good for the greatest number of people. One of the advantages to utilitarianism is that it provides a procedure for decision-making, ultimately, whatever produces the greatest amount of positive value. An advantage that is seen to be inherent within utilitarianism is that happiness is alleged to be something empirical, thus, it is measurable and comparable which would facilitate comprising an objective standard for judging whether an action is right or wrong (Arras & Steinboch, 1995). A significant difficulty with this theory is that it requires the calculation of probable consequences of every action, which is impossible. As well, a danger of this theory is that in principle it permits the interests of the majority to override the rights of minorities (Beauchamps & Childress, 1994).

Deontology, also known as Kantian theory, is an additional theory that has been influential in ethics whereby morality is grounded in pure reason. Within deontology, rules must respect people and must apply to everybody equally. Deontological theories

are rule oriented and treat moral worth as separate from the production of happiness or the satisfaction of preferences (Baylis et al., 1995).

Within virtue ethics, an additional influential theory to bioethics, a person's character and motivation define good acts. Essentially, this theory emphasizes the agents who are performing actions and making choices with the focus on the inner realities of motivation, intention, disposition and conscience of the agents. It is obvious that this ethical theory cannot be incorporated independently to fully understand the complexity of forces in the analysis of an ethical situation. However, the emphasis on character rather than on the conduct invites an examination of the person behind the decision.

The principle approach was originally developed by Beauchamps & Childress (1994) and became the dominant mode for engaging in clinical ethics in North America (Arras & Steinboch, 1995). The four principles: autonomy, non-maleficence, beneficence, and justice are used as guides and are believed to leave considerable room for judgment in specific cases. The principles approach, which has been widely embraced in health care settings, requires weighing and balancing of the various principles against one another.

Autonomy refers to the duty to respect rational and free choice of individuals by respecting the decision-making capacity of autonomous persons. In clinical settings, the principle of autonomy takes into account informed consent, competency, autonomous choice, decision-making capacity and issues of disclosure. Self-determination is recognized as a primary concept in bioethics, which parallels fundamental social work values. According to Linzer, "for a choice to be real, it must be freely made and based on

understanding, not helplessness and resignation...Autonomy is reliance on one's own powers in acting, choosing, and forming opinions"(Linzer, 1999, p.135).

Non-maleficence is an additional core principle within bioethics theory that reflects the obligation of not inflicting intentional harm. This principle is considered a routine part of health care; however, there are many controversies within health care that surround the terminally ill and the desire to adhere to non-maleficence. There are medical treatments that evoke an element of harm yet the desired outcome outweighs the harm.

Beneficence and non-maleficence are closely related with beneficence referring to doing what is best for the benefit of the client/patient. Beneficence is a "moral obligation to act for the benefit of others"(Beauchamps & Childress, 1994, p.260) and also substantiates a duty to assist persons in need.

The fourth principle is justice. This concept promotes that medical care should be equitable and fair; "...distributive justice refers to fair, equitable, and appropriate distribution in society determined by justified norms that structure the terms of social cooperation"(Beauchamps & Childress, 1994, p.327). Adhering to the principle of justice can be difficult under conditions of scarcity and competition in combination with some of the existing barriers to accessing adequate health care.

One of the criticisms that is directed at the principle theory is its inability to provide a framework for settling conflicts between competing principles (Arras & Steinboch, 1995). Ultimately though, these core principles promote consciousness of respecting individuals in choosing their own vision of the 'good life' and acting accordingly. Resolving medical related ethical dilemmas requires a thoughtful analysis

of the context in which they occur. Utilitarianism, deontology and virtue ethics as well generally ignore any discussion or analysis of broader contextual issues.

Additional criticisms of the widely adopted principles approach is voiced by Abramson (1996) who describes various concerns such as the concern of this approach being too rational, abstract and theoretical resulting with the likelihood of alienating emotion and lived human experience. As well, the principles approach may be too individualistic and does not adequately include the broader aspects of life such as relationships, community, political environment, religion and spiritual dimensions. "The most salient criticism of the principles approach...is the fact that it has been considered to be timeless and universally applicable by its proponents when it is really culture-based and has failed to attend to differences associated with gender, race, ethnicity and class"(Abramson, 1996, p.2).

Casuistry refers to a commonly implemented approach to the resolution of clinical ethical dilemmas with topic areas suggestive of the principles invoked in previously identified bioethical approaches (Mahowald, 1994). Casuistic reasoning starts with a particular case and initially compares its circumstances with analogous cases for which raised issues have already been resolved through the application of the suggested topic areas.

Bioethics, the application of general ethical principles and theories to the therapeutic practice and delivery of health care, has expanded and become an influential force within health care and the hospital setting. The discussion and evaluation of value systems on a personal and structural level enhances the quality of health care

disseminated and facilitates attending to inevitable conflicts that arise in the provision of health care.

2.4 Social Work and Bioethics

Social work is a profession with an underlying ethical foundation grounded in humanitarian and egalitarian principles. Social workers practicing within a health care setting will frequently confront ethical issues with existing social work ethics primarily being founded on the bioethics principles approach of identifying, clarifying and resolving ethical issues according to the previously discussed principles that are believed to be universally applicable (Abramson, 1996).

Because of the likelihood of encountering health related ethical issues and the unique perspective and skills social work brings to the medical setting, it is essential that social work be active in the pursuit of research in areas pertaining to health care. However, it is interesting that there has been minimal empirical research conducted from a social work perspective in the area of ethics since 1980 with the majority of literature available on social work and ethics primarily confronting the issues from a theoretical perspective.

Jansson & Dodd (1998) describe how little research had been conducted on ethics by any health-related profession prior to the late 1980's, with the bulk of research occurring towards the latter part of the 1980's. In examining the existing literature, Jansson & Dodd (1998) were able to identify only 15 empirical articles published by social work researchers focusing on the area of ethics from 1980-1996.

The literature review conducted by Jansson & Dodd (1998) highlighted that only two of the 15 studies examined whether social workers were able to identify specific

ethical dilemmas (Conrad, 1988; Kugelman, 1992). Also, only three of the 15 identified studies recognized and discussed the political context related to ethical choices (Abramson, 1990; Holland & Kilpatrick, 1991; Proctor et al., 1993). No studies examined the views of social workers with regards to controversial issues such as euthanasia or abortion, and only one study analyzed whether social workers were satisfied with the outcome of ethical issues in their practice settings (Davitt & Kaye, 1996). There were three studies in the literature that examined the process of ethical decision-making in multidisciplinary health care teams (Curtis & Lutkus, 1985; Joseph & Conrad, 1989; Kugelman, 1992). Significantly, Jansson & Dodd (1998) also indicated that there were no empirical studies that considered the consequences of ethical issues and choices for patients and their families available from a social work perspective.

Jansson & Dodd (1998) discuss some additional themes that emerged in comparing the existing 15 empirical research studies identified within the literature. Three of the 15 studies discussed the content of ethical dilemmas that social workers encounter (Abramson, 1990; Holland & Kilpatrick, 1991; Proctor et al., 1993). Five studies recognized the process of reasoning used by social workers in reaching decisions regarding ethical choices (Curtis & Lutkus, 1985; Dorbin, 1989; Foster et al., 1993; Holland & Kilpatrick, 1991; Lindenthal et al., 1988). There were eight studies that commented on the legal context and influence of ethical issues (Abramson, 1990; Curtis & Lutkus, 1985; Davitt & Kaye, 1996; Gerhart & Brooks, 1985; Holland & Kilpatrick, 1991; Kugelman, 1992; Proctor et al., 1993; Reamer, 1995) and eight studies that examined the relevant organizational issues (Abramson, 1990; Curtis & Lutkus, 1985;

Davitt & Kaye, 1996; Foster et al., 1993; Holland & Kilpatrick, 1991; Joseph & Conrad, 1989; Kugelman, 1992; Proctor et al., 1993).

It is clearly evident that social workers must take a more active role in the development and production of empirical research in the area of ethics, particularly ethics in relation to health care and the medical system. Jansson & Dodd (1998) developed a theoretical framework as a device to stimulate and encourage social worker researchers to adequately explore ethics. "The framework can be used to generate research topics with respect to health care professionals and patients as well as to identify gaps in existing research ethics"(Jansson & Dodd, 1998, p.18).

The framework proposes and provides a perspective that assesses and analyses ethical issues by taking into consideration concepts along three different axis. 'Axis 1' conceptualizes concepts pertaining to "Ethical Deliberations and Outcomes" whereby the types of ethical issues encountered in professional practice are considered. As well, gaining an understanding of whether or not social workers and other participants recognize ethical issues when confronted by them is also inherent within ethical deliberations. The nature of ethical deliberations is an additional component of Axis 1 which focuses on the method of ethical reasoning used by participants, as well as, the extent and experience of conflict during ethical deliberations (Jansson & Dodd, 1998).

Jansson & Dodd (1989) describe that knowledge obtained by assessing "Ethical Deliberations and Outcomes" will assist in preparing social workers for practice by alerting them to the possible ethical issues that may be confronted. This has not been comprehensively done in the existing social work literature pertaining to social work and bioethics. This will also promote the recognition of ethical dilemmas as they emerge in

social work practice and assist in guiding social workers to effectively participate in the process of resolving ethical dilemmas.

Axis 2 of this innovative social work framework developed by Jansson & Dodd (1998) is identified as "Contextual Features". The perspective attained on this axis does so by focusing on the practice environment on a variety of levels including one's personal perspectives and characteristics that may have an influence. Time, political factors, fiscal realities, organizational factors, external mandates, and court rulings are concepts that are identified as necessary contextual features.

Contextual factors can enhance one's perception and understanding of ethical issues that are not readily recognized in various influential bioethical theories, such as utilitarianism or deontology. Ignoring the influential contextual factors risks negating the important factors that often shape the process of ethical deliberations as well as the choices and eventual outcomes to the situation.

Axis 3 pertains to "Ethical Outcomes" and attends to issues of participant's perceptions of the process of ethical deliberations and options, including the consequences of the different ethical choices. Also, "Ethical Outcomes" includes the ethicists' assessment of the ethical deliberations along with the ethicists' perception of the ethical choices. Empirical research that involves the assessment of ethical outcomes can provide valuable information that can be shared with ethicists, patients and additional persons involved, as they contemplate ethical issues (Jansson & Dodd, 1998).

Jansson & Dodd enhance the topic area of social work and bioethics by identifying the minimal force that social work has maintained in the rapidly growing specialized focus of bioethics. Not only do Jansson & Dodd identify the existing gaps,

they also encourage social work involvement in empirical research as it relates to bioethics and provide a framework to assist in the process.

The unique role and perspective that social work maintains within a hospital setting, combined with the common occurrence of ethical issues encountered within a medical setting indicates the likelihood that social work will be involved in the deliberation of relevant ethical issues. "Data suggests that there is a significant role for social work in ethical decisions in health care, particularly when there is greater recognition that the locus of such decisions resides with the patient and the family"(Joseph & Conrad, 1989). Interestingly, evidence indicates that social workers that were more satisfied with their roles as hospital social workers and were clear about their role, as well as perceived that their roles were clear to other health care staff, had greater influence in ethical choices (Joseph & Conrad, 1989).

Landau (2000) suggests that a social worker's influence in ethical decision-making in a hospital setting is dependant on two related factors: what he/she can contribute to the decisions and also the place of the social worker in the professional constellation. Role ambiguity of social workers within a hospital setting may diminish the influence of social work in ethical decision-making. "The diffuse role expectations for social workers may undermine their ability to contribute to ethical decision making in hospitals by fostering interdisciplinary rivalry"(Landau, 2000, p.77).

Essentially, the findings of Landau (2000) indicate that social workers generally have a precise conception of their role in terms of the contribution that they can make to the ethical decision-making process. As well, social workers can take steps to increase their impact in the decision-making process by making their colleagues and other health

care professionals more aware of their distinct role which may require developing relationships with other professionals involved in ethical decision making.

Social workers bring a valuable set of clinical judgment skills to the ethical decision-making process and resolution of ethical dilemmas. Social workers recognize the need to consider the social and environmental factors and context that ethical issues emerge within. Psychosocial issues are particularly important when assessing and attempting to determine quality of life issues and potential difficulties with the course of treatment and plans. The role of the social worker in bioethical issues can enhance the process and information available since social workers interact with patients and their families around different issues more than do doctors, nurses and other health care providers.

2.5 Ethical Decision-Making

In the provision of health care, ethical dilemmas are a common occurrence whether they are recognized as such or not. Reamer describes an ethical dilemma as "a situation in which professional duties and obligations, rooted in core values, clash"(Reamer, 1999, p.4). In the assessment and resolution of medical ethical dilemmas, sometimes the choice of principles and direction to apply to the practice situation is neither clear nor self-evident (Levy, 1993). No precise formula exists in the resolution of ethical dilemmas with social workers and other health care professionals possibly disagreeing upon the ethical principles and criteria that ought to guide ethical decisions (Reamer, 1999). However, various concepts are commonly used as a guide in the clinical process of ethical decision-making particularly within a medical setting best associated with casuistry (Magwood, 2002; Jonsen et al., 1998; Mahowald, 1994).

Concepts that are commonly considered in the resolution of ethical dilemmas include medical indicators, patient preferences, quality of life, and contextual features of the case (Magwood, 2002; Jonsen et al., 1998; Mahowald, 1994). Obtaining a clear understanding of a person's medical status is crucial to adequately conceiving and assessing any bioethical problem that may arise. Medical indicators acknowledge the necessity for obtaining necessary facts about the person's health issue including possible diagnosis, prognosis, available treatments, and goals to intervention. Uncertainty and disagreement about the medical indicators can in itself contribute to an ethical problem. Medical indications also are reflective of beneficence and non-maleficence.

Consideration of patient preferences ultimately reflects the importance of respect for an individual's autonomy as well as the inherent need for informed consent. Patient preferences and autonomy are synonymous. Quality of life can only be determined by the individual and is interconnected with patient preferences. "The most fundamental goal of medical care is the improvement of the quality of life of those who need and seek care"(Jonsen et al., 1998). Thus, the concept of quality of life is also linked with beneficence and non-maleficence.

Contextual factors are an additional concept that is commonly used to guide the resolution of ethical dilemmas. Contextual factors refer to the social, legal, economic and institutional circumstances surrounding the identified case situation and assume justice as relevance. Medical indicators or facts, patient preference, quality of life, and contextual factors are the commonly used concepts in clinical settings to assist in the resolution of bioethical dilemmas (Magwood, 2002; Jonsen et al., 1998; Mahowald, 1994).

Not only is the final decision important when confronted with an ethical dilemma, but also the process of decision-making is inherently significant. Reamer (1999) discusses the importance of approaching ethical decisions systematically and provides a series of formulated steps to try to ensure that all possible areas of the ethical dilemma are addressed.

The initial step in Reamer's approach is to identify the pertinent ethical issues including the social work values and duties that may conflict. Any individuals, groups, and organizations likely to be affected by the ethical decision should also be identified. Generating thoughts of possible options and courses of action is the next necessity by identifying all viable courses of action along with as many of the involved participants as possible including possible benefits and risks for each.

Reamer (1999) then suggests the thorough examination of the reasons in favor of and opposed to each course of action, considering the relevant theories, professional codes, and personal values. Consultation with colleagues and appropriate persons is encouraged and once the decision is formulated, the decision-making process should be adequately documented along with the final decision. Reamer also encourages monitoring and ongoing evaluation of the final decision. Reamer's approach seems to contain elements inherent within the theoretical foundations of utilitarianism and deontology.

Often, difficult ethical problems in health care are framed as either practical problems or moral dilemmas with the resolution of the ethical dilemma requiring sophisticated problem-solving skills (Webster, 2000). Ethical decision-making can be a difficult experience for the professional involved. As described by Webster, "moral

distress arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right courses of action"(Webster, 2000, p.218). Moral distress is referred to as the "incoherence between one's beliefs and one's actions"(Webster, 2000, p.218). This personal experience can also emerge when the professional involved fails to pursue what is believed to be the appropriate course of action regardless of the reasons why.

In a study described by Hamric, moral distress has been a powerful factor in nurses' decisions about continuing on in practice. "In a study of moral distress in critical care nurses, Corley found that 13% of the nurses she studied had left nursing positions, and 5% actually left the profession because of moral distress"(Hamric, 2000, p.199). The concept of moral distress originated in and is most commonly discussed in the nursing literature; however, all health care professionals are affected by ethical situations. Further examination of the experience of moral distress needs to occur focusing on a variety of professional disciplines, including social workers within health care settings.

Not all professionals experience the same ethical issues as morally distressing, yet "...the issue of powerlessness surfaces repeatedly in the literature as both a central cause and key element of moral distress"(Hamric, 2000, p.200). This also suggests the importance of adequate preparation for ethical decision-making to ensure that professionals will recognize not only the issues pertaining to an ethical situation but also the dynamics associated with the process of ethical decision-making. Kugelman (1992) found that in addressing ethical dilemmas in social work practice, those participants who received no formal training in social work ethics "relied on organizational rules, organizational power, or personal experiences" when addressing the ethical challenges

(Kugelman, 1992, p.74). Adequate preparation may in fact diminish the experience of moral distress in social workers who may otherwise be compelled to engage in a decision-making process or formulate a conclusion that they do not feel is right.

Interestingly, Joseph & Conrad (1989) found that the majority of the ethical concerns of social workers in a medical setting were broader than bioethical issues and include concerns related to interdisciplinary ethical issues, organizational and societal ethical issues. Social workers should have a significant role in the process of ethical decision-making given that the traditional emphasis of the profession is on democratic values and facilitative skills necessary. Social workers view the process of ethical decision-making as best when there is input from all persons involved, within and outside the institution, which is often unique within a hospital setting:

> This is a distinct difference from physicians and nurses, who tend to operate within the institutional boundaries. The broadly inclusive scope of the social worker brings more information to the table, both complicating and facilitating the decision-making process (Doucet et al., 2001, p.85).

The research study of Landau (2000) identified several ways in which social work contributes to ethical decision-making within a hospital setting. Respondents of Landau's study indicated that the eco-systemic perception of the patient, or the person-in-environment perspective, is the attribute of social work that contributes the most to ethical decision-making within a hospital setting. As well, knowledge of the psychosocial meanings of the disease, illness, and hospitalization to the patient and family in combination with the knowledge about the life course of individuals and families was also highlighted in the findings of Landau (2000). Additional contributions

identified in the study of Landau (2000) are the personal communication skills of social workers and also the acquaintance with community social support services.

Social workers, doctors and nurses seem to agree on the basic set of ethical principles with these professions tending to develop different clinical judgment skills aimed at different but complementary patient problems (Shannon, 1997). Social workers, nurses and doctors may focus on different areas of concern within the decision-making process and if expressed, these different perspectives can enrich the overall evaluation of the issues.

Recognizing the value of others perspectives creates an atmosphere that facilitates the exchange of information that is beneficial to the overall ethical decision-making process. As Shannon articulates, "interdisciplinary collaboration is inescapable if one is committed to quality ethical decision making"(Shannon, 1997, p.26). Many hospitals now incorporate clinical ethic committees to discuss the emerging ethical issues. The clinical ethical committees promote the inclusion of the various professions within the hospital setting to engage in the decision-making process as it pertains to ethical issues. Ethical dilemmas are inevitable thus effective ethical decision-making processes need to be encouraged on a professional and institutional level. The promotion of education in ethical decision-making, encouragement of teamwork within the health care setting and acknowledging the sometimes difficult experiences in ethical decision-making can only be of sound benefit to the health care system.

A literature review of the key areas in my proposed research study area included a presentation of the role of hospital social work, social work and ethics, biomedical ethics, social work and bioethics, as well as ethical decision-making. These areas were

necessary to explore within the literature review, as they are inherent to the proposed research study.

Chapter 3

METHODOLOGY

3.1 Qualitative Research

The methodology used in the study will be highlighted in this chapter. Topics included will be the source of participants, participants, interviews, compilation and the analysis of the data. Qualitative research was chosen as the most appropriate method for studying hospital social workers experiences with ethics and ethical decision-making.

The most distinguishing characteristic of qualitative research is the emphasis it places on the participant's experience and the meaning of her/his experience. "There can be little doubt that the commitment to explicating the subject's interpretation of social reality is a (one might even say the) sine que non of qualitative research" (Bryman, 1988, p.72). Qualitative research was the most appropriate method to gather information about the experiences of clinical hospital social workers as related to ethics and ethical issues as this method provided me with the ability to gain a comprehensive understanding about my research participants' experiences.

Qualitative research provides an approach that facilitates the gathering of broad extensive information on a particular topic. Given that there is limited empirical research that exists in the area of social work and ethics, my goal was to acquire rich information in this area, with a qualitative research design incorporating an open-ended interview format being the best option to facilitate this. The intent of this research study was to explore the meanings of the themes that emerge from the data collected from clinical hospital social workers.

Some concepts of grounded theory were incorporated into the methodology to assist in shaping the qualitative interviews as well as guide the analysis of the interview data. An inherent belief associated with grounded theory is that people construct their own meaning for events and experiences based largely on their interaction with others (Yegides et al., 1996). Grounded theory provided guidance in developing an interview framework whereby "...questions must be sufficiently general to cover a wide range of experiences as well as narrow enough to elicit and explore the participant's specific experience"(Charmaz, 2002, p.679). Within grounded theory, data is collected and analyzed simultaneously from the initial commencement of the research. The early data analysis encourages the pursuit of emergent themes within the research. The aspect of constant comparison and open coding were inherent within the qualitative research design exploring the experiences of hospital social workers relating to ethics and ethical issues.

3.2 Data Sources – The Sample

The primary source of research data was obtained through the process of interviewing hospital social workers employed at Winnipeg's Health Sciences Centre. Winnipeg's Health Sciences Centre is a tertiary care hospital employing approximately 60 social workers in the following areas: Renal, Women's Health, Child Health, Adult Medicine, Adult Surgery, Critical Care, Geriatrics / Rehabilitation, Child and Adolescent Mental Health, and Adult Mental Health.

Initially, permission was requested of the Health Sciences Centre's Discipline Director to gain access to this population. Formal permission was then obtained from the Health Sciences Centre to have access to the proposed population of Health Sciences

Centre's social workers. Advertising the research study was done by putting up posters in the Health Sciences Centre's Social Work Department's main offices and distributing posters to all of the social workers' mailboxes and email addresses. Social workers read the poster and interested participants then initiated contact with me to gain more information and set up interview appointments. Posters were distributed three different times to promote participant involvement. Prior to the research study, it was anticipated that more social workers would volunteer for participation. After the initial poster advertising the study was put up in the social work offices, four social workers immediately volunteered to participate. Several social workers did volunteer to participate; however, it was surprising that fewer social workers than expected came forth to participate.

To promote diversity in the respondents and to ensure that there was appropriate representation from the various areas of the Health Sciences Centre, respondents were selected based on the areas of their clinical practice. Ultimately, the goal was to have representation from various program areas of the Health Sciences Centre including Renal, Adult Medicine, Adult Surgery, Geriatric/Rehabilitation, Child Health, Adult Mental Health, Child and Adolescent Mental Health, Critical Care, and Women's Health. The plan was for the first two respondents from each of the identified clinical areas to be selected to participate in the study. Interestingly, several social workers from the Child Health program were deferred from participating, as there was adequate representation from this program area. Unfortunately, there was no representation from social workers currently practicing in the areas of Adult Surgery or Critical Care. There is

representation from these areas in terms of participants past clinical areas that were referred to during the interviews.

Ten social workers were interviewed with all of the identified hospital program areas represented. Three of the participants held positions in more than one of the represented areas. This is the reason why the number of current areas represented equals a number greater than ten. As well, seven of the participants had held previous social work positions within the Health Sciences Centre and would often reflect back on their previous working experiences during the interviews. The combination of participants' current positions and previous social work positions held within the Health Sciences Centre results with sufficient representation of all of the hospital areas. The breakdown of the hospital areas that the participants were working in at the time of the interviews is represented in Table 1. Also, the participants previous practice area is illustrated in Table 2.

Table 1: Participants' Current Areas of Hospital Practice

PARTICIPANTS' AREAS OF CURRENT CLINICAL PRACTICE	NUMBER OF PARTICIPANTS
Renal	1
Women's Health	4
Child Health	2
Adult Medicine	3
Adult Surgery	0
Critical Care / Adult Emergency	0
Geriatric / Rehabilitation	1
Adult Mental Health	1
Child and Adolescent Mental Health	1

Table 2: Participants' Previous Practice Areas

PARTICIPANTS' PREVIOUS AREAS OF CLINICAL PRACTICE	NUMBER OF PARTICIPANTS
Renal	0
Women's Health	1
Child Health	4
Adult Medicine	2
Adult Surgery	2
Critical Care / Adult Emergency	1
Geriatric / Rehabilitation	1
Adult Mental Health	0
Child and Adolescent Mental Health	0

3.3 Data Collection

Data Collection was obtained through the course of conducting in-depth interviews using open-ended questions and probes. When social workers identified themselves as willing to participate in the interviews most seemed eager to meet. It was important that there was an interview location that promoted confidentiality and was comfortable for the participant. Several options for meeting location were presented to the social workers when setting up the interviews including: the participants' offices, the researcher's office, or an alternate private space whereby the researcher would arrange for a private room within the Health Sciences Centre. Eight of the interviews took place within the researcher's office and two interviews occurred within the participants' own offices.

The interview was to be no longer than two hours in length with the participant determining the appropriate time of day to meet. All of the interviews tended to be ninety minutes in duration.

The interviews continued until there was satisfactory representation from the various areas of the hospital taking into consideration the participants current areas of practice as well as any previous areas that they had provided service to. Also, the interviews continued until emerging themes had been exhausted. This method is described as theoretical saturation or theoretical sampling:

> Theoretical sampling is the process of data collection for generating theory whereby the analyst jointly collects, codes and analyzes his data and decides what

> data to collect next and where to find them, in order to develop his theory as it emerges (Glaser & Strauss, 1967, p.45).

Data collection halted when the data no longer produced significant conceptual variations.

The emerging themes assisted in determining any additional data that should be collected in order to explore the ideas. For example, initially there was not a question incorporated into the interview guide exploring social workers' perceptions about the role that the social work professional bodies have in the area of ethics. However, it was during the sixth interview that it became apparent that it was necessary to include this within the interviews and subsequently the latter interviews were modified to contain this area for exploration.

An additional data source was this researcher's journal. Journal entries commenced after the initial interview was conducted. This was a source to record thoughts, feelings, and themes that emerged after each interview was performed. As well, the journal was used to record any additional thoughts of the researcher in-between the interviews including areas that I wanted to explore in subsequent interviews. This data source was an aide in guiding subsequent interviews and was a valuable tool throughout the process of constant comparison of data gathering and analysis.

3.4 Ethical Considerations

3.4.1 Informed Consent

To promote informed consent, the researcher provided the participant with a brief description of the research study and reviewed the consent form with the research participant prior to the commencement of the interview (Appendix B). Each of the

participants read and completed a signed Consent Form, which included information about the research project and a list of the social workers' rights as research participants.

3.4.2 Confidentiality

Each of the research participants consented to having their interview audio taped. Each was informed that the audiotape would be transcribed. As well, they were informed that all identifying information would be removed from the transcriptions, replaced with a pseudonym or assigned a code number in the typed transcription and in the report, to promote confidentiality. They were assured that their responses would be confidential and would not identify them when the data was analyzed or the report was written. Given the small sample size, research participants were advised that there might be a chance that an informed reader could identify them.

The research participants were assured that the audiotapes and any additional data (written information and computer disks) would be kept in a locked drawer within my home and would be destroyed at the completion of this project. Participants were reassured that no research materials would be stored on Health Sciences Centre's property.

3.4.3 Review of Participants' Rights

The Consent Form incorporated an outline of participants' rights. This information indicated that participation in this research study was completely voluntary and participants may at any time choose not to answer any of the researcher's questions. As well, it was outlined that participants could refrain from answering any question that they would rather omit and could choose to withdraw from the study at anytime without consequence.

As well, participants were advised that once the study is complete and the thesis has been successfully defended, the outcome of the study would be made available to them. Participants were informed of the names and contact information for the advisor of this study and the University of Manitoba's Human Ethics Secretariat.

3.4.4 My Position at the Health Sciences Centre

Participants were aware of my role as a social worker at the Health Sciences Centre. I feel that my position gave me addition insights into the diverse hospital settings where social workers practice as well as insight into social work's scope of practice. This combined with my own experiences of identifying and addressing ethical issues and having the knowledge base and awareness surrounding the sometimes difficult processes that accompany ethical decision-making and the resolution of ethical dilemmas. I do not believe that my experience and position within the Health Sciences Centre affected my ability to be unbiased in the research. On the contrary, I believe that this additional information enabled me to have a greater understanding of some of the issues, struggles, and successes that participants spoke of in the context of their role as a hospital based social worker.

However, to minimize the potential for researcher bias regarding anticipated data and themes, several considerations were taken. Incorporating grounded theory into the methodology in combination with being conscious of the possibility of researcher bias reduced the threat of bias penetrating the data collection. Participants were informed that I, the researcher, am employed as a social worker at Winnipeg's Health Sciences Centre where the research occurred. However, it was reinforced to the participants that the

research is occurring on behalf of educational studies and not directly inherent within my employment role.

There is a possibility that some social workers within the Health Sciences Centre did not want to participate in the research study given that they might have known me, particularly if they were concerned about the threat of breaching confidentiality. Within my social work employment role, I have minimal direct involvement with the majority of the social workers employed at the Health Sciences Centre, thus; previously established relationships with existing colleagues did not impact the research process. As well, one measure that was implemented in the research design was to exclude those few social workers that I did have direct clinical involvement at the time the research was occurring.

3.5 Data Analysis

The processes involved in qualitative research are fluid and are very much interconnected. Although distinct, the data analysis phase is not disconnected from data collection. The data analysis segment includes various significant features that I will comment on in the context of this study.

3.5.1 Treatment of Data

The data collected through the interview process was in a combination of tape-recorded and written format. The audio-recorded information obtained from the interview process was transcribed to facilitate the process of thematic analysis, with the systematic coding procedures of grounded theory to assisting in informing this process. This researcher did all of the transcribing after each interview. During the process of transcribing, modifications were made to include the assigning of pseudonyms where necessary and change or delete any identifying information such as specific names of

people or specific hospital care areas. Although transcribing the audiotapes was a tedious task, this proved to be a worthwhile opportunity to become very familiar with the data. The process of transcribing facilitated the analysis process as initial themes started to emerge during this phase. As thoughts pertaining to the data would arise during the transcribing process, it was helpful to memo with these then used as a guide during the analysis process.

Through the process of thematic analysis inherent in the coding process of constant comparison, emerging themes were explored. The process of constant comparison is a method of generating and analyzing data that involves four distinct segments including generating categories, integrating categories and their properties, delimiting and then writing the emerging theory (Dey, 1999). Ultimately, categories were created from the collected data by coding observations.

Categories were analytic and involve conceptualizing some key features that provided a meaningful understanding that helped to perceive the participants under study. This method of open coding has been defined by Strauss & Corbin as "the part of an analysis that pertains specifically to the naming and categorizing of phenomenon through close examination of data"(Dey, 1999, 97).

Initially the data was reviewed and specific category names were assigned to small parts of the data. There was a vast amount of data and an enormous amount of categories seemed to emerge. This was the most difficult process of the data analysis particularly because the significant amount of data and it was evident that it was necessary to implement an organizational strategy to maintain orderliness. This was done by using color coded tabs and various colors of post-it notes. Once this initial first-level

coding was completed for all of the interviews, the second-level coding began. It is within the phase of second-level coding whereby there was an analysis shift with focus more to the context of the categories.

In the second-level of coding, the responsibilities included retrieving codes and placing meaning units into categories and comparing categories. It was helpful, but time consuming, to use the computer's 'copy and paste' options to place the data into the assigned themes. By doing this, it promoted organization of the data and facilitated comparison of the various emerging themes.

Ultimately, the data was broken down into discrete parts, closely examined and then compared for similarities and differences which facilitated the development of an integrative hypotheses about the relations between categories and their properties (Dey, 1999). Writing up the research was done by describing the framework of themes that emerged from the data with expansion guided by the memos written about the categories employed in the analysis.

3.6 Summary

Based on the purpose of the research and my own learning goals, a qualitative approach was selected because of the logistical realities of the study in combination with my own personal preference. Qualitative research methods was the most appropriate method to gather information from hospital social workers about ethics and ethical issues. Methods of data collection and analysis incorporated some aspects of grounded theory. In-person interviews were conducted with ten social workers employed at Winnipeg's Health Sciences Centre to explore issues pertaining to ethics and theoretical saturation was reached. Ethical considerations included the issues of informed consent, a review of

participants' rights, confidentiality, and the characteristics pertaining to my social work employment role at the Health Sciences Centre. A review of the data analysis included the approach, coding, and the emergence of themes. What follows in the Findings Chapter is a presentation of the subsequent themes.

Chapter 4

PRESENTATION OF FINDINGS

The presented data includes information gathered from all ten of the interviews. The data is presented in aggregate form to ensure greater confidentiality. As well, it was decided not to use pseudonyms or the allocation of numbers to the participants, also to further promote confidentiality. For consistency, the female pronoun is used throughout the description of findings. The following is a detailed presentation of findings that emerged from the interviews of ten Health Sciences Centre's social workers with representation from all areas of this hospital setting.

4.1 Scope of Practice

4.1.1 Social Work Perception

The social workers were asked to describe their role and function within the Health Sciences Centre hospital including a depiction of the current position held as well as any additional social work positions in other areas that they may have previously held at the Health Sciences Centre. All of these hospital-based social workers are practicing within the Health Sciences Centre yet the areas within which they practice are different depending on the health related focus of that area.

Although these social workers practice within different areas of the hospital setting with a wide array of patient populations represented, there are common descriptors that the social workers used to describe their scope of practice such as: case manager, counselor, community liaison, educator, and advocate. All of the social workers interviewed maintain a role that encompasses a combination of all of these components and is reflected in the following social worker's description of her position:

> I sort of see the majority of it as case management. So doing a lot of practical stuff... And the other side, the clinical stuff, would be helping people to make decisions about planning for the future...the biggest one would be helping people and their family members decide if they need to stop treatment and which then they would die. That's probably the most clinical stuff I do...and providing information...

Every social worker interviewed described the importance of assisting patients and/or their families with some of the practical issues that accompany health related issues. The degree to which this function is necessary is dependent on the need of the patient population being served. Social workers who described having a significant case management role also described having a proactive role in decision-making abilities about the course of a person's health care plan as detailed by the following:

> ...quite often I'm the one to setting the discharge date and I'm the one who liaises with the rest of the team if there's no real outstanding medical issues. I'm the one that will say to the physio and OT, okay where are we with this person? Can we do discharging? How long is it going to be...and I set the date. And actually I had one client recently where the doctor called me and said, do you think we can discharge this person, what do you think about that... But it's a very, very heavy case management position that I play and I notice when I'm away, nobody goes home.

Not all social workers described maintaining as comprehensive of a case management role as the social worker above. There is a variation evident that fluctuates from a minor case management role to very intensive with those social workers involved with longer-

stay in-patients more apt to being involved more heavily with the necessary aspects of case management.

Counseling is also an inherent role of the hospital social worker with the provision of counseling occurring in a variety of forms such as crisis-oriented, short-term, and long-term counseling. Social workers within the more medical oriented environments such as Adult Medicine, Adult Surgery, Geriatric/Rehabilitation, Critical Care / Adult Emergency, Women's Health, and Child Health described the need for resource counseling, supportive counseling, as well as counseling focusing on adaptation to illness and/or injury. Resource and supportive counseling were identified by all the social workers interviewed as a function of their role. "My current role is as a support, I offer support and counseling...on practical issues". Social workers develop a knowledge base specific to the area of practice that includes available resource options internal and external to the hospital setting. In working with clientele, hospital based social workers provide resource counseling to ensure that the available resources and the mechanism to which one would access these appropriate supports are known. "A lot of resource counseling because we are seeing more and more immigrants and refugees come through...so a lot of resource counseling".

All social workers practicing within the more medical oriented settings described the importance of the counseling role in assisting with the adaptation process that often accompanies the deterioration in one's health. "I work with families who have babies who are not well to begin with and so there's an area of adaptation with the families". Another social worker described adaptation more comprehensively in how the need is to

address more than just the specific physiological health issue but how the health issue affects all persons involved:

> The bulk of my work isn't that though, it's the day to day, ongoing adjustment to living with all of the repercussions of chronic illness, hospital stays, the disruption in family life, the impact on siblings, impact on parents, impact on marriages.

The social workers representing mental health areas described counseling in a way that takes a more traditional therapy format:

> And as a social worker I do the family assessment portion and treatment. The treatment is...largely family based so it may be more traditional family therapy or it may be that I'm working with a dyad like a mom and a kid. Sometimes I'm working with the younger kids in a theraplay kind of mode but by and large what I do is usually work with parents and the family work.

An additional social worker practicing within the Health Sciences Centre's mental health setting also described the counseling component of the role:

> ...I'm a person who will do family therapy...and then I actually run two different groups for the day program, so one group is our relationship and family group where we talk about our relationships and everything that entails, family, friends.

Although there are a variety of social work therapeutic modalities that is offered within the Health Sciences Centre, there can be difficulties in the provision of psychosocial therapeutic intervention within a medical setting. "I couldn't even do the whole counseling piece cause they were either too sick or they just weren't into it". The social work role pertaining to educator has an underlying impetus of client empowerment. Social workers described the role of educator as being necessary to

ensure that the patient and family are aware of available supports to better enhance one's coping skills and abilities. Education occurs to inform the patient and family on how to better maneuver through the health care system, as well as to provide information to assist with imminent care plan and treatment decisions. "You know, having them having information that helps them make kind of, you know, informed decisions if they have to". The role of educator extends to ensuring that patients are aware of processes at various levels. The relationship that social work develops with patients sometimes is necessary to facilitate the education process. As one social worker put it:

> I think sometimes that I take the role of educator as the patient because maybe...the patient thinks of me as an ally. Then maybe I'm able to educate them on why the team maybe thinks this way or that way and why this would be a safer way or more appropriate way to go.

All of the hospital social workers interviewed described the necessity of interfacing with the external community in an to attempt to provide patients and families with necessary supports and resources, as well, to try to facilitate continuity of overall care outside of the hospital setting. Social workers described communicating with a plethora of external bodies such as child welfare, justice systems, community clinics, medical establishments, educational structures, private agencies and non-profit organizations. The hospital social workers regularly interface with the community as determined by the need of their patient population. As described by one social worker:

> Lots of community resource liaising. Um, complicated discharge situations where there's children who have special circumstances, special needs, require equipment, home care, homemaker, outreach support, resources, stuff like that.

The aspect of advocate was identified as a component of one's role in two different forms. Most social workers identified that an inherent role of social work is to act as a patient advocate at the level of the patient care team, as a patient advocate amongst the greater health care system or advocating for the patient by interfacing with the external community resources and supports. This is illustrated by the following:

> So, we intervene at the level of an individual and a family in a health care team within a hospital... And I think the way this relates to ethics is that we are very aware and responsible for upholding the rights of individuals and families to make decisions for themselves... I think that there is kind of a whole theme too, as social work shall take the side of the underdog, the disenfranchised. That we have a special responsibility professionally to represent people who are not necessarily good at representing themselves, who can be oppressed by the health care system.

The hospital social worker as advocate also takes the form as a social change agent to influence the meso and macro levels of policy and health care to ensure and enhance appropriate patient care. One social worker described her influence in enhancing patient care by being involved in the development of hospital standards and procedures:

> ...when the College of Physicians and Surgeons are doing new guidelines we are part of these author committees... We just did one recently on therapeutic abortions and informed consent for therapeutic abortion and the types of counseling and support that has to happen if this is what you're doing for your client.

This social worker also continued to describe the necessary involvement of acting as an advocate by influencing direct hospital standards based on current clinical situations such as the following clinical example that led to the enhancement of practice procedures:

> She wasn't deemed incompetent, she was just making choices or in environments that were really hard for her not to continue getting pregnant. So there was some healthy discussion regarding that and a new policy guideline that came down that sort of said, just because they have a mental intelligence of x, that we just don't sterilize people anymore. That's not an acceptable standard of practice. So I think that we play a role in bringing those things to the larger groups...

The hospital social worker as advocate transpires at all levels of health care from the micro level of direct patient care to the levels of directly influencing policy and standards of care.

As previously stated, the identified components of the social work role do not occur in isolation and do overlap with one another. Hospital social workers assist in the provision of health care to the patient and the family. However, in the provision of psychosocial intervention to the patient, the hospital social worker intervenes not only focusing on issues pertaining specific to the physiological health impairment but is involved with various accompanying life issues. This is clearly evident in the following social worker's statement:

> What happens with chronic illness...it brings to the surface all kinds of other simmering difficulties and conflicts and gaps and issues that were probably there for a long time but become more difficult to manage with the added stress of

> somebody who is really sick. I'm often dealing with marital conflict, sibling relationships, alcoholism, emotional abuse, physical abuse, family of origin issues, big, big issues for a lot of people. The gamut of issues. It may be the illness that is the presenting problem but often it's how other things come to the surface. So, you're often dealing with all kinds of other issues as well.

Although there are commonalities with underlying skills and therapeutic intervention needs, several social workers identify their own practice to be specialized as a result of the population that is served or due to the program and treatment offered. One long-term employee, upon reflection of the various social work positions she has held at the Health Sciences Centre, identifies this phenomenon with reference to her currently held position. "In this area I think I'm pretty specialized". Also, there is a distinction made between one's own position and positions held by peers:

> My sense is that my job is very different than the jobs at the General...it's not the same kind of thing. Like, my clients are here for months and months and months, like six months to a year is common. And I get the sense it's very different.

As well, social workers made distinction with regards to the program areas that they practice in. "For outpatients there are only a few parts of the system that are doing that kind of work, you know". This mental health social worker reflects on the uniqueness to the type of therapy and treatment offered within the program area. Individual social workers working within more than one area or with more than one health care team also may have different roles depending on the needs and focus of the individual care setting.

Some social workers may feel that their role is specialized and perhaps different than another social work colleague partially resulting from individual social workers developing and determining their particular social work role based on the needs to their specific patient population or program area within which they work. "In fact the role that I've developed, and of course everybody does their own, you know, develops their role in their own way based on their comfort level and interests and inclinations". Another social worker discussed how she was beginning to introduce an empirical measurement into her practice and how her clinical practice was evolving:

> So I'm at the point now...where I'm comfortable enough I think that I'm trying to reanalyze my own practice. It's kind of nice in the day program portion and the different portions because the opportunity to grow with it as much as I want and what direction that I want. There's lots of opportunities.

This same social worker continued to describe how being a hospital social worker presents unlimited opportunity for developing one's scope of practice. "To be a social worker you can do anything you really want". This is reiterated in a statement by another social worker in a different kind of care setting. "I feel that it's not very, there are no restrictions to what my role may be". Not only is the social work role described as unique and specialized but also broad and malleable as required.

This characteristic of the social work role can enhance patient care by facilitating the provision of various patient and family needs that might not otherwise be fulfilled, "instead of saying I don't know or it's not my job, if it needs to be done, I'd say okay I'll find out. If it impacts their life and impacts discharge and how they're in the grand scheme of things functioning, then it's my job, not somebody else's". The social work

role is influenced not only by the patient care area, but also the underlying philosophical approach of the social worker. One social worker described how she implemented change within a new position to better improve the social work role. "So, I knew when I started that it was a challenge and I have been working on developing a role that I'm comfortable with and I think is more fixed on how I can be most helpful...to our families".

The broadness and vagueness that can occur when the hospital social work role is not adequately defined can present difficulties to the individual social worker. Several social workers interviewed, employed within the hospital setting for less than five years, articulated their initial difficulties in understanding the social work role when first starting to practice in a new position. One social worker when asked to describe the role of social work in the current and past position held at the Health Sciences Centre stated, "I think that's hard for me to answer because I don't think that I was really aware of what my role as a social worker meant". Another social worker interviewed also articulated the same difficulty in understanding the social work role. "You asked me, what is your role? I don't know because I don't think that people know. We get, over in medicine and surgery, we get whatever it is that people didn't want to do". "It's hard for me to understand the role of a social worker when it's not clearly defined". This person goes on to say, "So I think...half the problem is that we don't sit down as a team like a social work team and figure out indicators. And I know we have something floating around". If hospital social workers are unclear about their role then there may be inconsistencies between roles as each individual determines for him/herself how to intervene. "So just figuring out what is appropriate and what's not appropriate. And then it got to the point

where I just used my own judgment". After identifying the difficulty in understanding the social work role, this social worker went on to describe how it is a personal judgment when developing a standard on how to intervene.

There is a significant threat that when a social worker does not fully understand what his/her role and function within a health care team is, that the role will be externally defined by what the other non-social work colleagues are requesting. One social worker described the process of initially understanding the hospital social work role based on these external influences. "I figured it out based on what people were requesting of me". This lack of clarity can have an impact on the type of psychosocial interventions offered to the patient. The same social worker as above described the uncertainty about the extent to what the social work role could offer patients. "I remember this one person in particular that I saw in...the day hospital who I felt would benefit from coming to see me for some short term supportive type of counseling but I was not clear whether it was okay for me to offer that to her or not".

The social work role needs to be articulately defined, "...the indicators are changing...well, let's keep on top of them and change". This social worker made reference to identifying the social work indicators which are used by staff to educate other colleagues on when it is appropriate for social work to intervene, and also to set consistent standards regarding what types of situations would be appropriate for intervention.

Social workers must be able to define for themselves what it is that the social work role encompasses and offers the health care team. As well, it is essential that this can be articulated and it is the responsibility of social work to communicate to others to

ensure clarity regarding the social work role. "I think that we need to be way more confident and comfortable defining what it is that we do that gives us, that we can offer to teams and patients and families". It is evident from the interviews that all of the social workers participating in the study identified social work as a unique professional discipline different than any other colleague. All interviewed indicated that the overall role of social work enhances patient care.

The profession of social work and the social work role is distinctive compared to the role of other colleagues. Not only did the social workers make a distinction between themselves and their social work colleagues, but also the social workers recognized that what they offer is very different than any other part of the health care team:

> It has to do with a basic core of understanding of health. Individuals cope with illness, the stages of adjustment. It has to do with the fact that we have most importantly, the context always in the bigger perspective of how people live in the context of relationships, family, extended family, community, culture, language, all that sort of thing and that we uniquely look at people's problems like layers of an onion. And that is the view that we can bring to the table as well as having some, having expertise in interpersonal relationships, interpersonal dynamics, communication, as well as just the specific area that we work in whether it's brain injury...or whatever. But I do think we have a core of knowledge and sense of process, social interactive process is very unique to what we do.

A common observation made by those interviewed was the uniqueness of the profession of social work compared to other facets within the health care setting due to underlying ideological foundation:

> I think about the social work basic concepts that I learned in undergraduate school...which is different than a medical model which tends to be more, you're the patient and I'm the doctor. I'm going to tell you what to do and you will do what I tell you. We look for a more reciprocal kind of relationship.

One social worker commented on how she views social work as having an underlying ethical foundation particularly because of this identified ideological basis:

> You need to back up and start where the client is at in terms of what they're ready to talk to you about in terms of making decisions or making choices and things like that... I think that there is a natural link because I think that social work ethically should be client focused and client centered. And I think that ethics in general needs to maintain a client focus otherwise its really not ethical practice.

The skill base of social work is obviously different than other professional colleagues with social work having specialized skills to contribute. "There's pretty much nobody else that we work with that kind of has the handle on the ability to understand and intervene in group dynamics the way we do".

Furthermore, one function unique to the profession of social work is to provide an alternative perspective. Social work approaches a situation taking into consideration the various influences from a more global perspective:

> I think that the role of social work is to maybe represent sometimes repeatedly the bigger picture to the health care team...and to challenge the way of thinking that sometimes, our beliefs and feelings do contribute to how we make decisions about things. And to challenge the dogma by suggesting alternatives to I guess represent, for example, an alternative perspective.

Another social worker clearly described how providing an alternative perspective and a broader understanding of a situation can enhance not only the overall knowledge base of a situation but will also provide a foundation from which strategizing for the best outcome and provision of health care is possible:

> I think that it definitely there are consults within teams and when you bring up the whole issue of let's reframe that and look at it in a different way, they're not necessarily the worst people on the face of the earth. These people are people and they may make choices that we might not necessarily make for ourselves but you don't have a right to pass judgment on that... I think that you need to separate the choices, or the poor choices that the client may be making from what is. Or you need to get a context of why they're doing that.... You can bring that perspective to the team. Like, there's a reason why this is happening so if you really want to have a positive impact then here's some strategies that we can use to work with this family and not to get into an adversarial relationship with the family which I think sometimes happens.

The role of social work is not strictly limited to sole interaction with the patient and family. A significant responsibility of the social work role is to communicate with and offer a greater understanding of a situation to the health care team. One social worker described that an inherent role of social work lies in "...educating the team as well about why the patient is feeling the way they are feeling about the situation and why it would make more sense to go this way". Social work has a professional responsibility to provide an alternative perspective and a greater understanding of a situation and doing so must be proactive in identifying conflicting situations. "I think social work should

play a key role in making sure that the team is taking a second look at those kind of things". Ensuring that all involved have a clear understanding of the situation will facilitate the impending decision-making process, which is a process that hospital social work commonly participates in at various levels. As stated by one of the hospital social workers, "I'm generally a big player in terms of the decision-making process and just trying to figure out a plan that we can be happy with, all of us can be happy with".

4.1.2 Colleague Perception

There is a variation in terms in how other non-social work hospital colleagues understand the social work scope of practice. Several social workers reported that fellow hospital colleagues do not fully realize social work's scope of practice and skill base. "I think I'm respected, I'm asked questions, but maybe sometimes I think that it could be a little bit more realized about what I do". This is also reiterated by an additional social worker. "So, they seem to be clear but it seems to be pretty primitive and really superficial kinds of things. I don't think they are fully aware at how far social work can go in terms of providing support to the person or patient".

Although the realm of the social work role may not be fully understood by hospital colleagues, others may be able to identify the social work functions based on apparent differences from the non-social work health care professionals. "I think that they're pretty good about it but you see the roles are kind of blurry here anyway...I think they would understand some of the nuances of what makes me different from a nurse or the OT...." A fourth social worker implies that there may be underlying reasons for lack of clarity regarding the social work role. "So until social workers as a team, we get

together and figure out what is social work and what is not social work related, then I don't think it's fair for the team to know either".

Other social workers reported having a very different experience with their non-social work colleagues. "I think I'm pretty specialized. I mean, they know exactly what to give me". The degree to which non-social work colleagues understand the scope of hospital social work practice is influenced by various factors. This includes professional risk indicators and criteria to initiate social work involvement, clear documentation on social work assessments and intervention in combination with direct colleague education regarding social work's scope of practice. This is reflected in the following social worker's experience. "I think there's a fairly clear, indicators and criteria, for social work involvement that all nursing and it's nursing that I'm getting consults from, but they have a very good idea of what social work is suppose to do or does or is there for". Later on in the interview, this same social worker again made reference to the importance of having clear guidelines and indicators for initiating social work involvement when asked what influences her colleagues' understanding of the social work role. "Yeah, we have criteria guidelines, risk indicators, things like that. They have that. I'd say for the most part I get very appropriate consults".

Because colleagues may rely on the documented social work referral criteria and risk indicators, it is essential that this documentation be up to date to facilitate a comprehensive understanding of the hospital social work scope of practice and that colleagues are educated in this realm. Another social worker described how her colleagues were questioning why she was involved in certain clinical situations and

didn't understand the purpose of social work intervention because it was not stipulated in the risk indicators and social work involvement criteria:

> They have our criteria and they say, like, these are your criteria. There aren't things in there like a newly immigrated family who might need help with supports and things like that…so we've redone our referral criteria and high risk indicators and with some education in the fall that might settle that.

Essentially, directly educating one's team and colleagues is identified by several hospital social workers as necessary to ensure a comprehensive understanding of social work's scope of practice. The following social worker described how various colleagues were well aware of the social work role as a direct result of her effort in educating and clarifying the role of social work in her clinical area:

> A lot of hard work with my team…I've worked so hard. I mean, they know what I do now…. it's frustrating and it's hard work but they understand the range of my skills and what I'm capable of doing. You know, I'm getting all appropriate consults when I might not have necessarily in the beginning…I still think that we need to take responsibility in that, what does social work do? You know, and how are we voicing the services that we can offer people?

Another social worker described how she was preparing to have a more formal education session and at the time of the interview she was "planning a little kind of symposium thing or information session because the staff doesn't really understand…what social work's role is".

When colleagues have a general knowledge base of social work's scope of practice, further clarification may be required on an as needed basis. "For the most part I

would say but sometimes they need education and reminders. That I'm not just there to clean up the dirt kind of thing, you know, when everything falls apart". Clarifying one's role can occur in a very informal, non-threatening type of one on one interaction as is evident from the following social worker's description:

> I had one experience...where one of the nurses was freaking out because one of the patient's family members kept bringing her forms that needed to be filled out and she was stressed out...and I calmly said, well, you don't have to. If ever you get a form then just call me and I'll come and look at it and talk to the patient about it...I said, if you need any of that just let me know and I'll do it. That's my job not yours. And it really kind of placated her and calmed her down and stuff.

Essentially, colleagues develop an understanding of the social work role from various sources. The same social worker as above described how within her care setting, non-social work colleagues recognized the scope of her practice by observing her interact with patients:

> I would automatically go see patients, talk to them about their coping...and I think the team, some of the team members, would overhear me asking these types of questions and talking to the patients in this way that I think, they realized that was where I was willing to go with patients.

Additionally, clear documentation of assessments and interventions can assist in encouraging a better overall understanding of the scope of hospital social work practice. "I document in the chart and I have a sort of concrete way of doing assessments...cause I found that helped promoted my role in what I do".

The hospital social work role is expansive and can at times be difficult to concretely articulate the scope of the social work role to non-social work colleagues. This is expressed by one of the interviewed social workers:

> We are way...too fuzzy and so it is hard for other people sometimes on our teams to know what it is that we do because we don't always, we're not always able to articulate that clearly. I think it is important and I think that we have to do it. And I think the more comfortable you are doing something unique and significant and professional, the less you have to do that because people begin to know by working with you how you can be useful and how you can be useful to patients and to the team.

Ultimately, it is essential that social workers engage with colleagues in various forms to promote a coherent understanding of the role of the hospital social worker.

4.2 Working in Teams

4.2.1 Multidisciplinary Team

Within the hospital setting, social workers are not working in isolation. The number and type of professionals working with a patient will vary depending on the clinical setting as well as the individual team setting. Frequently, the multidisciplinary hospital team working directly in patient care consists of social workers, physicians, nurses, speech language therapists, occupational therapists, physiotherapists, nutritionists, and managers. However, the composite of the direct team not only varies between different hospital settings but also may include various specialists consulted on an as needed basis.

Given the various disciplines that may be involved in a patient's care, it is essential for the multidisciplinary team to be able to communicate with one another to ensure that all involved are striving for common goals and are aware of pertinent information. "They're pretty helpful in terms of sharing information and sharing ideas. And that also helps because at that discussion we have clarified who's doing what". All social workers interviewed and consistently attached to a regular team or program area attend rounds or team meetings on a regular basis. Regularly scheduled rounds are common within the hospital setting to provide an opportunity for the multidisciplinary team to discuss various types of patient issues and on occasion, program issues as well. The following social worker when interviewed talked about the different types of rounds held within the same care area:

> There's two different rounds on the ward itself. One of them in the mornings, we have a new rounds where social work meets with nursing and we have invited allied health like OT, PT and such to attend.... So we meet with the nurses and we discuss psychosocial, specifically psychosocial issues and practical issues and just coping and stuff. And then they're on Friday mornings, more medical focused rounds run by doctors and there are mostly doctors in attendance. And I will attend...it is important to attend those rounds too because it give opportunity for us to raise issues in terms of patient care and remind the doctors that there is more to a person than just test results and progression of the disease.

The two social workers interviewed who provide clinical service to different mental health programs both described having very comprehensive and productive

rounds whereby all members providing care to the patient are expected to regularly attend:

> We have inpatient nurses, outpatient nurses, the inpatient and outpatient psychiatrists which is really good in terms of continuation of care. The occupational therapist, dietician, myself, the three case managers, the psychologist, like everyone is expected to be there and every single person is discussed in fine detail....And as a group we somehow come up with a decision.

When discussing opportunities surrounding meeting with the multidisciplinary team to review patient issues, there are different experiences reported. Only three social workers out of the eight that are regularly working within a consistent medically oriented patient care setting reported having all of the multidisciplinary team members, including the physicians, attend rounds. Several social workers practicing within a medically oriented setting described that although rounds are an opportunity for the team to discuss patient issues and care plans not all of the multidisciplinary team members attend. "Okay, so we have what we call our big rounds which is our entire team but the [physicians] never come. So the [physicians] don't come to our rounds and it's just the nurses and allied health". A physician not attending rounds was cited by several of the social workers interviewed. The absence of a physician from rounds, the multidisciplinary team meeting, can have an impact on how the social worker functions in his role and difficulties can then ensue. "There's a problem with no [physician] so the rounds are ad hoc.... It's a big stressor. It impacts on how I get information cause I can't get all of my information when I want it, like in the mornings when it's rounds. I have to scurry about and ask at different times of the day about what's going on". As is evident

in the preceding description, information dissemination at rounds may not be comprehensive when an individual of the team is absent, particularly when it is the physician. Another social worker employed in a different medical setting within the Health Sciences Centre also described how her method of information gathering and practice is altered because no physicians are represented at her weekly rounds. "So if you ever have questions, I mean, you just do your rounds individually. Like, I get my list of questions I have for the doctors...usually I just make my trip up to the clinic and I catch everyone and I corner the doctor to get them to sign whatever it is that needs to be signed or to just discuss something in terms of decisions".

Although the impetus of having rounds within a hospital setting is to promote dialogue and communication amongst the various professional providing care and treatment to patients, it can also be a great learning opportunity for the individual professional's personal growth. For example, one social worker interviewed described how rounds were a significant source contributing to her knowledge base when she initially began working within the hospital setting. "It was helpful. I really enjoyed it cause then that's how I learned. You know, I kind of learned medical terminology. I kind of figured out the whole social work role sitting there. Like, this person needs this, can you guys take care of that? That was really helpful".

The content and structure of rounds and team meetings can be influenced by the underlying treatment focus of the unit. Understandably, social workers within the medically oriented units described how the focus of rounds could often be fixated on the physical nature of the medical issue. "I think working in the medical is very different because the medical obviously has to be made by the medical people". The underlying

medical model of a given unit may prevent having social issues identified or addressed appropriately as described by the following social worker from the Women's Health and Children's Health programs:

> There are certain physicians, physicians and nurses who have, and other team members as well, who have their own belief about what is in the best interest for this client. And they tend to compartmentalize this client into little bits, so it's the breathing, it's the broken leg, or the whatever. It's not the whole, so they have a broken leg but then they're going home to this dysfunctional family.

The underlying impact of the medical model philosophy is also reiterated by another social worker providing service in the area of Adult Medicine:

> I get really frustrated and I think it's because they are more medically entrenched and so there's a different philosophy between sort of a medical model versus even a rehab model versus addressing psychosocial issues that are ongoing and their lack of, I mean, I think they really all acknowledge it but don't want to be a part of trying to address it. Just give it to the social worker to deal with. So it can be very isolating some times.

An additional social worker expanded on this phenomenon by describing the different experiences she had interacting with two different teams, one within a mental health setting versus a more medicalized setting:

> Because it's...mental health those rounds discuss a lot more of the psychosocial aspects of the patient rather than just the medical aspects of the patient or reason for being admitted. So I felt that I had more of a reason to speak up in those rounds whereas rounds in the intensive care units, the surgical intensive care unit,

> they're all so medical so I'd often be standing there wondering what the hell they were talking about and not getting any of the medical information, what it all meant....And they don't ever really bring up family or psychosocial issues around patients up there.

Given that people being provided with services through the mental health programs are often experiencing health related issues naturally intertwined with psychosocial issues, the underlying foundation of the programs and how the team interacts is reflective of this. "In mental health, I mean, everything stems around the goal of is this a therapeutic decision? Would that be therapeutic for the person? And so that's how everybody sort of debates it back and forth".

If the majority of the multidisciplinary team is focused on issues pertaining to medical physiology of the patient, it can be difficult for the social worker to identify and address issues of a psychosocial nature. However, there are various contributing factors on whether or not psychosocial issues are addressed within the multidisciplinary group setting. If the group process is one that does not necessarily incorporate the identification of broader psychosocial issues, then it may be the responsibility of individuals who recognize the importance of these issues to present them to the group. One social worker describes how her participation in the identification of psychosocial issues during rounds can vary:

> We all speak up if we get the chance, but we don't always get the chance. Like if I'm having a day where I'm tired and I'm just like whatever let's just get rounds over with, there's things to do. If I'm not going to speak up...or no one asks me so I just don't want to and I know that other allied health people definitely feel the

> same way. We could be talking about these issues and be proactive instead of, at least knowing what everyone's opinion on the subject besides knowing what medications they're on. There's other stuff that we could be talking about and I think that every single person on the team recognizes that our social problems are an issue. Everyone, you know, doesn't like dealing with them but everyone, we avoid them instead of confronting them.

This social worker went on to describe how factors that influence whether a person will voice his or her opinion is not just specific to social work. "People don't always voice their opinion. So, being straight forward and speaking up and all the team members doing the same thing which isn't always going to happen". When asked what factors influence the degree to which social workers would interact with the multidisciplinary team, her response was, "having a general understanding of the medical situation, I think. Communication skills, confidence, ability to speak up, and competency". One's comfort level with regards to asserting oneself may be something that develops over time with ongoing interaction with the professional team. Within the interview, the following social worker described how although she feels confident in her clinical social work skills and has extensive hospital experience, her comfort with voicing opinions within a new position and with a new multidisciplinary team continues to develop. "It's funny because I'm still not at that comfort level yet.... Like I'm getting there, it's something that you build with time".

There are various experiences reported by social workers with regards to one's comfort level of voicing opinions within a group team setting such as rounds. Several social workers indicated that they felt confident and comfortable in being proactive with

identifying and addressing any necessary issues. "With this team, I'm completely comfortable voicing my opinion". This same social worker continued to describe how other allied health team members are not so comfortable in initiating and voicing their opinions and so often relies on her to do so. "They might not be so strong when it comes to dealing with the other medical staff but...when I present things, they back me up on them. They just aren't willing to put their foot out there". Although there are individual social workers that may not initiate discussion or identify a clinical issue within the group setting, an alternate might be to address issues in a more intimate, less intimidating setting. Two different social workers interviewed described not feeling comfortable speaking up within the multidisciplinary group setting but feel that they effectively address issues and concerns on a more individual basis with the necessary team member. This is depicted by the following social worker's statement pertaining to her process of address issues and identifying concerns:

> I think how I tend to do it is to do it more one on one. I'm not comfortable bringing it up at rounds, like where we should be doing it. Sometimes I am, but not always. If I had a problem with what the doctor was doing or what the care plan was doing then I would speak to him individually....yeah, not in that team situation but on individually. Not at first, I think that I have to feel comfortable with pretty much everyone on the team.

One additional factor that impacts on one's ability to communicate with the members of the multidisciplinary group is the opportunity of direct interaction. As previously stated, rounds or regularly scheduled team meetings play an important role within the hospital setting by ensuring that the patient care team consistently has an

opportunity to communicate with one another. Although an individual social worker may have the skills to assert him/herself within the team setting, if an integral member or members of the professional team do not attend this can create a barrier for communication. "Sometimes I think it's not necessarily whether you are comfortable or not in speaking your mind, although it can be. Sometimes it's a matter of, do you actually have an opportunity to speak to that person or are they available? But charts can be very helpful in that, right, just with communication". Communication amongst the patient's health care team occurs in various forms as is evident by the previous social worker's statement. As well, ensuring that there is an overt process to keep the team informed can enhance good team communication. "In mental health you get the notes and the minutes, you get notified of the meetings. You know, they have a process already established as working together as a team". This Adult Mental Health social worker discussed the various tools that can facilitate good communication amongst the multidisciplinary team and foster an essence of group cohesion. This same social worker reflected on a very different experience in a more medicalized patient care setting within the Health Sciences Centre and how there can be a lack of process for information dissemination and overall communication. "In terms of the program I don't know what's going on in our clinic ever. You're not informed, there's no process on how they do things. It's just a mess".

Although the individual social worker does contribute to patient care as well as group process, the dynamics of the multidisciplinary team does impact on how an individual team member may practice. For example, one social worker that spoke highly of her clinical practice in terms of the type of work she does as well as the environment

within which she works, attributes this in part to the underlying respect that all team members have for one another. "This team is very democratic and they also think that every team member is equal". Another social worker also reported that the overall group dynamics of the team has an influence on the degree to which a social worker may participate. "I think some of that comes from the teams as well. If you work in a negative environment, it sort of breeds the negativity in terms of not taking it to the next level". A social worker from the Child Health practice area also illustrated how team process and group dynamics influence the social worker's individual practice. "There are ways in which people work together that aren't optimal from my perspective and I don't always feel that I'm doing what I can do best or how I can be most helpful".

One consistent sub-theme that emerged from the interviews is the importance of building relationships with colleagues. This is reflective and previously alluded to with regards to a person's comfort level of voicing one's opinion. Every social worker interviewed identified how necessary it is to build relationships with fellow colleagues to promote group cohesion and enhance one on one reciprocal interaction. "I have excellent interpersonal relationships. I think we have kind of degree of continuity in the way we see problems in a way that allows us to work together and collaborate well". Essentially, the social workers described how building and maintaining good multidisciplinary relationships facilitates the provision of good patient care. Team meetings and rounds are an obvious opportunity to engage in relationship building. "In my first position, I would always attend rounds in the...unit so I definitely developed more of a rapport and became more comfortable in that team more quickly". This same social worker illustrated how her ability to address patient care issues differed within another care setting where she

had not developed that sense of rapport. "I still never developed a rapport yet with that team to feel comfortable enough to speak up about different issues". Another social worker from the Women's Health Program also identified the importance of relationship building and how this promotes overall communication within the team setting. "I've I think worked really hard on building relationships with team members so that I don't generally have a problem with not accepting something or presenting my piece".

Not only do good working relationships contribute to an individual's confidence to voice an opinion, but also relationships assist by promoting receptivity to the opinion. One social worker described how she recognized the integral role that relationships have on the provision of patient care:

> I work really hard at being a team player and I work really hard at building relationships with the people I work with because I think that those two things are key in having your voice heard. So if people respect you and respect your work, they'll listen. And I think then that you can engage in conversations with people on your team.... I may have a disagreement with somebody but because I have an established relationship, that's okay, and be able to work out a solution. I mean I think those are the two key things in working in health care. Crazy actually when you think about it in terms of medical ethical situations, but it's true.

Not only does self-confidence enable one to build good relationships but also, strong working relationships will result with staff being more apt to solicit one's professional opinion and involvement. This is consistent with the following social worker's observation. "Like if they respect you and you work well with them, they're going to like you, they're going to ask you more. You're going to develop that

relationship". There is a reciprocal relationship between an individual social worker's self-perception of confidence as well as overall good professional relationships. Another social worker from the Child Health Program illustrated this concept:

> I think a lot of that...is who the people are, not just nurse or social worker but people who have developed a rapport and I think at the core of those good relationships is confidence in yourself that what you do is present...I think that what makes for really good team relationships is people feeling secure in what they do, what they could offer and being willing to be open-minded and admit what they can't do and what they're failures are and not be worried about defining themselves.

Another sub-theme that emerged within the interview data is the overall perception of working within the multidisciplinary team. One social worker commented on how much she enjoyed the opportunity to interact and learn from so many various professional disciplines. Not only does the diversity within the multidisciplinary group setting provide opportunity for individual and professional growth but there is also an element of accountability associated with a multidisciplinary group. "I think that is the beauty of having a team. If somebody is dismissive of one thing, somebody can say, no we better get that checked out". The statement from a different social worker employed in the Child Health area of the Health Sciences Centre also reflected this belief that the multidisciplinary team can encourage accountability:

> I think multidisciplinary is a protective measure to make sure that...I do think that when you broaden the responsibility, you tend to get more input. You tend to get

> more opinions. You're not as at risk of falling into a particular point of view as you would if it was one person who was exercising sort of godlike authority.

Although it was evident that the majority of the social workers interviewed recognized the attributes of a multidisciplinary team as overall beneficial to patient care, groups must still be mindful of decision-making process. If the group members are concerned with how colleagues will perceive their differing opinion, they may experience anxiety to conform to the overall group opinion. One social worker interviewed described her concerns associated with overall group decision-making and opinions. "I think probably in many teams. There's a danger of too much group-think and after all people feel that they all kind of have to agree". This social worker continued by describing her own personal evolution to the point where she was aware of this phenomenon and was able to recognize and avoid the process of group-think:

> So what I want to do, and what I've been trying to do, is offer a different perspective. You know, to do something that is a sign of a mature social worker, and it's taken me a long time to get there, by having a difference of opinion and being comfortable with saying, well, I just don't see it that way. I see it this way and not worrying so much if people agree or don't agree. Do, you're letting go of that constant anxiety of, is my team going to approve of me if I take that view. I think that is very, very hard. It's very hard. It's very compelling as a human being on a team to want your colleagues to approve of what you do or what you think.

This social worker clearly articulated the difficulties and pressures that can be associated with working in a group environment. This social worker also briefly alluded

to one of the benefits contributed by hospital social work in providing an alternate perspective to the multidisciplinary team.

Another common sub-theme that is evident within the interview research data is that social workers recognized that their role is unique within the hospital setting and enhance overall understanding of a particular situation by providing broader clarity, as well as, presenting an alternative perspective to the situation at hand. Social work has the training, knowledge base and essential skills required to understand the complex psychosocial and economic needs that are associated with illness and injury. Social work's overall understanding of systems theory and the impact that various forces have at the micro, meso and macro levels allow for social work to present the hospital care team with a comprehensive explanation of various psychosocial influences. Sometimes it is necessary to say, "that's not really the view I would take on this. I would suggest there's another way in looking at it". This person's view is also consistent with an additional social worker's opinion:

> When you bring up the whole issue of let's look at it in a different way, they're not necessarily the worst people on the face of the earth. These people are people and they may make choices that we might not necessarily make for ourselves but you don't have a right to pass judgment on that.... I think that you need to separate the choices, or the poor choices that the client may be making from what is. Or, you need to get a context of why they're doing that....you can bring that perspective to the team, like there's a reason why this is happening so if you really want to have a positive impact then here's some strategies that we can use to work with this family.

This is a comprehensive example expressing how social work enhances the understanding of a particular situation by providing an explanation and giving the underlying context to a situation. This further provides the necessary background and understanding to enable the multidisciplinary team to interact with patients and strategize more effectively.

There are various descriptions from the social workers with regards to the decision-making process that occurs within the multidisciplinary team setting. Most social workers interviewed commented on how patient related decisions that would be discussed at rounds or team meetings are done in environments to solicit the input of all involved. Generally, if there were any pressing issues that require discussion amongst the various disciplines then rounds would be the forums for discussion. Therefore, if the multidisciplinary team is working with a patient then most social workers reported being able to have input with decisions in a team oriented manner.

When asked if there is one particular person on the team that the social worker feels makes the final decisions on where the care team is going to take the patient's care or long term plan, several social workers responded similarly to the Renal social worker, "probably doctors". This is further explained by the Child and Adolescent Mental Health social worker because "the doctors feel that the bottom line is that they're responsible for the patient so they're always wanting to know what we're doing and provide some input for support. So, yeah, yeah, we do feel like we're in it together". Not all patient situations warrant the involvement of the various allied health care team members; however, when the members of the multidisciplinary team are involved in a patient situation there seems to be a feeling of overall ability for the team to engage in the

decision-making process. This is reflected by the social worker representing the Renal Program. "Sometimes we have made the decision that someone needs to stop dialysis or needs to go into a personal care home...we all sort of go into together and make those kind of decisions together".

One social worker did express frustration about not being fully involved in patient related decisions where the involvement of social work would be beneficial. "I tend to get the calls after the meeting...so I just want to be involved in those because I'm going to have to debrief anyway with them". This social worker continued to describe how she has been making it known to her various team members that she would like to participate in various patient related decisions. "I never did any formal education, but I just made, pretty subtly I would think, that I just want to be involved in those decisions". She went on discussing how at times there is inadequate proactive planning that occurs in terms of patient related decisions:

> I find that we'll be walking down the hall and going into a meeting and talking about it thirty seconds before the meeting happens. Then it plays out and probably gets out of, it could snowball without us because we probably don't have an exact plan of what we're doing and what you're thinking about. We think, okay, we have to meet with so and so, and then the meeting is happening and we're thinking okay what were we doing and then somebody just starts talking. Then that's done but it's with the planning that could've been better. But especially with us because it's chronic illness. We should be planning way more than we do.... We do always have people using time as an excuse, but we do

> have time to plan before a crisis happens and then it always ends up in a crisis before we have time to plan.

When the program area or team is led by one individual or discipline, not only does that person have the ultimate say in particular decisions, but the person's overall working philosophy and practice style can influence the way in which all other team members provide service to the hospital's patient population. This is evident in one social worker's description of how she experienced a shift in patient service provision when there was a change in the physician heading the team:

> Dr. Peters had worked on this team for...lots and lots of years and finally retired from the team within the last year so we have a new younger psychiatrist. And his model of practice and the way he works was pretty, I'd say set in stone, so things are changing. Like, he moved on and we can start to grow and develop as well.

Clearly, this social worker is implying that exploration of different treatment modalities were probably unlikely until the head physician retired. This is a concise example of how one team member, either the leader or director, may influence the overall working methods of the multidisciplinary team.

Not all social workers practicing at the Health Sciences Centre reported feeling like an inherent part of a team. Two different social workers identified difficulties associated with the Children's Emergency area with the following social worker's description reflective of both people's opinions:

> Places like Children's Emergency, that's not really a team. You're more of a consulting service and a lot of times you're trying to find, casefind. People aren't

identifying social issues and you're ostracized from the team, at least in Children's emergency. It's a tough place to work.

Additionally, a social worker providing clinical service to an outpatient clinic also made a comparable statement. "No, I don't feel like a team player, a team member. I feel like a consult service". Essentially, these two areas do not have consistent social work presence as social work is only called in when deemed necessary by the existing staff.

4.2.2 Social Work Team

When exploring the concept of working in teams, social workers interviewed not only identified issues associated with the immediate patient care environment but also discussed issues associated with the group of social workers employed at the Health Sciences Centre. Three different social workers expressed feeling isolated from other social workers within the hospital, somewhat as a result of how programs are developed in combination with the overall lack of group cohesion experienced. The Health Sciences Centre does not have one overall Social Work Department instead social workers are grouped into areas of commonality such as the Medicine/Surgery, Women's Health, Child's Health, and Mental Health program social workers. There are other social workers within the Health Sciences Centre who are associated with program management. One social worker identifies how program management has contributed to her isolation. "Because we're under program management and we're not officially under the discipline director, I feel like I'm practicing on an island".

Social workers are physically separated from one another, which instills a barrier in the promotion of a social work team essence. The following social worker gave the

impression that there is difficulty with overall group cohesion amongst the social workers at Health Sciences Centre and how this impacts on clinical practice:

> I still don't feel that the social workers who work in the hospital...work as a team and are supportive of each other. Certain groups are of each other...but I think that it's important that as social workers, because we're social workers and because we know the importance for it for one, of being able to function as a team and being able to do our jobs and say things and not worry about being respected by your colleagues...knowing that it's safe for you to share what's going on with you, to vent if you need to, to screw up if you have to and you're not going to be judged. And I think that's lacking. I think there's a certain cohesiveness of all the social workers in the unit that is lacking. And I remember thinking, how can I function as a social worker on a team of multidisciplinary people when I don't feel like there's a team of social workers in the whole hospital.

A third social worker reiterated this belief regarding lack of group cohesion amongst social workers themselves. "We have to work as a team but how can you work as a team when we clearly are not a team...? Not everyone is going to get along but I think it is so important to have cohesion and we don't have that". These three social workers have identified concerns associated with the Health Sciences Centre's social work group. It can be difficult promoting group cohesion amongst a group of individuals who physically are separated from one another in office space and practice area. Promoting group cohesion at the professional level will have overall benefits with the provision of individual support, education and skill enhancement.

4.3 Role Overlap

Clearly defining one's scope of practice when working in a large hospital setting amongst numerous other professionals is essential. Role blurring and the overlap of professional roles do occur within the hospital setting. Nine out of the ten social workers interviewed agreed that they recognized the occurrence of role overlap between social work and another professional discipline within their particular hospital setting. Interestingly, only one social worker interviewed stated that the role overlap was not her experience and felt that the role of social work was clearly defined and understood by those that she worked with. This social worker that indicated that role overlap was not occurring within her setting continued by explaining that she works within a care setting that does not require the involvement of any additional allied health professionals. Her team is limited in numbers and consists only of physicians, nurses, and social work. As well, the hospital setting that she provides social work service to was described as an area of short hospital admissions with minimal discharge complications and comprehensive community follow-up if difficulties do arise.

According to the social workers interviewed, the experience of role overlap between social work and other professions is a common experience. Particularly with providing support to patients and families as this concept is broad and at times vague. A social worker within the Child Health program described how at a unit meeting, role overlap pertaining to support was discussed:

> We were talking about support, psychosocial skills…we were talking about how we define ourselves and what it is we do well, and how we do it differently than other people, other disciplines. There were a few voices that spoke up and said,

> yeah but you know, psychosocial support, we do that too. We don't have a monopoly on caring, you know. Other people hold people when they cry and give support and understand about families and all that kind of stuff. Which is true, but what I heard there that I responded to is that that's true and we would be really, really bad as a hospital taking care of people if that didn't exist.

The perception that the social workers expressed varies in terms of whether or not role overlap is beneficial or a hindrance to good patient care. "There is, definitely...there are very distinctive advantages to the fact that there is overlap in role in teams where things work well, and I have other relationships with team members where it's a huge problem". All nine of the social workers that identified role overlap as an occurrence identified it as both a positive and a negative experience. Essentially, the social worker representing the Geriatric/Rehabilitation program indicated that "it depends on the team". The following social worker reported that a slight overlap in roles is inevitable with the hospital setting and described how overlap materializes in her area of Adult Medicine:

> I think that nursing is involved heavily with psychosocial issues...the nurses they have the luxury to get to know the patients even more than I would. They provide twelve-hour care everyday, let's say. And they see patients through thick and thin and have many more opportunities to have deep discussions, like in the middle of the night.... In that way I'd say it overlaps.

This social worker expanded on this idea by stating that role overlap can be beneficial for patient care. "Most of the time I feel that it enhances the care of the patient in that at least there is someone to hear them and listen to then and hear their concerns".

Again, this role overlap between social work and nursing is associated with the overall provision of support to patients.

The social workers interviewed identified that there is role overlap between social work and various other professional disciplines. Occupational therapy, Home Care, aboriginal advisor, nursing, and physicians were identified as having somewhat of an overlap in roles depending on the particular care setting. One social worker described how the overlap in roles between social work and occupational therapy were proactively created to enhance patient care. "OT asked me to go on a lot of assessments with them if they were kind of not sure about the social issues and wanted me there to watch for dynamics. So, I think there's overlap". Another social worker also reported overlapping with occupational therapy specifically with regards to joint home visits in preparation for a patient's discharge:

> In the beginning anyways unless things get out of control when I go on the OT home visits...I'm just kind of there you know. Kind of there as an observer and they're prepared to jump in if things get really messy and really hard...and just be there as an additional support.... I'm very lucky in that the OT's that I work with right now, they're not territorial.

The boundaries between professional roles can be blurred and for new roles being developed within the hospital setting, communication amongst the various multidisciplinary professions to clarify service provision can minimize frustration and negative experiences associated with the overlap. One social worker described how poor planning in the implementation of a newly created position has resulted with confusion and difficulties associated with role overlap:

> In Women's I've seen one of the areas of overlap between social work and we have a unique position over there, that's aboriginal advisor position which is supposed to be someone who is to help the aboriginal women cope I guess. I'm not quite sure what their role is and I think that there is some overlap between those two roles. Social work at Women's and the aboriginal advisor haven't traditionally worked very well together, I think for a couple of reasons. The role was developed and put in place with no planning, with no role negotiations that happened.

This social worker continued to describe the day-to-day difficulties pertaining to patient care because of the role overlap and ambiguity between social work and the aboriginal advisor. When there is significant role blurring, accountability to one's professional function and responsibilities can be minimized.

Essentially, because there is a tendency for overlap to occur within the hospital setting, various professional disciplines need to make distinctions on what it is that they provide to the multidisciplinary team that distinguishes them from one another. Social work needs to articulate the uniqueness that social work brings to the team and although the provision of support to patients may cross over the various health care providers, social work intervenes at a more intensive level. "But what we do is way more than just patting people on the back and giving them a Kleenex". Making distinctions between the roles of various professional disciplines is a necessity. Even though the following Adult Mental Health social worker viewed role overlap as a regularly occurring phenomenon, it is not viewed as a hindrance to patient care because there is a distinction between roles. "I'm expected to do all the things the nurse therapist does but my specialty is working

with families. So I'm a person who will do family therapy". This is also evident in a description provided by a social worker from the Renal Program who articulated an existing overlap between social work and occupational therapy; however, indicated that there is a distinction in the service that both disciplines would provide. "So her and I overlap a bit but she doesn't get into the things that I get into".

To facilitate understanding of one another's roles, the multidisciplinary team must have ongoing communication and negotiate roles as necessary. One social worker described that to minimize confusion between roles, "OT, physio and social work, we all communicate constantly". A social worker in the area of Child and Adolescent Mental Health described how the blurring of roles in this area is a frequent occurrence:

> It gets kind of blurry because sometimes the doctors do family work or work with parents and other times it's more traditionally what the social worker does in the area....and for where I fit in social work sometimes I like to flex...or, like I say, use a different kind of modality like do theraplay instead of just family therapy.

Role overlap in this given health care setting is a common experience. For example, social work is providing individual and family therapy yet so is nurse therapists. The nurse therapists are described by this same social worker as providing care by, "doing mental health assessments and doing play therapy or therapy". Good communication within the multidisciplinary team setting is necessary to negotiate roles and distinguish service provision from the various professional disciplines. This mental health social worker indicated that there was opportunity to discuss issues pertaining to role overlap with the multidisciplinary team and that the "climate is open to it".

The overlap of roles may also inevitably occur if a particular discipline is unable to provide adequate service due to lack of staffing. If there is insufficient staffing within a health care setting, another discipline may just adopt those functions of patient care as their own. This was identified as an overall concern in the Women's Health and the Child Health programs due to lack of social work positions to fulfill the existing patient care needs:

> ...probably with our nurse clinicians in some of our specialty clinics in both Women's and Children's hospitals. Because we don't have enough staff, I don't believe that we have enough staff to meet the demands of our clients, they end up doing things that should really be within our scope of practice.

This social worker continues by providing a specific example of how the scope of practice may extend beyond the appropriate professional discipline if there is limited time or funding for the necessary position:

> For example, in our neurology clinic they have kids that are given really bad outcomes, diagnosis outcome...and the prognosis is the child is going to die. Often it is the nurse clinicians that start with those families up front instead of us. I think that social work should play a more major role in sort of the more case management stuff with those clients if we had the resources to do that.... So I'm hoping that over time that that'll be recognized in a more solid way and actually have some funds that would back that up.

Ultimately, lack of clarity or overlapping of roles can contribute to difficulties in collaboration. Overlapping of roles between social work and various professional disciplines seems to be inevitable within the hospital setting requiring ongoing clear

communication and negotiation within the multidisciplinary team to minimize confusion. Also, communication and inviting input from various disciplines when developing new positions is essential to distinguish each profession's scope of practice and specialties. Overall effective communication is essential at all levels of the health care system for the promotion of good patient care and identify any gaps and ambiguity.

4.4 Initiating Social Work Involvement in Patient Care

Social work is not involved with every patient and family associated with the Health Sciences Centre. The involvement of social work varies depending on the needs of the particular health care setting, patient population needs, and allocation of social work resources and funding. There are social work indicators documented and distributed throughout the hospital setting to assist by educating staff on what types of situations warrant the involvement of social work. The process of initiating and expectation of social work involvement in patient care also differs depending on the care setting.

There are patient care settings whereby the social worker within that setting is required to be involved with all of the associated patients. When there is an automatic expectation that social work will be involved, this eliminates any ambiguity or confusion regarding when social work may or may not be providing service. Two social workers interviewed described how the expectation within their care setting is that social work will become involved with all of the patients associated with that care setting. These two social workers do not rely on other professionals to initiate a formal request for social work service, but are aware that when a new patient comes to their care units, social work is to automatically initiate a psychosocial assessment. "We get involved from our own

initiative rather than a referral being written. So it's routine that when a new person comes in with a new diagnosis, social work gets involved". Another social worker describes this similar expectation. "Basically every person on the ward...I pick up from the moment they get on the ward. So, I pick them up from that moment, I review the chart and I don't really receive consults here which is another reason I think why the team just assumes that I know".

A common method to initiate the involvement of social work, as well as various other health care professionals, is through formal consultation. Not all patients and families require the involvement of social work thus staff is to notify social work when there is a situation that warrants social work expertise. Appropriate and inappropriate requests and consults for social work were identified by the social workers interviewed. When the multidisciplinary team has a clear understanding of social work's scope of practice and when to initiate request for social work involvement, the threat of confusion or inappropriate expectations are minimized. One social worker described how the multidisciplinary team in her hospital care setting is well aware of what the social work scope of practice is as well as when to consult social work. "I think I'm pretty specialized. I mean, they know exactly what to give me.... We have criteria guidelines, risk indicators, things like that. They have that. I'd say for the most part I get very appropriate consults".

Another social worker also agreed that she was also consulted appropriately with her team aware of social work's scope of practice and partly due to identified indicators for consultation. However, she stated that her regular presence at multidisciplinary team rounds provided her with an opportunity to remind staff of social work's ability and was

the biggest contributor to her being appropriately consulted. "It was important for me to be there in rounds because I don't know if they would consult social work appropriately in terms of they would have a patient who came in and experienced domestic violence or something and I would have to hear that in rounds and pipe up and say, well, I'll talk to them.... And they would say, oh yeah, I'll write you a consult type of thing".

Consults requesting the involvement of social work are not always appropriate. For example, staff may not recognize the need for social work in certain circumstances when it would be a very appropriate consult and patient need. One social worker discussed the difficulties of social work consults from the Children's Emergency department. Currently within the Health Sciences Centre's Children's Emergency department, the social work presence is minimal due to funding issues. Without having consistent access to social work or consistent social work visibility, staff within that area may not be as cognizant of recognizing psychosocial indicators. A social worker talked about a recent experience she had in the Children's Emergency Department whereby she identified situations that would benefit from social work's involvement although no consultations had been initiated by staff. "We went in and said, do you guys have any consults? Oh, no, there's nothing for social work. I said, well you know, we're just going to flip through the charts. And each evening we picked up about five". She continued by describing a situation where staff within the Children's Emergency Department did not effectively consult social work due to delay in the formal request:

> I had a mom who came in with five kids in tow, age twelve down to two. And she's been here all day...so they procrastinated at doing the referral. So, a quarter to four we finally get the referral and I went down there and the reason she was

> here had nothing to do with her kids being sick. It had to do with her husband had beat her up that morning, had stolen all the money and had eaten all the food and the kids were hungry.

Evidently, this is an example of a particular hospital care setting not effectively requesting the involvement of social work services in a timely manner.

Another social worker agreed by making similar comments regarding the Children's Emergency Department. "Children's Emergency, that's not really a team. You're more of a consultation service and a lot of times you're trying to find, casefind". This social worker also indicated that the more heightened situations might be appropriately consulted, however, seemingly less severe situations may be missed:

> They'll call you in on the difficult ones, like horrific ones, then they'll call you in. But then you have an aboriginal mother from the north with no family here who's crying with her baby in, you know, in emergency in one of the rooms and they won't think that that's an appropriate social work consult. Not identifying that there's no supports here, no family here, language may be a barrier, you know, like those issues.

One social worker believed that the social work indicators may not be fully expansive of all possible psychosocial needs and because of this, some social work consultations may be neglected as is explained:

> I wouldn't say that all the consults from Women's are appropriate and we miss some because they have this, they're very rigid.... They have our criteria and they say, like, these are your criteria. There aren't things in there like a newly immigrated family who might need help with supports and things like that.

Having up to date social work indicators and referral criteria to circulate to the various hospital units may encourage appropriate consultation.

Another instance that may lead to inappropriate consultation is if the multidisciplinary team is not fully aware of each individual discipline's role and function within the team. "I think that there were times when I got a social work request that was not appropriate. You know, can you assess this person's activities of daily living for discharge and I was like, that's not something. I'm not an occupational therapist. I'm not a Home Care nurse. That's not appropriate for me".

Additionally, another phenomenon identified pertaining to inappropriate consultation and unrealistic expectations regarding addressing psychosocial issues is when staff identify old issues for present intervention. For example, "I get consults with depression, so to speak, depression where the depression took place five years ago or where they were sexually abused when they were three and they're twenty-seven. Which is kind of a violation in my view to be intervening for on that basis". A second social worker also identified this as a concern. "Sometimes you get a consult from them on a woman who had a history of post-partum depression and it's her sixth baby and you think, do you really want to drag that up"? A third example of this is as follows:

> So, if ever they've been investigated for child abuse or sexual abuse or things like that, we get consults every once in a while because it says positive for scan. So you go and look at the chart and think, she was three, she's 36, am I really going to go in and talk to her about that experience? And she's in a stable relationship. Like, unless there's something in her current life constellation that would comprise like a risk factor then I wouldn't necessarily go in and see that person.

Essentially, when teams and various staff are aware of social work's scope of practice, this enhances and facilitates appropriate initiation of social work involvement. Also, social work indicators and referral criteria can be a useful reference tool for various health care settings to utilize as a guide for appropriate consultation.

4.5 Professional Issues

4.5.1 MIRSW/MASW

The Manitoba Institute of Registered Social Workers (MIRSW) and the Manitoba Association of Social Workers (MASW) are the guiding professional bodies for social work practice in the province of Manitoba. The MIRSW and MASW develop guidelines, criteria, and standards of practice to direct social work service provision in Manitoba. As well, this provincial professional body also has involvement with the Canadian Association of Social Workers (CASW), the national representative for social work. These professional bodies publish newsletters, which are disseminated along with various other information to keep social workers updated and connected to the social work community. A social worker in Manitoba becomes a registered social worker when accepted as a member of the MIRSW. Although licensing of social workers in Manitoba is currently not mandatory, it is a requirement that Health Sciences Centre's social workers are registered with the MIRSW. There are a small number of Health Sciences Centre's social workers that are not registered because they had been hired prior to it being an induced mandatory standard for employment.

Initially, there was not a question within the research design that specifically asked the research participants their opinion on the role of the MIRSW and MASW with either overall clinical practice or as a resource when confronted with an ethical dilemma

or clinical difficulty. It was during the sixth interview when I recognized the need to ask a question regarding the influence that the MIRSW/MASW has had on the individual social worker's practice. This question was incorporated into the remaining interviews, thus, only five of the ten research participants were asked a direct question pertaining to the role of the MIRSW and MASW.

Only three social workers interviewed commented on the influence and role that the MIRSW and MASW has had, either with providing a foundation for competent clinical social work practice or as a possible source to turn to if clinical difficulties arise. Two of the social workers interviewed stated that the MIRSW and MASW have not been influential in guiding their practice; however, both of these individuals did believe that there is potential for social work's professional bodies to take a more active role. One social worker acknowledged that the MIRSW and MASW have not been overtly influential as a guide to her clinical practice. "They haven't really influenced my practice very much and I don't hear or see them that much. Like I think they could take a more active role. I think it would be great if they could take a more active role with the faculty and the students sooner". Another social worker discusses her lack of clarity regarding the role of the MIRSW and MASW:

> I don't see them being a role at all for assisting. I could see guidelines because they kind of set.... I've read all of the material. They try to set standards, but what are the standards? I don't really get the whole thing.... Whether or not I could phone them and bounce something off of them, I don't know.

A third social worker did believe that the MIRSW and MASW were beginning to take a more active role and identified a contribution that this social work professional body had been involved with:

> It has become more progressive over the last few years looking at the special, what is it, professional issues committee looking at our standards of practice last year. There was this huge body of work that was done by the association which really nothing had been done here for a long, long time in Manitoba. The whole licensure and that kind of stuff and recognizing the importance of that.

This social worker continued by expanding on the area of professional licensing by stating, "I don't think that there will be a positive trickle down effect in terms of the professional association unless there's mandatory licensing". When this social worker was asked whether or not the MIRSW or MASW has a role in assisting social workers with the resolution of ethical dilemmas or clinical difficulties the response was, "I think that our professional association really hasn't been on the front scene with that". However, this social worker did continue describing how the CASW did have more active participation in such issues:

> Locally I don't think that we have a lot of voice in that regard but nationally I think we do.... Writing letters of support relating to, for example, to that case...in Ontario. So, supporting the Crown in moving forward with retrying.... I think that we could do more, be more active.

All three social worker that commented on the role of social work's professional bodies all stated that the MIRSW and MASW have greater potential to influence social

work clinical practice. However, the Manitoba professional social work bodies are not currently identified as a significant source of information or assistance.

4.5.2 Code of Ethics[1]

The social work code of ethics outlines expectations of conduct for social workers and can be used as a resource to assist in decision-making and encourage a professional standard of behavior. The social work code of ethics provides a significant ethical foundation to the profession. The question, "What is your knowledge and/or use of social work ethical guidelines", was built into the research interview guide. If a social worker being interviewed were unsure of what that meant, they were prompted with, "CASW Code of Ethics", or "social work code of ethics".

Four social workers reflected on their introduction to the social work code of ethics in university. "You go over the social work code of ethics and the importance of that and having that be your guide". Interestingly, another social worker believed that the social work code of ethics is not sufficiently reviewed within the social work university program. "Even the code of ethics for social work, I don't think is well looked at the university level".

Social workers suggested that they were generally aware of the social work code of ethics. "I think I kind of know it in my heart but I don't, not as much as I should". Also, that the social worker may not be specifically aware of the code of ethics; however, likely is aware of the underlying principles. "I probably couldn't tell you the content in it but I could sort of guess".

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[*] At time of the interviews, the CASW 1994 social work code of ethics were in use. The CASW recently released a revised 2005 social work code of ethics that have been distributed to all Health Sciences Centre's social workers via e-mail. This may have impacted on research findings if interviews occurred after the

Three social workers stated that they have occasionally referred to the social work code of ethics. "I have a little bookmark and I have it around". Also, "I have a copy on hand. I don't necessarily seek it out to look at it but I'll be looking and go, oh, it's the code of ethics and pick it up and scan it just to remind myself". Additionally, "I think I've referred to the actual document only once or twice". Another social worker acknowledged that she does not refer to the social work code of ethics. "I would say that I don't refer to them".

Not one social worker interviewed identified the code of ethics as a tool that had been utilized when they themselves were involved in an ethical dilemma or a difficult clinical situation. Interestingly, when asked during the interview what would be a general source of support for social workers in an attempt to resolve an ethical dilemma, two social workers identified the social work code of ethics as a source. "I think that definitely knowing, remembering your code of ethics and following that guideline". One social worker did not give the impression that the social work code of ethics would be of assistance when working amongst a multidisciplinary team. "I think that may clarify things for social workers but not necessarily for other people on the team".

4.6 Education and Training

Given that the purpose of this research study was to explore hospital social workers' knowledge base regarding ethics, it was important to get an understanding of social workers initial sources of ethical information and theory. Social workers were asked the question "do you recall addressing ethical ideals or decision-making skills in your academic program"? Participants were probed with "university education,

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revised code of ethics was distributed. Given that the interviews occurred prior to distribution of the revised code of ethics, it is the 1994 CASW code of ethics that will be referred to in this document.

workshops, reading, life experiences, direct work experiences, etc". Three categories emerged from this question including University Education and Faculty Issues, Workplace Training and Orientation, as well as General Education in Ethics.

4.6.1 University Education and Faculty Issues

In exploring the possible sources of ethics related education there emerged a sub-theme focusing on university education and related university faculty issues. Four social workers criticized the overall general social work university education program as insufficient in preparing one for a hospital based social work role. "I don't think the faculty prepares us and tells us what our role is as a social worker". This is echoed by another social worker when she states:

> I don't feel that I learned very much in my social work degree. I feel that I learned more in my sociology degree than I ever did in my social work degree.... I really don't feel that our faculty does a very good job with preparing people to apply theories and to realize that it is something internalized, you know, how we practice.

A third social worker identifies that she does not feel like she has been adequately prepared to perform the functions of her hospital social work role:

> As to the school itself, we are focusing on policy but it's on the macro policy. I think as social workers, we need to know what the micro is. We need to know how to deal with EIA and we need to deal with income assistance, disability. I mean, we're being called to do these things and I feel that I have no training in it.... I think that there are a lot of gaps in our education. I don't know if it's different with the MSW courses but I don't feel, I don't feel that if I just did my

> BSW without my different life experience, I don't feel that I would do half the job.

Another social worker reflects on the role that her field placement had in preparing her for her role as a hospital social worker. "...Considering my placement, where I got for my placement. I think that is crucial and was really, really the clincher in preparing me for my role in social work. Classes and courses, somewhat".

University education is a good source of theory based knowledge but obtaining the necessary skills to be effective within a hospital social work position must be complemented with additional sources:

> ...I see sort of, our knowledge gained by a social work degree is, promotes thought and sort of a general knowledge of a lot of things. So, but it's not going to help me, more of a theory base of knowledge. Um, practical skills that I would have got right here from the social work school, probably not. That would have been more in practice and life experience, and whatever.

In discussion specific to social work, ethics and ethical theory related education; only three people recall having some discussions about ethical related issues in their social work university program. The depth to which ethical related topics were addressed for these social workers varied considerably. "Very, very briefly. I think that was more, like in one of my classes there we got into discussions about the big ones like abortion, or, you know, and more so the code of ethics". This social worker recalls two specific classes whereby ethics was touched upon. "Yeah, there was in one particular class that I remember, Criminal Justice and Corrections. That was definitely covered in that class. Probably in Social Work Practice, Introduction to Social Work Practice. It was touched

upon probably". Additionally, a third social worker also recalls a specific class where ethical related issues were incorporated in class material:

> I think that Alan touched on it in a field focus class for corrections. I think. But I don't think he ever called it ethical dilemmas. I think he might have touched on things with inmates, yeah. Maybe it has been called something different, I don't know. And maybe that's the problem too. Why don't we call it what it is and everyone could be on the same page"?

This statement above brings attention to the ambiguity that can be related to language and the confusion that can occur with inconsistent language. With the use of explicit language and curriculum, essential knowledge and skills required for hospital social work practice would become more prevalent.

However, six social workers indicated that there were no discussions whatsoever with regards to ethics and ethical theory within their formal social work university education. "No, not specifically. No, I guess it's just partially common sense". When asked, "do you recall in your formal education with your university degrees, ever learning any kind of ethical theories or ethical decision making", a social worker responded as follows:

> No, actually I don't.... It certainly wasn't a core course so did I take anything as an elective that was like that, no. I didn't get any of it throughout university. In fact, I'd be surprised if you spoke to anyone who had formal training about ethics. Yeah, I don't think that it's addressed. Kind of frightening actually to think of that from a professional standpoint for social work.

Although several social workers stipulated that they did not have any concrete overt university education that focused on ethical issues and ethical decision-making, the underlying foundation of social work education was thought to contain a similar parallel belief system as ethical theory. Even though social workers may believe that they are limited in overall concrete understanding due to limited ethics related education, social work and ethics are identified as being inherently intertwined in principles. One social worker discussed how she viewed similarity between social work principles and ethical theory. "I think social workers, the education that I've had anyway...the themes of what are basic human rights about that social work has a role in intervening in private troubles but also being appreciative of the concept public grid". Another social worker shares the view that her social work university education incorporated core ethical principles. "I think that...we were taught...in terms of competing values all the time. That was just a big part of that program was always trying to look at that". A third social worker also reflects a similar belief. "I think social work training or social work education and practice is ethical. We are taught our code of ethics.... Yeah, so I guess it's kind of inherent in it.... I almost feel that it's second nature".

In addition, two faculty related issues emerged during discussions regarding social work university education. One social worker identified concerns with the university entrance requirements for social work. This social worker stated that to enhance overall service provisions, the individuals providing social work service must be suited to the profession. She expanded on her apprehension associated with the current entrance criteria:

> I think the faculty of social work and one of the biggest disservices that we have is that there's no interview process.... It sores me that respiratory therapy, physiotherapy, all these other degrees have an interview process and social work who, we are the people who are suppose to be communicating and doing counselling and there is no interview process.... I think that's a very, very sad statement.

Another social worker identified a very different faculty related issue. She believed that the University of Manitoba social work faculty needs to become more involved in the identification and resolution of ethical related issues at the varying levels of society. For example, this social worker described an incident whereby the faculty of social work in Ottawa prepared a position statement regarding anti-Semitic acts that had been occurring. This position statement was sent out across Canada for endorsement to state that "this isn't an acceptable standard of contact for people". This social worker strongly believed that the University of Manitoba social work program could engage in similar activities as the University of Ottawa, and overall needs to be more proactive in societal disconcert.

4.6.2 Workplace Training and Orientation

Health Sciences Centre's orientation and training for staff was an area that emerged in discussion with five of the social workers interviewed. Social workers deemed workplace orientation as integral to the promotion of good social work clinical intervention. Orientation was identified as necessary not solely for social workers new to the hospital but also those social workers moving within the hospital into a different social work position.

Current workplace orientation was deemed to be inadequate by those interviewed. "My training here when I got here, they were just going to show me my office and took two hours off and showed me around. And that was it. I had corporate orientation and that was it. That was my training". Another social worker reflected on difficulties that could have been prevented with comprehensive orientation:

> I think I basically had to figure out on my own most of my job. How to fill out charts, how to fill out the different consult forms that we have, which one was for which and how to do what, where to get certain forms from for certain resources to help patients, where to find those resources.... And I know that that added to my feeling of overwhelming stress that I experienced for the, I'd say for the first three weeks that I'd work here. I think I walked around with chest pains for about the first three weeks because I was so overwhelmed.

A third social worker reflected on how she was not adequately prepared to perform in a previous social work position. "It was such an important job I felt, but wasn't prepared to do it".

Suggestions were provided on the information that would be of assistance to new staff if incorporated into an orientation process. "You know, but it would have been nice to have had at least some medical terminology. Like there were some consults that I couldn't read, it was Greek". A second social worker discussed initial difficulties pertaining to lack of knowledge in the child protection component of the social work role. "It's hard to manage that way especially with no training too in child protection. I just learned by picking up the phone and phoning Child and Family". Another social worker identified how a colleague:

> ...pulled me aside about a week and a half into my job here and said, this is a big book, this is our policy, you should read this. I mean, that could be incorporated into an orientation for new, especially new, new, new employees whether you came from you're a new grad or whether you came from Child and Family Services or wherever. If you're new to the hospital, to that particular hospital it's important to know that stuff.

Additionally, even incorporating the roles of the various multidisciplinary team members was identified as a necessary component for orientation. "I know their roles a little bit but not a whole lot. I don't even know what is the order of the doctors, like resident or senior, junior or junior. I don't know. Like, nobody takes the time to introduce". One social worker expanded on the previous idea and identified a need for staff orientation pertaining to the hospital team setting and the underlying team belief system. "Here's what you might experience on some of the teams, you might, some people think that a social worker on a team is valued and supported and they really use you. Some you might find are, don't think that you need to be there or that you're required".

Staff orientation can occur in various forms. One recommendation on improving Health Science's process of orienting new social workers to the hospital setting included an informal process of pairing new staff with existing social work staff:

> I think it would have been very beneficial for, had I even been sat down for half a day by a supervisor...someone who is a colleague, or someone, a senior social worker.... So I think it would be very beneficial for somebody to be able to sit down and say, you know, these are technical things that you should be aware of.

This social worker went on to describe how improved staff orientation would have enhanced improved overall social work clinical skills and would have diminished the overall heightened stress experienced with the transition. "It would have relieved a lot of stress had it been more structured and planned about what I needed to know". Identification of the need for ongoing workplace training was initiated by five social workers interviewed. "I believe strongly in workplace training. In other jobs I've developed workplace training programs and I don't really feel that there's a training program here".

Several specific topics were identified as requiring increased training to ensure optimal hospital social work clinical practice and to enhance core decision-making skills with the multidisciplinary team setting. For example, social workers indicated that further training is required in medical terminology, cultural issues, anti-oppression and human rights issues, as well as legal issues in health care:

> We talk lots about aboriginal here and we talk lots about aboriginal training but we don't talk about any other culture. We don't get training in any other culture or what some of their different beliefs are. Then how does that impact our care to those populations as well?

This social worker also spoke about the need for further training pertaining to legal issues. "And we should be a little bit more trained, I think, in legal issues and health care because I think that there's a lot of them".

Ongoing workplace training occurs in various organizational settings. Two social workers observed that their past experiences in private businesses included significant ongoing corporate oriented training and that this practice needs to be extended into the

hospital system. This statement reflects the differences observed between private business and the hospital setting:

> You know it's interesting and I've always said this, when I worked at...a business, we had diversity training and they wanted us to be accepting of gays and lesbians because they bring in business. They wanted us to be accepting of different cultures because they bring in business. It's all about the bottom line. That doesn't even happen here in the hospital where it should because health care and how people understand their health issues can be very tied up into a lot of cultural.... It blows my mind that we're not as a system trained on how to deal with those issues in a sense that way.

4.6.3 General Education in Ethics

Social workers were asked about their sources of specific ethics related information. Evidently, social workers are obtaining ongoing information and training in ethics related topics, especially in areas focusing on health related topics. Social workers recognize that there are internal organizational resources available to educate staff with regards to ethics. "But there are opportunities if people were to take advantage of those opportunities in terms of the educational sessions". Health Sciences Centre has an active Ethics Consultation service that acts as a resource, available for clinical case consultation. As well, the head of the Health Sciences Centre's Ethics Consultation Service arranges for periodic presentations on ethics related topics, referred to in the hospital as Ethics Rounds. Ethics rounds occur approximately four times per year and are open to everyone to attend, with a forty-five minute presentation provided by a guest speaker. Social workers identify ethics rounds as a primary source of ethics related education. "I like to

go the ethics rounds that we have. I'm always interested in ethical areas". "I love the ethics rounds but I hardly ever get there because I'm too busy with other things". One social worker commented on how she valued ethics rounds as a source of information and then continued by describing an actual ethical situation that had been presented within this forum. Clearly, this social worker's knowledge base is enhanced by attending ethics rounds as she was able to describe the presented ethical case in detail and illustrated the various ethical themes and concerns inherent in the case. The case presented at ethics rounds enabled the social worker to reflect on difficulties associated with good ethical decision-making. During the interview, she identified various ethical themes inherent in health care such as quality of life and resource allocation that had been discussed in association with the presented clinical ethics case. It is obvious that this forty-five minute presentation made a significant impact on the social worker and enhanced her ethics related knowledge.

Although not all social workers have attended the ethics rounds, social workers are aware of this as a possible source of information. "I know that ethics does different educational sessions...many times I wanted to attend them but I just can't get...there". An additional internal organizational based resource that four social workers interviewed have identified as their primary ethics educational source is the Health Sciences Centre's Ethics course. This eight-week course takes place annually and covers various topics inherent to bioethics.

> I took the ethics course.... It's a very introductory course but it's still very interesting...here at Health Sciences Centre...various people known in their field...other various people in the facility to speak to different areas of ethics.

> Decisions about end stage care, organ transplant, things like that. Pretty important stuff.

Again, although not all social workers have attended the ethics course, there is awareness that the opportunity is available. "I'm interested in the ethics course here but haven't looked into it".

One social worker spoke about her previous place of employment whereby various courses were offered and staff were encouraged to participate in the ethics related education. "...I worked there for ten years, and there were lots of courses there that were offered on ethics".

Social workers identified a need for ongoing ethics education. "I think we could use more training, for sure, in ethical decision-making". Another social worker that had been a participant in the ethics course as well as a frequent attendee at ethics rounds stated:

> I think we need way more general education about ethics and the role of ethics in the provision of health care. Like, just focused on increasing our awareness of how many moral decisions we make all the time without realizing that they're moral arguments. Like some of the stuff that we did in our course where you think about decisions being arrived at in terms of the health care plan. But what goes into that? How is that arrived at? By who? Who are the influences...? Like we don't think about that in part of the way we work in a daily way, and yet it is.

Social workers that have participated in ethics related education believed that the information obtained did enhance their overall social work clinical practice. In reflecting on the role of ethics related education, one social worker stated:

> I think it gives me a starting point from where and how I back up and begin my assessment. I think it definitely molds in how I interview. I would say that you go in with a belief that the client that you're working with has. At the end of the day, there you need to work with them in terms of what is going to work for them in terms of a plan.... I think the ethical courses and that kind of stuff give you a background for that to some extent in terms of you know, having a framework to work with that family.

Another social worker that had not participated in any ethics related education indicated that it would be beneficial to her clinical social work practice by providing her with a framework to approach difficult situations:

> For me it would be helpful because it would be easier to say, this is an ethical dilemma, so okay, let's think about it on those sort of terms. Maybe pull out my handbook and kind of figure out how I could solve it that way rather than thinking, god, this is really tough. You know, like this is a struggle but why is it a struggle?

4.7 Ethics: Initial Perception and General Comments

All ten of the interviews included a question that explored the social workers' general understanding of ethics including any words or concepts that they believe to be associated with ethics. It was reinforced to the research participants that asking this

question was not to test their knowledge but instead an overall exploration of social workers' perception of ethics.

There were a wide variety of responses to this question. There was some unsurity with this question as is evident by this social worker's statement. "I don't think I have a clear understanding of what exactly, I mean, I have a general concept but I don't think I have something I could put into words". Another social worker was also expressed unsurity. "That's why I struggled with even coming here. Like, do I know enough about ethics to even come and sit down and talk about it? No, I don't feel that I do". However, with probing, all social workers responded to this question with a wide array of comments.

Morals, moral obligation and moral judgement were the most common answer to the question. "Actually walking here I was thinking, what does ethics mean to me because I would probably get it mixed up sometimes with morals". Another social worker that has participated in the Health Sciences Centre's ethics course responded more confidently:

> Beneficence.... You know, least amount of harm, most amount of good, best interests of...the child, the family. Moral judgment, moral obligation, being conscientious, integrity, honesty, sharing of information so that families have the right kind of information to give them, help them make choices. And aversion to paternalistic approach.

A third social worker responded to the question by stating, "Dilemma, conflict, conflicting values. There's obviously a problem and yeah, I would say to me it's like a competition of values. Right, and important values".

There were responses to this question that linked one's understanding of ethics directly to health care provision as well as social work practice. This social worker describes how her understanding of ethics is intertwined with the provision of health care:

> To me ethics is about awareness and practice. The provision of health care that is mindful of rights and responsibilities, and moral obligations, and personal awareness. Ethics has to do with the honoring of basic human rights and needs. To me ethics is the study of how we kind of implement rights or responsibilities within the health care setting.

Another social worker also directly links her understanding of ethics to her clinical social work practice:

> Ethics to me would be like what guides my practice. Like how I approach people, like fairly, confidentiality, like non-biased, like all that sort of thing. Like, how I would approach someone equally.... And the best interest of the client of course.... But people talk about ethics and I wonder, what does that mean to them as opposed to what it means to me.

Again, another social worker's initial response to the question exploring her understanding of ethics is related to her clinical practice. "It represents making decisions and how to develop your practice and do your social work practice on the information that you are given and it's not necessarily all black and white and things that are right and wrong". Maintaining an awareness of ethics and ethical based decisions means that one must take into account the various perspectives influencing the situation. One social worker mirrored this belief in discussion about her understanding of ethics. "I find ethics

fascinating because it's looking at so many different sides. I don't think there has to be a right answer to a problem. You know there might be an obvious to what I think is right but I think it's important to look at all the different sides to things".

Ethical issues specific to social work practice also included commentary about client empowerment as well as social work's role to support client self-determination. Social workers also stated the importance to maintain a client-centered focus in practice to ensure a foundation of ethical practice. One social worker brought up the area of abortion and how this relates to her understanding of ethics. "I think the other thing that stands out for me in terms of ethics are choices that people have the right to make in terms of choices in terms of pregnancy termination or moving forward with pregnancy".

Not only did social workers discuss ethics specific to social work practice and how ethics guides practice, social workers also remarked about encountering ethics in practice. Ethical issues were identified as something that is commonly encountered in health care. One social worker stated that ethical issues arise frequently in her health care setting. "Probably on a daily basis I would suspect with some of these complex needs and complex decisions. Yeah, yeah, I would say they occur frequently". This social worker also went on to acknowledge that ethics is pervasive throughout the various hospital areas:

> I know it happens and I know that when I was involved in the ethics course, it was evident that everyone of us had issues from our different areas. And because also in my experience with going to different areas within the hospital, there's recurring issues with those very things.

It is evident within this statement that this social worker's experience has taught her that ethical issues are inherent within the various areas of the hospital setting. Interestingly, when asked her understanding of ethics one social worker indicated that her understanding is merged with the particular practice area within which she works. "And it means different things when you work in different areas. I think I would have answered that question differently when I worked in...oncology or somewhere like that".

A few social workers discussed how ethics is encountered in practice and the impact that this has on the individual and members within the multidisciplinary teams. One social worker discussed how she believed that ethical issues are not adequately recognized because of the intense daily demands. "There's an awful lot of acceptance just to get the job done and get through the day. You know, an awful lot of, maybe they'll vent it...maybe they'll say that's the way it goes here, tomorrow there will be another one". She also described how staff can become immobilized from action if they do not know either how to address a situation or unsure about where the appropriate venue would be to tackle the issue.

A social worker also described how staff could at times ignore ethical related issues and refuse to identify them as such due to the philosophical framework that is used to approach the situation:

> I think that many physicians can argue themselves into a place where they say this is not about emotional issues, ethical issues. This is about the correct medical decisions.... They don't think that their decisions about care have to do with ethical issues which is horrendous because everything has to do with ethics. I mean ethics come into everything we decide all the time.

Ethics is something that is inherent within health care provision and frequently intertwined with decision-making in a hospital setting. Evidently, hospital social workers encounter ethics and ethical issues on a regular basis.

4.8 Clinical Ethical Issues in Practice

4.8.1 Communication and Decision-Making with Patients

Social workers identified issues specific to interaction pertaining to patients and families as important concepts. Adequacy of communication, decision-making process including the influence of relationships as well as issues related to informed consent and informed decisions emerged in the interviews.

Social workers stressed the importance of good communication skills with sufficient communication skills necessary for good clinical practice. Although difficult at times given the sensitive issues addressed within a hospital setting, communication is best when overt and direct. "I feel like you just say it as honestly as you can". One social worker discussed the importance of having direct communication with patients and families and how she has improved in communication skills over time:

> ...people dance around the issue, they're awful issues to talk about and no one wants to do it.... I'm getting better at that but just being, don't dance around it...just being way more straight forward with people and if there's an issue we need to lay it out on the, which is obviously a good clinical social work practice but my personality is more to don't want to hurt anyone's feelings...but sometimes you just have to do it. And it's way better when you do...people obviously get rid of any other preconceived notion about things when people are clear.

Essentially, a strong social work clinician will have effective communication skills as underlying social work training studies the inherent dynamics of interpersonal relationships.

A social worker explained how difficulties and confusion could arise when the patient and family are unclear about goals and treatment plans due to poor communication by the health care team. She elucidated on how patients and families may not fully comprehend what it is that the physician or health care team member is trying to relay due to inadequate and unclear communication:

> The doctors will say things like, we can treat this baby very aggressively but we don't recommend it. But lots of people don't know, what does that mean? Aggressively? What are they saying? When they hear the word aggressive I think their perception is everything that could possibly be done. But really what the doctors mean and what they hope families detect is aggressive means caving in somebody's ribs so that they can do, you know, resuscitation. They don't really talk that way to these parents and so the parents get confused and want the doctors to do everything that they can, perhaps. And the doctors are feeling that they really shouldn't. They get themselves caught up into crazy conflicts because of difficult ways of not communicating with families in the way that's helpful even though their intention is good.

This social worker continued to describe difficulties that she has witnessed due to insufficient communication with patients and families. She talked about a profound situation whereby inadequate communication ultimately resulted in the emergence of a clinical ethical issue:

> There's a situation that I came across...she asked to have an abortion and got an abortion...and at the time had asked to receive a tubal ligation. And she told me at the time she was told...that it was taken care of, that she received a tubal ligation. Well, that doesn't happen when you have an abortion. That procedure does not happen, not reality, not practical, and it just does not happen. It has to be scheduled as a separate procedure. So, she wasn't sophisticated enough to know that in fact that couldn't have been happening to her. But thought she had her tubes tied. She became pregnant again...

The social worker elaborated on the difficulties that this patient had in confronting her pregnancy and the accompanying decisions resulting from the miscommunication. This patient believed that a staff member had reinforced that a tubal ligation procedure had occurred during the abortion procedure. If the patient was cognizant that she did not sustain a tubal ligation, then she may have taken further precautions to prevent pregnancy. This is an example of how unsatisfactory communication contributed to a complex ethical situation.

Another hospital social worker expanded on this idea by stating that good social work clinical and communication skills can prevent the emergence of a complex ethical conflict:

> It certainly could if good social work skills are being used. Yeah, it could. I think that it could because we are trained to look at things from a global perspective and maybe most of us are aware of issues that could arise and we could deal with them early on rather than, you know. I guess communication would be one of the

> skills that would help prevent the situation from escalating. So, yeah, I would say absolutely it could be prevented.

Social workers also recognize that good communication is intertwined with a good decision-making process. Also, the reciprocal connection between ethics, communication and decision-making was identified during the interviews as is evident by the following statement:

> I think the way that ethics has an impact with where I work is, families understanding what the situation is. I don't think that communication with families is always very good. I still think we have a number of people who work with families, and they think they're working with families but they are not really involving families on decisions being made or they're making decisions perhaps for families that families may not be very happy with if they knew what was going on.

This social worker articulated that poor communication could lead to conflict between the multidisciplinary team and the patient or family. The members of the multidisciplinary team may not even be aware that there is inadequacy with communication nor might they recognize when there is clinical fragmentation in the decision-making process. "Decisions around treatment, management of illness, caregivers, things like that. I think that people working with the families don't intend for that to happen, they may not even realize it and think that they are making helpful decisions".

Not only was the influence of communication on decision-making discussed, but also the accompanying processes required when striving for clinical decisions emerged during the interviews. A social worker from the renal program talked about the process

that occurs when a person is considering discontinuing dialysis thus ultimately choosing to end their life. "But people wanting to stop dialysis and the rigmarole that sometimes has to happen before we allow them to stop. Like, psych is called, family is called, doctor is called and then they can be allowed to stop treatment". The social worker believed that this process of including all significant family and team members in the decision-making process generally is the optimal route when discussing issues such as discontinuing life-sustaining treatment. She also discussed the decision-making process in more detail pertaining to a situation whereby family may not be in agreement with the patient's decision:

> I find that it is a process, like the family will come around eventually. We'll say to them, we'll have a family meeting and that person can make that decision and we've told them that, that this is the person's decision.... It tends to be a process and we just keep talking about it and eventually the family comes to the conclusion that they need to stop.... I actually like having family meetings too because I think that it's good for family members to engage in that....

Decision-making in conjunction with health care provision is a fluid process. It is ongoing and topics may need to be revisited to ensure all involved understand the significance of what is being discussed as well as clarifying accompanying expectations of those involved.

The decision-making process that occurs within a hospital setting may at times be complex and frustrating for all involved. As previously identified good interpersonal relationships amongst colleagues can facilitate communication and decision-making within the multidisciplinary team setting. As well, building and maintaining good

relationships with patients and families can contribute to enhancing the inevitable decision-making process. A social worker identified how a pre-existing relationship with the patient can be an asset when addressing concerns associated with one's decline in health and exploring alternative living environments such as a long-term care facility. "Where you do know the individual and family really well, it's much easier to address because you can talk to the individual and go through the process...of how disappointing and how awful this is and at least come to a place where you can reach a decision".

An additional area pertaining to communication and decision-making that emerged was informed patient consent and informed decisions. When interacting with a patient and family, the goal is to ensure that they are aware of the pertinent health related information. The expectation is that the health care team ensures that the patient, family and significant involved individuals are sufficiently informed of the current health state and informed of the potential risks and benefits in order to adequately make an informed decision. Prior to agreeing with procedure or care plans, the patient and family also must have all of the pertinent information to facilitate and warrant an informed consent.

Social workers identified informed consent as an important communication related topic that is also closely connected to ethics and required for sound ethically based decisions. One social worker identified a situation pertaining to informed consent whereby a patient and spouse were not adequately aware of the severity of the health related situation but yet attempting to determine with the care team an appropriate treatment plan. The patient and spouse in this case were not overtly outspoken and were not ones to probe the physician for information. The social worker involved in this case talked about how patients who are more inquisitive with the physician may in fact obtain

more of the necessary information required for an informed consent. The following illustrates how a patient that does not question the physician or multidisciplinary team member may not obtain the full realm of health related information:

> I asked the nursing staff how much of this, and this young patient she was only 22 and her husband who is probably 25, 24, how much are they really aware of how sick she is? And they're saying, well they're not really aware of it because the doctors up there are all about treat, treat and get better.... So they, for them having to come to this and make this sudden decision, life changing, life threatening decision, all of a sudden. Not really realizing how sick the patient is, I feel is unethical...and they aren't the type of family who asks the hard questions, you know, am I going to die? Is she going to die? What are her chances, what is her prognosis? What are her chances of getting through this?

This social worker continued to explain the predicament and personal conflict that she herself experienced personally with being involved and knowing that there was information that needed to be clarified and made more explicit to the patient and family:

> So I felt that the doctor should have gone and explained all of this stuff to them without them having to ask the questions like I asked. But too at the same time, I didn't feel like I was, what's the word...I didn't have the authority to explain all of this stuff to them cause I'm not a doctor, I'm not a nurse. I'm not a medical person you know.

As well, social workers identified the need to obtain a person's consent not only for proceeding with medically oriented treatments and plans but also throughout the

therapeutic psychosocial related interaction. One participant identified how the concept of informed consent is encompassed in social work's ethically based practice methods:

> I think about the social work basic concepts that I learned in undergraduate school about...having a contract with a client or a patient, that need for our profession to have consent from a patient or family to work with them. We don't presume that we can enter into a hospital room and tell people how to proceed with coping with their family problems.... We believe that it's only ethical to only...the focus on having consent, agreeing to work with someone as opposed to imposing our treatment on. Which is different than a medical model which tends to be more you're the patient and I'm the doctor, I'm going to tell you what to do and you do what I tell you.

Another social worker from the Women's Health program talked about the importance of being open about the various systems and resources that will be involved as supports or interventions during hospitalization and after discharge once back home. "I'm starting to get into the routine to ask my patient. Like, can I have your consent to talk to public health once they, if they do call me.... I think that's great because at least you know and they can tell me what they want shared and what they don't want shared".

One final observation made about the complexities associated with informed consent is related to obtaining permission and input from children and adolescents. Although this overlaps with capacity and concerns associated with substitute decision-making, informed consent is also significant and necessitates addressing. "The ethical issues around consent to treatment in dealing with children and adolescents and their sort of legal age but their consent to treatment is a different kind of concept. Informed

consent to treatment is a different kind of concept than legal age of majority, which is sixteen under the Mental Health Act". Naturally, there might be conflicts that arise as a result of an adolescent's maturation and ensuring that they adequate understand all of the necessary information to facilitate an informed consent. One social worker discussed how this might be especially conflictual when the adolescent might not appreciate or recognize the need for intervention, particularly if there is mental health related concerns.

4.8.2 Capacity, Competency, and Substitute Decision-Making

Social workers revealed that in practice, they encounter ethical issues pertaining to patients' decision-making capacity, competency and subsequent substitute decision-making. Although the issues are somewhat related, they are also very different when the patient is a child versus an adult.

As is related to difficulties associated with informed consent, social workers reported having confronted clinical issues when the multidisciplinary team has had to rely on parental direction for medical treatment. One social worker practicing in mental health, discussed how children and adolescents are sometimes needing hospitalization against their will albeit necessitated for medical reasons:

> Kids don't often want to be here but they have a legal guardian and their legal guardian has the right to, if it's medically indicated...that the child's there then the physician will be working with the parents around the necessity of a hospitalization.... So if the youngster doesn't want to be here but the parents want them to be here and they need to be here for medical treatment, they stay as an inpatient.

However, it is the hospitalized individual that the multidisciplinary team is required to focus on in terms of treatment planning and strategizing. This can be very difficult and challenging if the child or adolescent is resistant to treatment. This social worker also shared how the antithesis can also be encountered in practice whereby the legal guardian of a mentally ill child does not recognize the need for intervention. "It's rare but it's very difficult if you've got a kid who is really sick and he's got a parent who doesn't necessarily see the importance of having him stay or doesn't want him to stay and that's really hard".

Another social worker shared a difficult case that she was involved in whereby there were ethical issues revolving around the allocation of an appropriate medical substitute decision maker for a hospitalized baby:

> Child and Family Services agencies were fighting over this baby...and nobody was really taking responsibility and the mom had a chemical dependency problem that made it impossible for her to be able to make informed medical choices for this baby.... Their little boy lived for nine months...and was deteriorating like, slowly and slowly and slowly over time and it was awful to watch. There was no family around; there was no support system around. There was nothing and he was basically there being care for by our staff. So, we involved our legal council and had a consultation with them. At the end of the day, Winnipeg Child and Family Services apprehended the baby, gave the order for the comfort care and he died the next morning.

This case exemplifies the complex ethical related situations pertaining to substitute decision-makers that may be encountered in practice.

Additionally, social workers discussed the emergence of similar ethical issues for the adult patient population as well. Due to medical illness, injury or natural aging related causes, adults may have diminished decision-making abilities. One social worker discussed the intricacies associated with assessing a person's capacity for self-determination with regards to a person's decision-making capacity:

> I find it really, really interesting when you get into ethically and capacity and a lot of those kinds of issues where maybe somebody has the capacity to make some decisions but have to be declared completely incompetent because they basically lack insight. You know, and you've exhausted all of those possibilities and then you feel that they have the capacity to deal with their finances and make some aspects of their decisions but they just...go under the Public Trustee and it's a global thing.

This social worker as well discussed a clinical situation whereby an adult patient had been deemed globally incompetent to make treatment and planning decisions because she did not have insight into her physical limitations. However, when this patient was discharged into the community, she was declared competent. "But you take out that piece that they test you on what you can do and she was declared competent again in the community.... I find a lot of that grey area of, I find it very arbitrary when people are deciding incompetencies".

It can be difficult for a social worker to maintain a focus of what it means to work in the best interest of the client when confronted by capacity and competency related issues. As described by a Geriatric/Rehabilitation program social worker:

> The biggest one, I had a lady who...had the capacity to make a lot of decisions and I had to panel her and I knew she didn't want to.... I went home lots of nights thinking that this...there was people, she's right, there were people who were physically worse off who didn't have to go to a personal care home but it was because she didn't have the insight.

Although the patient illustrated above was not competent to make her own decisions, the fact that she did have the capacity to give input, albeit limited in insight, left the social worker feeling somewhat conflicted.

Another social worker discussed the ethical issues that can arise when a person's substitute decision-makers may not be making appropriate decisions. "I don't believe that this person should still be dialyzed when she is in the state that she's in and they're continuing to do it. So I don't know what the answer is though cause the family is hanging on to it and she can't make the decision".

4.8.3 Self-Determination

All of the hospital social workers interviewed indicated that they had encountered ethical related issues in the realm of self-determination. Although patients may be competent to make their own decisions, people do make choices for themselves that conflict with the health care team's recommendations. In health care, this is referred to as non-compliance. Social workers discussed the difficulties in seeing patients make poor choices around their diet and treatment regimes. As well, they talked about how they are at times expected by the care team to convince the patient to comply with the recommendations and the difficult position that social workers may then find themselves:

> I think that's an issue that...non-compliance is an issue everywhere in my program...and some people will call me to tell these people that perhaps they shouldn't be doing this and I don't try to get into those kind of things because I feel that it's...a self-determination issue.... What am I supposed to do about it? I mean if we've informed them and if we constantly are educating people and supporting them...I'm not going to change this person from doing that...

Another social worker in the Children's Health program also discussed difficulties that some patients have with the outlined treatment regime and the experiences her patient population has with non-compliance. She too shared a case where a teenager was put on a strict diet including strict fluid restriction and that the care team had ongoing difficulties because this patient was chronically non-compliant as per the treatment plan. This created tension between the patient and various members of the team with the social worker intervening at the team level by providing an overall perspective to the reasons behind the teenager's actions.

Social workers can be conflicted between the team's expectations of changing the patient's non-compliant behavior and supporting the patient's right to making his/her own choices and self-determination. A third social worker as well discussed the difficulties she encounters around the issue of "offering transplant to people who may be seen in, what's the word I'm looking for, non-compliant".

Not only do social workers confront self-determination issues in the form of non-compliance but also when patients may make decisions that contradict team member's perception of what constitutes appropriate lifestyle choices. The Health Sciences Centre is an inner city hospital that provides care at the highest level and has a very diverse

patient population. One social worker describes how her multidisciplinary team has requested social work intervention based on what they believe to be poor lifestyle choices:

> I get...people telling me to fix somebody or some will call and say this person has a psychiatric issue. And I go downstairs and I talk to this person and I had this one guy who had run one of the seedy hotels, like for years and you know, like with brawls.... And I'm told psychiatric issues so I go down and I talk to him in physio. You know, he just makes different life choices than you or I but he is quite appropriate and this is his life experience and this is the way he chooses to live his life. I get a lot of calls to fix people and they don't like it very much when I tell them that they're not broken.

Conflicts related to patient self-determination can occur in numerous situations that social workers are involved in as is evident from the following statement:

> Yeah, there's lots of situations like that. Well, I wouldn't say lots but I can certainly think of a few. Either around treatment decisions, discharge decisions, housing decisions. These are the three areas where it's most common where I would encounter and they require a lot of communications and clarifications and exploring of motives behind those wishes on both patient's and team.

Several social workers discussed how ethical issues could emerge when patients want to discontinue life-sustaining treatment such as dialysis. Ultimately, when the patient is making a decision that differs from either the health care team and/or the family, a conflict can arise. Another social worker from the Women's Health program

discusses how conflicts associated to the issue of breast-feeding is interconnected with self-determination:

> If a patient doesn't want to continue with treatment, I feel that it should be their choice. Well I guess it does come up over at Women's. Breast-feeding or not breast-feeding. And I have gotten into a debate but a constructive discussion with the lactation consultant.... And yeah, I have dealt with that and I feel if they want to bottle feed then they can bottle feed if they're informed and if they know that it's going to cost more money and the benefits of both.

Another associated treatment and procedure related example pertains to a situation that a social worker encountered where a patient was denied the medical procedure that she was seeking. The social worker described how a 24-year-old woman was requesting a tubal ligation after her third child was born and the physician denied the request stating that the patient was too young and was concerned that the patient did not fully appreciate the overall permanency of the procedure. The social worker continued to describe how this was not an isolated event with women seeking tubal ligation:

> It's dependent on the doctor. If the doctor for whatever reason doesn't feel that they want to do it, they won't. So, do things like, you're still young. You could turn yourself around and you could want more children.... You know, again paternalistic.... I really think that respect should be given to that decision.

There are numerous factors that impact on a health care related decision thus at times creating difficulties on adhering to a patient's autonomy and self-determination.

Given the various forces that impact the decision-making process as well as the final outcome, social workers identified one of their primary social work functions was to

act as a patient advocate within the hospital system to ensure that patient autonomy and self-determination is upheld appropriately. Social workers are concerned with upholding autonomous choice and decision-making capacity. Not only is self-determination recognized as a primary concept in bioethics but also parallels fundamental social work values. This transpires into direct practice as is described by the following social worker:

> It can be difficult sometimes but I find that team members try to respect people's wishes and certainly I see my role as being such and try to advocate for the patient as much as possible...to try to meet the patient's needs as much as possible.

Another social worker reiterated this belief when she talked about how she approaches decision-making with a patient. When orienting a patient to her approach with regards to assisting in the decision-making process she stated to the patient, "it's your life and I'll support whatever decision you make".

However, it is not always feasible to be able to support all of the health care related decisions that are made by patients and/or substitute decision-makers. There are decisions that people make that may not be realistic given the available resources in conjunction with one's capabilities. A patient's expectations may exceed what is realistically accessible. Social workers value autonomy and try to support patients in their exertion of self-determination; however, social workers do confront situations whereby supporting a patient's autonomous decision is difficult because the decision is not realistic. One social worker described how she has encountered this phenomenon particularly when a patient's care needs increased to the point of having to consider long-term care placement:

> Usually what will happen is you'll have a young person who's 50, who is married and is needing to go into a personal care home and they're maxed out with home care. You know, usually their partner is still working full time because of their age and completely burnt out in terms of the amount of care that this person requires. And so here you have an individual who's refusing to go into a personal care home, a caregiver who is really having a hard time, saying to this person, I can't do this anymore. And you know, a health care team going, oh my god, what are we going to do?

Although in this situation the patient is wanting to return to his home and not consider long-term care placement as an option, realistically this is not possible due to the person's high care needs that exceed what can be provided by formal resources such as home care. As well, this person's spouse is also affected by the decision and indicating that she can no longer manage with the demands of him being within the home due to his high care needs. The social worker described that when confronted with this type of decision, she works with the person to explore realistically what the options are. This is not always an easy process and may require intensive social work intervention including grief and loss counseling as the person realizes that what is desired is no longer possible.

Another social worker also discussed the difficulties that can occur when working with an individual who may be making an inappropriate decision. This social worker described how it might be necessary for the person to act on their autonomous decision to recognize any associated limitations to that decision:

> I think there are times where physios or OT's have said, you have to allow people to fail sometimes. You have to allow them, a competent adult, they have the right

> to make that decision even if we feel it's the wrong one. I say that an awful lot even though I find myself saying, oh god, this person is going to fail. I recognize that it's their right to try that.... It's hard to allow people to fail.

This social worker also continued by describing how the philosophical foundation to the medical program limits the patient's individual autonomy and self-determination. For example:

> Rehab is a very 'you will do' kind of process. You will do, you will learn. You are going to do this today, you are going to do that today. It is goal directed. It is client centered but it's still very much, we define what it is that we think you should be accomplishing and then we go in and discuss it with them. And if they don't want to do it then we have to convince them of it.

Social workers identified feeling conflicted when working with adolescents, whose treatment and care plan are ultimately determined and consented to by their parent or guardian, yet may not be embraced by the adolescent. A social worker described how children and adolescents might not recognize or agree to the required treatment but because they are not legally at the age to give consent, the parent or guardian provides the necessary direction. It can be difficult, however, because it is the adolescent that the health care team is trying to work with. "So, on the inpatients you're dealing with those kind of situations of kids who are acting out, and you're going in there to calm down and they're telling you that they don't want to be there and you can't do this and they want to speak to a lawyer. It's tough".

4.8.4 Quality of Life

Quality of life is an ethical concept that social workers incorporate into practice by assisting patients and family what it is that they define as sufficient quality of life and is often interconnected with self-determination and decision-making process. It is important to be aware of how a patient defines quality of life for himself, as this is a very individualistic concept. A social worker described how she incorporates this into her practice by exploring with patients how they define quality of life and what this means in terms of overall lifestyle:

> I ...try to integrate this in a little bit and try to look at coping issues and adaptation issues and well how will you know it's time and talk a lot about quality of life. Especially when people are mobile because they'll say, if I have to go into a wheelchair I'll just kill myself. Well, what if you can still walk but fatigue prevents you from taking your kids to the ex? Challenging what people are thinking.

Social workers also identified how it is necessary to be conscious of one's personal belief system in terms of quality of life because this may impact when working with patients and families. One social worker described how she overtly would identify her own value beliefs in clinical practice to avoid complications:

> I make judgments on that all of the time in my practice, right, because I think that people can have great quality of life if they use certain aides and if they, they don't have to isolate themselves at home. So that's, those are my values but I really try to stay where people are at and I'm always really up front about, these are my thoughts...

As well, social workers expressed how difficult it could be to work with individuals who have a low level of quality of life and situations pertaining to quality of life are commonly encountered in health care. One social worker from the Renal program identified that she was working with "two situations...right now, of people who aren't competent who are living in personal care homes and in my opinion probably have a very, very, very low level of quality of life and the family choosing to keep going with dialysis". Another social worker discussed how difficult it is to work with the families of babies born with significant birth defects and watch them develop and live to have limited quality of life. Even though quality of life is subjective as each individual determines for herself what constitutes good or poor quality of life, social workers did have opinions on what would be considered good or bad quality of life pertaining to their patient population.

4.8.5 Boundaries

Social workers must be conscientious about professional boundaries to ensure that one practices within the professional scope of practice and to ensure that clientele appropriately understand the nature of professional relationships. Ethical issues and conflicts do occur as a result of boundary difficulties. In discussion with social workers, three main categories emerged pertaining to how boundaries are incorporated into practice and some of the accompanying difficulties those hospital social workers would encounter.

Initially, social workers identified the necessity to proactively set boundaries when developing and maintaining a clinical working relationship with patients and families. One social worker described:

> ...if I do get involved in more intimate closer kind of counseling relationship with someone and then, or group setting as well, and then I run into them on the street. I often will tell people that I wouldn't approach them unless they approach me for confidentiality reasons because I don't know who they may be walking with.

This social worker proactively discusses with patients the limitations that would occur outside of the professional setting.

A second category that emerged is conflict that occurs when there is a compromise of professional boundaries. Social workers discussed ethical conflicts that they have been prevalent in their clinical settings. One social worker described how conflicts associated with professional boundaries had occurred in her hospital area. She described a situation whereby a nurse became friends with a patient and extended invitations to have the patient's daughter visit. "A nurse befriended her and would invite her three-year-old daughter to sleep over at her home. If that isn't a clear indication of boundary problems, I don't know what else is.... They got very attached. That's a major compromise of professional...performance". This social worker talked about the concerns associated with enmeshment between staff and patients and how this might occur in a setting whereby people may be hospitalized for a long duration with staff working very closely with them. It is essential that staff recognize the need for the implementation and maintenance of appropriate professional boundaries.

As well, the third category that emerged is boundary issues associated with systemic processes. Ethical conflict related to boundaries does not only occur on an interpersonal level but can also occur at the systemic level. Social workers identified various ethical conflicts associated with systemic boundaries and processes. One issue

that was discussed by several social workers was the accessing of old patient information used for current referral and intervention requests. A social worker shared:

> I think that the boundaries are a huge issue in our, well, even in how we receive referrals from Women's.... The fact that a nurse would go back to an old chart five years ago and pull out something...and then issue a consult based on that I think is really.... I would imagine that most people who come to our organization don't expect us to pull old records and then pull that information out.

Accessing and utilizing patient information is also described in the following:

> I would imagine that clients don't really realize that if they've received, or have an encounter or care here that information comes forward all the time. Or if they've had a psychiatric admission. We've had women, and you read this chart, like the psych chart comes with them. So now they've delivered a baby and you read ten years ago their suicide note and you think, like, is that relevant at this point in time and making a judgment about the relevancy about that information.

Additionally, there was another example provided by a social worker describing how information that might have been gathered as a child will follow them into adult care and the appropriateness of this. Social workers questioned whether or not more boundaries should be imposed within the hospital system pertaining to patient information.

4.8.6 Disclosure of Patient Information

Social workers were asked in the interviews about the mechanisms by which they communicate with their teams. What became clear was the necessity of the patient's chart as a tool for multidisciplinary team communication. As one social worker indicated, "sometimes it's a matter of, do you actually have an opportunity to speak to

that person or are they available. But charts can be very helpful in that, right, just with communication".

The process of documentation was discussed during the interviews with social workers describing how documentation is recorded and within what type of chart. There was more than one example where a social worker within one program would be required to document patient information in multiple charts and files. All social workers interviewed acknowledged the significance of medical files. This is evident in the subsequent statement:

> I know that what I write down is accountable. I am accountable. I'm accountable on many levels and there's patients where this history will follow them everywhere...and so on a level of writing about a patient, or a patient's history, or that patient and their parenting...I take those things seriously.

As well, the aspect of documentation and legal accountability was discussed. "Some of the stuff that I see, it goes to court". Another social worker also referred to legal accountability of medical documentation. She spoke about when social workers:

> ...have a need to retain files for a long period of time and they keep shadow files in their office and I think that at some point you've got to let that go...that information should be in the chart. You should never have little cryptic notes on the back of your documentation or little stickies or things like that because legally, if something ever happens with that client then that would be called. All of those sticky notes and all of your impressions would be fair game in terms of a legal encounter.

Documentation is routinely incorporated into the social worker's scope of practice to record patient related information including psychosocial assessments and ongoing intervention methods and goals. Documentation challenges hospital social workers with each social worker determining for himself the most appropriate manner and location to record information. However, social workers identified questioning and struggling around determining the best way to relay recorded patient information in the most appropriate manner. One social worker summarized this by stating, "I think there are lots of questions in terms of documentation. How do we do that, what's the best way to do that? How do we make sure that that's respectful of the clients but also letting your team know what you're doing and what might impact on the care they're providing".

Social workers obtain intimate details and information about patients during their assessments and interactions. One common struggle identified by social workers is determining what information should be documented within the patient's medical file. One social worker reflected on this when she stated:

> ...how much do I tell my team? Do I tell my team, you know, this man is having an affair on his wife and you know, what do they need to know and what's confidential in terms of my service? For me the way I make my decisions around that is I try and share what is medically important for them to know.... Maybe there's depression, maybe there's anxiety, those are really important issues for them to know. But they don't need to know the dirty details about people's lives.

Another social worker reiterates this concern about determining what patient information, if any, should be kept confidential including being withheld from the multidisciplinary team. "You're expected to chart just about everything and in some situations I don't feel

comfortable to chart everything. So in that situation I would be conflicted". This social worker spoke about how she is conscientious with how she documents to be respectful to the patient as well as give the multidisciplinary team an overall idea of the situation. "I would either try to document the conversation in a way that would not expose the patient or the parties involved in a way that would be detrimental to their care".

Two social workers described how they might document patient information in a general way but then provide more detail to colleagues in a verbal manner. "So we're very vague in how we document...but we definitely talk about them". A social worker from the Adult Medicine program described apprehension associated to this type of vague documentation and acting as the information gatekeeper:

> It gives me an uneasy feeling sometimes in my stomach, like butterflies. It depends on the situation and the issue obviously right. Because I do feel responsible I guess, in a way. And what if something happens and it comes out that I've known about it and haven't communicated it to the rest of the team or even documented it and are held responsible for whatever.

It is evident from the interviews that social workers have numerous unanswered questions concerning appropriate documentation. As well, there is no consistent standard of practice for hospital social work documentation with social workers determining for themselves how to document and how much information to relay within a person's medical chart. Not only are social workers questioning appropriate documentation methods, but one social worker also felt that she was not adequately trained in documentation. "I really feel that in my own training I don't have a strong background in documentation".

4.8.7 Confidentiality

The interviews included a question asking social workers to describe any ethical issues that they had encountered within the hospital. The accompanying probe was for social workers to reflect on a case where there were conflicts regarding various ethically related topics, including confidentiality. Every hospital social worker interviewed had comments about their experiences with conflicts and difficulties associated with confidentiality.

Although efforts are made within health care to promote confidentiality, social workers identified how hospital environments can ultimately discourage confidentiality. As a social worker from the rehabilitation hospital relayed, "usually when you talk about anything about coping it's like...the curtain is drawn but if there's other people around they just don't want to hear about it. They share enough emotional and physical stuff because they just have no privacy". Another social worker in the adult medicine program also discussed how the hospital environment is not always conducive to maintaining patient confidentiality and indicated that this does impact on the way she might clinically intervene. "You go talk to a patient and close the curtain, like the patient in the next bed is not hearing it. That is something that is difficult to do and I don't really feel comfortable asking really hard open questions that I might do if we had more privacy".

Social workers struggle with issues associated with confidentiality and keeping patient information appropriately private within the hospital care team setting. Two social workers identified ethical conflicts linked to confidentiality in terms of sharing patient information with family. One social worker described how difficulties have

arisen when clinically working with a family system but directed by the patient to limit the amount of information to that family. She gave the following example:

> I had a patient this week who received news of her progression but she doesn't want to share it, the information, with certain people in her family and that becomes the confidentiality issue because then you have to remind yourself, who is your client and who am I here to serve.

A social worker from the mental health area also commented on the difficulties with maintaining confidentiality when working and interfacing with the family system. She talked specifically about the difficulties surrounding working with children and adolescents and how difficulties can arise with regards to patient information and associated confidentiality issues as is described below:

> I find with children you're always layering that with dealing with their guardian/parent and we're very mindful of what kind of parameters are around the therapy. So, we're talking to kids about the information that they share with us. Under what circumstances would it be shared with someone else and why including their parents and always negotiating around, you know, if we provide written feedback then what is the purpose of that document and who does it go to.

Although social workers value patient confidentiality, it was apparent that there are times whereby social workers will proactively break confidentiality in their provision of patient care when it is believed to be in the best interest of the client. Social workers in all different hospital areas interface with internal and external community resources. "When you think of the issue of confidentiality it's huge in terms of how we interact with

agencies outside of our organization". One social worker discussed how it is frequently necessary to proactively breach confidentiality for the best interests of her patients:

> ...I will bend the rules in terms of confidentiality when it comes to safety of individuals and as long as I can keep it in the parameters of health care. So, whether it's home care services, sometimes I just want to make sure that people are okay cause I'm worried about them. So I'll phone the home care coordinator and say, I just want to make sure this person is okay so can you keep your eye on them and that's all I'll say and they'll know what I mean. So those, I definitely break confidentiality.

While hospital social workers may at times proactively breach patient confidentiality, there are several difficulties that do arise with regards to preventing that breach of trust. Social workers are regularly required to collaborate and interface with external community resources and do have to be conscientious about what patient information is appropriate to disseminate to the agencies. One social worker described how it is difficult to interface with external organizations in achieving appropriate patient supports yet doing so without divulging too much information:

> ...we kind of struggle with that and we try to achieve balance because we've been criticized in the past. You know, the agencies that are out in the community are often frustrated with our lack of sharing of information. At best they can understand it and worst they don't and they just find us to be creating barriers.

There are times when hospital social workers are involved in a patient situation where the social worker believes that the patient would benefit from the involvement of external

organizations but legally cannot access the appropriate services due to parameters around confidentiality. One social worker identified the following situation as an example:

> If you have a pregnant woman who you know is using a chemical during her pregnancy, if she has no other children in her care, you can't, you cannot liase with any external agencies in terms of case planning or case planning for that family system until there is a live born child that falls under the mandate of the Child and Family Services Act.

Another social worker described a conflictual situation whereby she believed that it was necessary to inform a community daycare of a child's infectious disease; however, due to issues of privacy and confidentiality this action was not taken. This particular situation was discussed at length within the health care team setting and was a situation that caused the hospital social worker great anxiety and stress. She stated, "I really questioned that we were handling that ethically, in terms of the larger community issue. Although I know the concern the ID [infectious diseases] group had around privacy and confidentiality and the stigma". This case challenged the health care team to balance the responsibility between the individual patient's right to information protection versus the needs of the larger community to be informed.

The Personal Health Information Act (PHIA) is legislation that provides health care workers with a guide in terms of appropriately disseminating patient related information. Although this legislation is in place to protect patient information and guide the professional's practice, one social worker described her confusion and lack of clarity with PHIA. "I struggle with the whole PHIA bit...and I've had lots of circumstances over in Women's, whether or not I've breached PHIA and whether or not that was

ethically okay to breach PHIA with child protection. So when I think of ethical dilemmas, I think of that".

An additional dilemma associated with breaching confidentiality that was identified was when patients have pre-existing personal relationships with the staff that are involved in their care. As the Health Sciences Centre hospital provides care to various patient populations, social workers might encounter patients who are known to them outside of the professional setting. Encountering and addressing this type of situation was described by a social worker. "I've had situations where I've known that the person works in the same environment that let's say my family member works and just being aware of that. And I make the patients aware of that and reassure them that I would not share any information about their condition or anything, or even that I've met them".

Three social workers identified how ethically based conflicts relating to confidentiality arise outside of the professional setting, particularly when seeking support. "In terms of confidentiality, I think that one of the biggest things we struggle with is how to help staff be able to debrief and talk about the cases that they need to talk about and work through things without breaching confidentiality". Another social worker described how she does not adequately have the necessary supports for debriefing incorporated into her workplace environment and thus relies on her husband for debriefing. Although he may act as a support when this social worker needs to discuss work related issues, she recognized how this act does pose a conflict associated with breaching confidentiality. "I'm breaking confidentiality probably daily. And I'm struggling with that whole piece. Like, is it ethically right for me to go home and talk to

my partner about what's going on at work"? Another social worker also described the concerns associated with revealing patient information within a personal context and the necessity to be mindful of respecting patient health information. "I'm very aware...in terms of sharing my experiences at work in a more familiar parts of my life, like home and things like that. Sometimes it's hard not to talk about work at all but just making sure that you don't identify information". Ensuring that hospital social workers have access to required resources and supports for debriefing and case consultation would reduce situations whereby social workers seek out debriefing in an informal setting resulting with confidentiality conflicts.

4.8.7 Resource Allocation

The hospital social worker's role encompasses a component of interfacing with external organizations and community liaising. When discussing ethical conflicts that the hospital social workers have encountered in clinical practice, every social worker identified having experienced ethical conflict associated with resource allocation.

Social workers illustrated how they experienced conflict as a result of limited external hospital resources or inaccessible external resources that are necessary for patients' overall well-being and safety. One social worker from the Women's Health program described her feelings of inadequacy when the system is unable to assist the patient as is required but yet the patient and health care team are expecting the social worker to implement the resources and services. "I see a lot of situations like that and it's really frustrating because I feel that I'm seen by the team and the patient as someone who has the answers and the resources and am able to assist them in that way. Sometimes I just can't". A social worker from the Renal program also discussed her frustrations when

external resources are inadequate to meet the patient's needs. "You're phoning Child and Family Services and you know that this family probably won't get what they need...I could hardly handle it". A third social worker also described the difficulties with resource allocation when external organizations are inadequate. "I think the childcare services for people who have disabilities are non-existent, except for the Family Centre and you're lucky if you can get half an hour a week.... And rurally it's even scarier". A fourth social worker also described how the lack of external community resources is an issue in her area of practice. "There's not a whole lot out there and it kind of makes us look dumb. Here I'm saying, there are support workers out in the community who can help if you can't cope with your twins but there's a four to six week waiting list".

Social workers identified difficulties that occurred because external community resources have strict eligibility requirements that patients may not be able to meet. "And people falling through the cracks and not really fitting anywhere because of their financial status or age or something else". Later in the interview this social worker again referred to difficulties arising where there is strict eligibility requirements for service. "I can't just bend the rules and make people more flexible and ensure that they'll have the services that they need".

Not only do social workers encounter resource allocation complexities with external organizations and resources as conflicts were acknowledged to revolve around internal resources as well. Ethical issues associated to internal hospital resource allocation included areas of treatment options and overall patient health care related decisions. Organ transplantation is an issue commonly intertwined in ethical discussions of resource allocation. One social worker described a clinical case where she was

involved with an adolescent girl who was requiring a kidney transplant; however, had not been compliant with existing dialysis care. The medical team was resistant to pursuing the kidney transplant because they believed that if this patient were unable to maintain an adequate pre-transplant treatment regime, she would be unable to adequately sustain the post-transplant care regime. This social worker discussed the conflicting views held by the various members of the multidisciplinary team with some members opposed to proceeding with transplantation and others supporting the procedure. This was a complicated clinical dilemma that was not easily resolved and with it arose various accompanying ethical issues articulated by the social worker. "Is it ethical for us to withhold this because she's not compliant with dialysis? Is it truly about our lack of belief that she can comply to post transplant care...or is it that we are punishing her, that we want to see her tow the line"?

Another social worker also discussed resource allocation in conjunction with dialysis:

> The general sense that I get from dialysis is that they'll pretty much dialyze anyone...sometimes people think that we dialyze too many people, like an 85-year-old person who maybe should not get that intricate treatment.... You usually hear, stop dialyzing so much. I guess it's another ethical issue...

A third social worker also discussed how conflicts of resource allocation emerge when evaluating one's appropriateness for transplant:

> ...I have serious concerns about him going to transplant. And providing the service to him and him being compliant and really taking the full advantage of it and I wonder about the resources that are being used for that particular patient and

> not being available for somebody else. And I struggle with that because I don't know what the right thing to do is. And I don't want to limit people based on their social situations and supports and lifestyles and stuff like that.

Social workers also discussed how unequal access to internal hospital resources and treatments may be a result of individual health care providers making subjective decisions. Five social workers discussed how obtaining health care resources might be dependent on a particular person determining the medical treatment options. A social worker reflected this view by stating, "sometimes your treatment or your decisions or how you've been treated is all dependent on that person…their whole hospitalization is based on personality and communication…and who's the big person who is deciding it". Another social worker also identified this as a concern when she stated:

> …there have been situations where the patients have been seeking treatment and the doctors have decided not to offer…that doesn't seem to follow any rules or regulations. It's just kind of seems to be used half hazard kind of thing. Whatever the doctors feels that day, to me it sometimes feels that way.

This hospital social worker also explained how a person's medical treatment and care plan could change and be influenced if the attending physician also changes:

> Yeah, they often disagree and it often seems that whoever is attending makes the decision which is problematic. In that week one person may be attending and saying one thing to the patient and the next week somebody else may be attending and saying something very different.

Social workers discussed ethical conflicts of resource allocation at the various systemic levels. The health care system is complex and ensuring that patients have

adequate access to treatment and medical care requires a broad examination of resources internal and external to the hospital facility. One social worker discussed some of the barriers patients within her program area experience when having to relocate to Winnipeg from a rural community. This social worker also described how she believes that the health care system has a responsibility to ensure patients have access to the necessary treatments by providing the necessary resources and supports not currently inherent within the health care system. She describes:

> ...our day program prevents admission to the hospital, right? So rather than having somebody sit in the hospital at twelve hundred dollars a day, its cheaper to run a day program and that is one of the main philosophies behind the day program. So, then, maybe, does the hospital system need to look, you know, helping people coming to the city and pay for their accommodations so they can attend treatment? I think that's a big issue.

Furthermore, social workers described conflicts that emerge within the hospital as a result of limited internal social work services in particular situations. The limited social work services in the Children's Emergency department have resulted with non-social work staff having to compensate. "I think emergency, with staff, feel like they have to do everything because they haven't had...good social work support there".

Social workers within the Health Sciences Centre are allocated to particular treatment and program areas and are responsible for the provision of social work services within that area. One social worker spoke about the difficulties that new patients within her program area have with accessing social work resources due to limited resources combined with a high demand for service. "Right now I have a two month waiting list,

so if you're referred to me in the...clinic it will take you two, maybe even three months...to get in and see me.... I think it's crazy to take so long to see a social worker".

Another social worker also described conflicts coupled with the allocation of internal hospital social work resources and services. There should be no barriers for people who are wanting to access social work services; however, given the limited staff and services in some areas this can pose difficulties for patients and social workers. This social worker describes her concerns with ensuring patients have sufficient access to hospital social work resources:

> From an ethical, from a personal ethical perspective, I find it a challenge to set limits on the services that you provide...you're pushed to try to priorize, I mean priorize workloads and stuff, and I find it really hard to put a parameter on an identified client need. I haven't been able to do that I guess. If a client phones or a family member phones, I'm not sure how you would ever say you will have to go somewhere else to receive that service. You know, if people have been passed around the system or things like that, I think that the buck has to stop somewhere. So that would be my other thing that means something to me in terms of ethics is you can't really, unless you have another plan in place for a family, I think it would be ethically irresponsible just to let them fall off the face of the earth if they've reached out for assistance.

This social worker articulated the various ethical conflicts that arise when evaluating effective resource allocation of social work services. Unfortunately, hospital social workers are constantly trying to priorize provision of service within the allocated time

allotted by funding. At times social workers struggle with providing patients and families with the time required for effective assessment and intervention.

4.8.9 Personal Versus Professional

In exploring social workers' experiences with ethical conflicts, they were asked about whether or not they had faced situations where they might have been conflicted between their professional responsibility and their personal value base. Four social workers indicated that they have experienced no ethically related conflicts in this regard because they had not encountered such situations. Two of these social workers immediately identified abortion as an area where health care staff may experience conflict. Although these two social workers believed that working with women seeking abortions may bring about conflict for some staff, they did not believe that this would be an area of concern for them due to their own underlying belief system. "I haven't come across that yet.... Like, I haven't worked on the abortion ward yet or anything but I'd be fine because I'm pro-choice". As well, the second social worker indicated, "I'm pro-choice so that's not an issue for me".

Another social worker described how she had not yet encountered a clinical situation where she was conflicted between her professional responsibilities and her own personal values; however, she pointed out how she is conscientious about avoiding potential conflicts by avoiding clinical situations that are discomforting to her. She described how she is self-aware and has sought out social work positions that are compatible with her belief system. She described how she has some discomfort working with certain patient populations and limits her intervention in these areas because of her

known uneasiness. She illustrated how she has discomfort working with individuals around substance use because of her own personal experience:

> One issue actually is...had asked me to see one gentleman about alcohol counseling and I have persons within my own family who have issues with alcohol and at this point I am not in a place, I am very angry with alcohol and so I'm not in a place where I feel comfortable in talking to people about alcohol abuse. And basically I referred them on...

Two social workers gave descriptions of clinical situations that they were involved in where they did experience conflict between their professional social work role and their personal values. One social worker discussed a case that she was involved in where the gentleman that she was working with was progressively getting sicker with increasing physical limitations. This person was aware of his disease progression and possible future outcomes. When meeting with the social worker he stated that if he got considerably worse, he would proactively end his own life. The social worker reflected on her response to the patient's comments, "Normally, I would do lots of safety planning around that sort of comment and I didn't, so like, where are my values? Is that right, is that wrong? I don't know". This social worker expressed feeling torn and unsure of her own belief system in this situation and recognized that her lack of clarity with her own beliefs impacted on how she intervened with this person.

Another social worker initially stated that she had not encountered an ethically based conflict between professional expectations and personal beliefs. However, upon discussion of what constituted a possible dilemma in this area, she talked about a recent experience she had where she was expected to intervene in a situation that she did not

fully agree with. "I did disagree with it and I didn't understand it and instead I was expected to make some fast action in an afternoon basically so I didn't have time to process it.... We sort of made the decision based on policy of our...program". Ultimately, a person had presented to the Health Sciences adult emergency department requiring life-sustaining treatment. However, because the person was not a Manitoba resident, the decision was made to have him returned to British Columbia to obtain the necessary treatment. Initially, the patient did not want to return to British Columbia but yet the social worker was expected by her program to convince the patient that it was necessary and then assist in making the arrangements for his departure without receiving treatment. Essentially, the social worker experienced a personal struggle in carrying out her professional responsibilities but was able to carry out her tasks because she understood it as a necessary program policy decision.

4.8.10 End of Life Issues

Encountering end of life issues can be difficult and enriching for social workers on a personal level. Seven of the social workers interviewed discussed the end of life issues that were predominant in their hospital clinical practice. The additional three social workers stated that they provide social work service to areas whereby they do not encounter end of life issues.

Social workers were involved in the end of life care for both adults and children. "I have certainly developed a role in being present as a support to families in the dying, the actual dying process of their child.... Which is a very, very hard part of my job but an unbelievably rewarding part of my job too". As well, the social worker scope of practice is diverse when involved with end of life care. Social workers are involved in

various aspects of end of life care including providing support, counseling, engaging in the accompanying decision-making process, and educating patients and families. "I did a lot of self-teaching in terms of helping families to be able to take control of end of life decisions as they became closer".

End of life issues force social workers to intervene at an intimate level that can be challenging to one's comfort level. One social worker talked about how when she began working within a hospital setting, she had personal difficulties when encountering end of life issues. "I remember the first time I had...I had a consult of the person who was dying. They're dying and we're treating them...I probably walked by their room five times before I could go in". Although this experienced hospital social worker described feeling less discomfort when encountering end of life issues than when she initially began working in the hospital, she relayed having ongoing trepidation when encountering current end of life issues. She spoke about how she has felt uncomfortable when people proactively declined life-sustaining treatment or chose to discontinue life-sustaining treatment because her instinct is to value life at all costs. She described:

> And I think I don't have it figured out, like how, like looking at dialysis as an elective. It's not something that we have to have. Everyone can choose not to have it if they don't want to and if they don't then they're going to die... I think that's what I struggled with the most...don't choose to stop that. You have that inside you but that person has the right to choose. That's sort of been a struggle if that makes sense.

Social workers spoke about specific difficult clinical situations where they were involved in providing clinical intervention with end of life care. One social worker

reflected on how significant of a personal impact one particular case had on her. She spoke about the untimely death of an adolescent girl and it was apparent in the social worker's description that this situation was challenging. "That was really awful. That gave me nightmares.... That made me, that just haunted me to be present with those parents and the intensivist telling those parents what had happened and that they were not going to be able to bring her back".

Another social worker reflected on what she considered to be a positive experience when a patient that she was working with decided to discontinue life-sustaining treatment. This was a poignant experience for the social worker:

> One gentleman that I'll never forget the experience of it because it was how I felt that it was handled perfectly but it was because he was elderly, he was very sick, he was failure to thrive as they tend to use the word, he was not gaining weight.... He had his wife help him make that decision and his sons. We waited for his daughter to come in so they could have a family meeting then they told me they were ready...the doctor said, so you have something to tell me? And he said, yup, I'm ready to die. So it was done and that was it.

One social worker described encountering an ethically based conflict when a competent patient expressed desire to discontinue life-sustaining treatment; however, the patient's family opposed the patient's wishes. Although a competent individual can make his own medical treatment and planning decisions, end of life decisions do have significant impact on the person's family. Making decisions to continue and discontinue life-sustaining treatment often is a process involving those who would be most significantly impacted by the decision. This is evident in this social worker's statement:

> There's been a few situations...where the family doesn't want the person to stop and we've determined that the person is competent and the family doesn't want for them to stop. I find that it is a process, like the family will come around eventually.... It tends to be a process and we just keep talking about it....

Social workers indicated that although there seems to be a process established regarding decision-making around patients' end of life issues, it would also be beneficial to have increased discussion with the multidisciplinary team about personal impact and beliefs associated with end of life care. One social worker that works with chronically ill people voiced how it would be beneficial for her multidisciplinary team to discuss controversial issues such as euthanasia:

> Well I think that what our team doesn't talk about is euthanasia and how even just as a team we feel about it. Like I just think that would be a very helpful discussion. It doesn't mean that you have to support the cause, I personally believe that you have to follow the law. But that doesn't mean that we shouldn't not talk about it.

4.9 Factors Influencing Patient Experiences, Treatments, Care Plans

Social workers identified various subjective influences that could affect a patient's care. As previously discussed with resource allocation, social workers spoke about how a treatment plan may differ based on an individual health care provider's preference. "Their whole hospitalization is based on personality and communication...and who's the big person who is deciding it".

On top of that, the hospital environment was identified as impacting on the level of care that a person receives. As previously discussed, hospital environment was

identified as a concern associated with maintaining and promoting confidentiality. The hospital environment was also discussed as being undignified at times given the intimate and personal issues that people face when confronted by illness and injury. "I just think that it's a very dehumanizing place.... The bathrooms are shared, there's no private bathrooms. They're doing, they're learning how to cath and they're doing these very, very private things and it's a very dehumanizing place".

Social workers also identified the influence that a patient's demographics might have on care. Social workers acknowledged the role that values associated with ethnicity and culture might have in overall ethically based discussions. "I think as our population gets more diverse, especially, Winnipeg is becoming more diverse, that we are going to see more and more conflicts with clients". Another social worker spoke about how hospital staff must be conscientious of the influence of culture and ethnicity in the provision of good health care. "I think that people are pretty aware of not discriminating based on those issues. Like, they want to take it into account in terms of people's preferences and people's beliefs, but I think the teams are pretty aware of not to discriminate". A third social worker, however, did believe that a person's ethnicity and socio-economic status did influence patient care in terms of when social work is requesting to intervene:

> Many of my consults...because they are from poverty stricken families or first nations aboriginal families, is almost an immediate consult to social work. Whereas somebody not from that cultural group perhaps with the very same or similar background may be at risk, may not get referred to me.

4.10 Personal Impact

Hospital social workers routinely encounter complicated clinical situations and ethically related conflicts. Social workers described how these heightened situations could leave impressions. Throughout the interviews, social workers described the personal impact that working within the hospital setting has on them in varying degrees.

Social workers described how daily experiences in their clinical roles impacted them. Six social workers from different hospital areas reported incidents from daily clinical intervention that has been anxiety inducing. One social worker discussed anxiety with working with people who are dying. Her experience of discomfort was illustrated when she stated, "getting used to people dying and that kind of stuff has been definitely a struggle. It's not really a personal belief but a comfort level". She also described feeling discomfort when having to explore with a patient the fact that they can no longer return home and the need to pursue a personal care home.

Another social worker from the Women's Health program also discussed the personal impact of dealing with the high volumes of difficult situations. She spoke about how the daily intensity of the hospital setting does impact her personally and how she rationalizes her limitations:

> Sometimes it really gets to me because I've been doing this so long and there seems to be no end or no dent in the amount of volume of really high-risk worries and stuff that come.... I think I tell myself on some level, this is about all that you can do at this point, at this stage and this is all I can do at this point in time.

This social worker also described how health care staff has become desensitized to the heightened nature of clinical situations due to the frequency, volume, and quick pace

within the hospital. When asked how she copes with the personal impact and accumulated stress of working with difficult clinical situations she stated, "I guess I cope with trying to be healthy outside of here". She indicated that she consciously uses humor as a coping mechanism. "I try to make people laugh. Even if the situation is awful, I try to.... I have a bizarre sense of humor and I find that it helps and so do other people who I connect with. Pretty dark humor".

A third social worker also described the accumulation of stress and anxiety that she experiences within her clinical social work role. She described how she routinely encounters difficult clinical situations and conflict but did not initially recognize the personal impact that it was having until her spouse acknowledged.

> I've really struggled with that for a long time thinking, how could I really not be bothered by this...Like, how could I not be bothered by this? He said, you are bothered by it because you're bitchy sometimes when you come home. You're upset, like, that day I just came home and I cried, cried, cried.

She spoke about the difficulties of interfacing in difficult clinical situations. "Some of the stuff that we see here is hard. It's hard to deal with, it's hard to cope with.... You're just put in your office and you just deal with it". This was also evident from an alternate social worker's description. "It's not necessarily easy with people with devastating diseases. I mean, some days it can be a little much...how does that impact us in our work is my biggest question".

Another social worker discussed the intense anxiety that she experienced when initially starting out and adjusting to her hospital role. It can be very overwhelming for someone when initially getting orientated to the medical environment. She stated, "...it

was very overwhelming to be new...and walking on to, especially the...units and dealing with people laying in beds with tubes coming out of them and not conscious and...just laying there so vulnerable". Social work training does not adequately train and prepare individuals for clinical practice within a medical setting. This was identified as contributing to this social worker's initial anxiety. "...I think that added to the overwhelming stress that I experienced for the, I'd say for the first three weeks that I'd work here. I think I walked around with chest pains for about the first three weeks because I was so overwhelmed".

Although not as intensely experienced as the previous social worker, a sixth social worker described how her apprehension associated with her limited knowledge of hospital areas beyond her scope of practice causes her to feel dread when called upon to provide temporary coverage for others. "I know nothing about any other part of the hospital. Sometimes I just dread when...calls me to do coverage. There's a lot of times where I'm unsure so I just don't do it". Apparently, this social worker reported avoiding anxiety inducing situations by at times declining to provide social work service outside of her scope of practice.

Social workers also discussed the positive personal impact that daily clinical practice in a hospital setting has had on them. One social worker described how she recognizes that her communication skills have improved in combination with feeling more confident to address difficult clinical situations. "A year ago I would've just been beside myself but now I can do it.... It's emotional, but it's not scary like it used to be". Overall, this social worker recognized that her clinical skills and intervention techniques have improved. She stated that over time she has become more confident in her decision-

making abilities and will proactively address issues that she once avoided. As well, this social worker also described how encountering difficult clinical situations has made her more proactive in her personal life to confront health related discussions and topics with family.

In addition to the previous comments, another social worker stated that her previous encounters with ethical conflicts and overall difficult clinical situations, also resulted with a positive personal impact. "They made me more sensitive to issues and be more aware of issues and potential issues...it's definitely made me more aware and conscious of issues. To ask questions and communicate about them in advance".

Four social workers articulated the negative personal impact that they have experienced. The degree of the negative impact varied. One social worker described how she could at times be consumed by work-related situations and how this impedes on her personal life. "I hate when something has to come up on a Friday afternoon...how I was in that situation may play over in my mind. Oh, I should have said this, I should have done that". This social worker also referred to the personal impact of her previous role within the Health Sciences Centre. "...I used to wake up with night sweats. Like, all of these awful things...I remember, I would wake up in the middle of the night".

These social workers also reflected on past clinical situations including those that they identified as ethical dilemmas. One social worker described at length an ethical dilemma that occurred while in a previous role of the hospital where there was non-professional conduct by a staff member towards a patient. The patient's mother approached the social worker for guidance to address the concern. Ultimately, this social worker was proactive in providing suggestions for resolution and had approached her

superiors to discuss the implications of the non-professional behavior. The director of the clinic made it clear that he did not want the incident and ethical dilemma to become known which contradicted what the social worker believed to be the appropriate course of action. This incident left a significant negative impact on the social worker that she described as "I felt this sort of residual stuff that they talk about".

Not only did this social worker make reference to experiencing moral residue, but also provided an explicit description of what it was like for her to identify a concern as an ethical dilemma and want to openly discuss this with her team:

> It's sort of like the feeling of being abused I suppose...it's like you really feel that you're wrong and that you've made a mistake and you shouldn't talk about it...and that this has occurred but if you do something else about it, it will be your fault for making something worse happen.

By identifying the ethical dilemma and proactively seeking out resolution, this social worker was not considered a team player by some of her colleagues. "It was pretty miserable...I really feel like there was a witch hunt after that and they didn't want me there anymore because there was a couple of circumstances that have happened there and I wasn't someone to be passive". Ultimately, this event contributed to the social worker seeking out a different hospital position. Even though this event occurred years ago, it has significantly impacted the social worker and how she practices today. "I said I would never let this happen again. I'm pretty cautious about things. Like, I really try to make those distinctions about boundaries and accountability".

Another social worker from the Child Health program spoke about the resulting personal impact that occurred when she identified and questioned how an ethical issue in

her area was being addressed. "The point is that I really questioned that we were handling that ethically, in terms of the larger community.... For me it was a question and Jane Smith hasn't spoken to me since. Never, not so much as said hello to me in the hallway". Evidently, proposing an alternate perspective to an ethically charged situation resulted with the social worker having negative consequences including the breakdown of personal working relationships.

4.11 Addressing Ethical and Clinical Conflict

4.11.1 Ethics Consultation Service

The Health Sciences Centre has an ethics consultation service available whereby any person can request their involvement to provide an ethically based opinion on a situation. This is a hospital wide service that is implemented to provide staff with additional support and guidance when confronted by an ethical conflict. Social workers were asked about the most important ways to resolve ethical dilemmas in the hospital context with utilization of the hospital-based ethics consultation team presented as one of the options. Exploration of social workers' knowledge and involvement with the Health Sciences Centre's ethics committee and consultation service transpired.

Six social workers indicated that they either had no or little knowledge about the ethics consultation service. To their knowledge, these six social workers had never been involved in a case where the ethics consultation team had been involved. However, four social workers did recall being involved in clinical cases where the ethics consultation team was involved with varying opinions about their experience. Social workers reported having both positive and negative experiences emerging from their involvement with the ethics consultation service.

One social worker described how she had been involved in several cases where the ethics consultation service had been initiated. This social worker believed that the involvement of the ethics consultation service enhanced patient care and significantly assisted in the resolution of ethical conflicts. "I think it's a great service to have". She spoke of the benefits of having an internal hospital service that was somewhat removed from the team setting being able to come in and give a fresh perspective on a conflicting situation:

> Ethics I find they'll talk to you, but they take the lead for a bit, which is great, and then they'll leave and then you sort of go back in. Which is okay too and I think that is really helpful for teams sometimes to have somebody who is not...cause sometimes you get emotionally caught up in those situations and you're not sure what's right, like, what is the right way to proceed. It's nice to have somebody who is not so caught up in it.

Even though the ethics consultation team was identified by another social worker as a valuable resource, this social worker also indicated that she had suffered negative repercussions by her multidisciplinary team when she suggested the involvement of the ethics consultation service.

> I have consulted the ethics committee for a case...once that I remember. And the specialty, the folks at that specialty clinic haven't spoken to me since. That's all fine to say all this, that we have this consultation service, it's meant to be non-biased. People aren't meant to suffer repercussions...but I guess I did because they were very angry with me.

When asked why multidisciplinary teams might have resistance to consulting and requesting the involvement of the ethics consultation service, this social worker expressed the following:

> I think that bringing in an ethics consultation group in a medical health care situation brings in rightly or wrongly...the ability of the health care professionals involved, in their own minds, to come up with morally right, caring, compassionate treatment plans. It calls into question at a very basic level in people's minds that they're not doing a good job...

As well, another social worker also described how she has been involved in multidisciplinary teams where members of the team are resistant to idea of involving the ethics consultation service. "I don't know if it's a territorial kind of thing or if they feel that what's the point of going to ethics because they aren't going to tell us what to do anyway". She continued to reflect on the reasons why people might be resistant to the involvement of a formal support service to resolve ethical dilemmas. Although the ethics consultation service may not provide concrete suggestions, she believed that their involvement was still beneficial because it provides the team an opportunity and a forum to discuss pertinent issues. "It's not a matter of telling them what to do, it's a matter of having a place to talk about the dilemma and how to best try and look at options to handle it".

It can be difficult if the multidisciplinary team supports a consult requesting the involvement of the ethics service yet the primary physician guiding the patient's care opposes the request. One social worker described how an ethical dilemma arose in her area when the team was not in agreement about involving the ethics service:

> I remember last year, there was a consult to ethics and the primary pediatrician did not want it to happen. So then it becomes an ethical dilemma. Well, the pediatrician doesn't want the ethics consult, what are we going to do...because we as a team felt that most of us felt that way, it went through anyway.

Evidently, even the process of involving the ethics consultation team can evoke conflict or anxiety if multidisciplinary team members are not in agreement with the request.

4.11.2 Approaches, Supports, and Resources

Social workers were asked what skills or supports they think are required to effectively address ethical issues. As well, hospital social workers were also asked if they feel that they have the necessary skills and/or supports required to recognize and/or address ethical issues that they encounter. The hospital social workers did believe it important that social workers are at the forefront of assisting patients and families resolve ethically based clinical conflict but also recognized that one must have the underlying necessities. "I think that social workers need the skills and the tools to be able to move those issues forward and feel comfortable and supported in taking those forward". Social workers spoke about what methods and supports they have used in past clinical situations, as well, spoke about what would be beneficial during times of clinical conflict.

Interestingly, when asked what supports would be of assistance in the resolution of ethical dilemmas, one social worker indicated that she was concerned because she did not think that she would even be able to recognize an ethical dilemma if she encountered one in clinical practice. "To be honest, I don't know if I came across a dilemma whether or not I would really know…whether or not it is an ethical dilemma because I am not aware of what really an ethical dilemma would be…". Education and training was also

noted to be important in specific areas that are often intertwined with ethical conflict. "We should also be a little bit more trained, I think, in legal issues and health care because I think that there's lots of them". Increased knowledge and training focusing on ethics would provide a foundation to enhance one's abilities and confidence in identifying and examining the inevitable conflicts that arise within the hospital setting. This social worker reflects on how additional education in ethics would be of assistance to her clinical practice:

> For me it would be helpful because it would be easier to say, this is an ethical dilemma, so okay, let's think about it on those sort of terms. Maybe pull out my handbook and kind of figure out how I could solve it that way rather than thinking, god, this is really tough.

Another social worker also reflected on the need for ongoing training focusing on ethical issues. "Well, look at the child welfare system. They have frequent training, every year they have training and a lot of it is cultural and diversity and dealing with ethics and dilemmas and things that they're dealing with all of the time". A foundation of knowledge would enable social workers to actively reflect on past clinical situations and identify what has been worked for them as well as provide insight to determine proactively what types of supports and skills would facilitate future interventions.

Essentially, social workers did identify various supports and resources to aid in the resolution of ethical dilemmas. Social workers did acknowledge that there are options available to them and that there are various outlets for reconciliation. "There's definitely places to go when I feel that it's something that's severe, I feel like there's a place where, where it can be, where the family can take it, where I can take it…". Just

knowing that there are options to assist when in a bind is helpful to social workers. "But I think that when it really comes right down to something that is burning with me that isn't sitting right and doesn't pass the smell test, I find that there's a way to not keep it a secret, that there's places to go with it. So that helps".

What emerged from the interviews was the recognition of various personal attributes, skills, and knowledge that would enable one to be more effective in addressing ethical dilemmas and clinical conflict. Confidence, the ability to speak up, approachability, open-mindedness, medical knowledge, logical thinking, facilitation skills, mediation skills, and overall communication skills were identified as beneficial personal attributes that would enhance one's ability to assist in the resolution of ethical conflicts.

One social worker spoke about these various attributes. "For sure, facilitation, definitely, like to be able to conduct sort of meetings and process...definitely, communication and facilitation...mediation". She also stated, "having a general understanding of the medical situation...communication skills, approachability, confidence, ability to speak up. And competency". Another social worker viewed the ability to be aware of different values as a necessity. "Just being aware of diversity and different views and also being aware of resources because if you're not aware of different resources, how can you think of different options"? A third social worker acknowledged the importance of self-initiating and "really just trying to learn what you're working on".

As well, it was also noted that maintaining appropriate perspective on the situation is essential. "Being person centered or family centered...so the ability to not take it personal". As well, an alternate perspective was offered pertaining to underlying

philosophies. A social worker believed that it is necessary for overall better patient care to have the health care system make a shift in perspective. "I really think if we were dealing with it looking as looking at patient as the customer it would be a completely different focus. You don't treat your customers the way people are treated here".

Essentially it is important of social workers to be aware of their underlying approaches and philosophy. It is also beneficial in the resolution of ethical and clinical conflicts to be proactive in developing a strategy to address the issue. One social worker verified this when she indicated the importance of "just sitting down and coming up with a plan prior to taking action".

When confronted with a difficult case or a clinical conflict, the important role that social workers maintain by bringing in an alternate perspective on a situation is significant when involved in the resolution of ethical dilemmas. One social worker indicated how helpful it is to her multidisciplinary team to reframe a situation and look at it from a different perspective. This in itself can at times aide in defusing a conflict by offering insight. "I find that it helps staff a lot when I put it into…that frame. Like, okay, well this person is being difficult. How are they being difficult? Why do you think he is reacting that way to that"?

Seeking out opinions and assistance from those with the specialized knowledge can contribute to the resolution of clinical conflicts and difficulties. Social workers identified a plethora of resources that have been accessed to aide in the resolution of past clinical conflicts and made suggestions on what overall resources would be of assistance if confronted by a hospital based ethical dilemma. Internal and external hospital resources that were believed to be helpful in the resolution of ethical conflicts included

legal advice, patient representatives, ethics services, religious leaders, various medical specialists, employee assistance programs, critical stress management, Child and Family Services, and social work specialists. When unsure how to proceed, social workers recognize the value of other's knowledge and experience to assist in increasing one's ability to resolve conflicts. "Thankfully there's enough people around too who are, I think, informed and becoming informed and people to consult about that". Another social worker also refers to the initiative that social workers take in obtaining necessary input from other professionals when confronted with a clinical conflict. "Staff at Children's in particular, wouldn't hesitate to call and consult with one of the legal representatives or with the patient rep's office". Actively consulting with other individuals can assist with clarifying the dynamics and difficult issues that arise within an ethically based conflict.

Informally, guidance is also sought from other professional disciplines. One social worker indicated that the primary person that she seeks guidance from is a nurse within the Health Sciences Centre. "I have a friend who works on one of the medicine wards who is a nurse and I'll just say, what's your experience here cause this is totally sounds crappy to me. How do you see it"?

Social workers not only discussed the benefits of consultation with other professionals, but also recognized the vast knowledge available from the social workers within the hospital setting. It was acknowledged in the interviews that having a social work specific resource to consult might be beneficial for appropriate suggestions. "Maybe having a specific person within a department who is better versed or whatever to

address these issues and be able to consult with that person. I think that would be helpful".

Social workers recognized the value of overall support and identified the need for increasing global supports and not just at times when experiencing an ethical dilemma. Social workers profoundly spoke about the benefits of debriefing, with several social workers indicating that this is a mechanism that enhances clarity when struggling with a case. As well, this is also a method used for personal stress management. Debriefing was described as beneficial not only on a one-to-one basis but also in various forums. "And debriefing. I mean I think doing that as a, whatever that would be, either the social work department or as a team, as a multidisciplinary team approach, I don't know what". Having someone in a similar professional setting to debrief with facilitates mutual understanding of the issues. The hospital social workers identified other hospital social workers as the ideal candidates to engage in debriefing with. A social worker affirmed this in her statement:

> I certainly will verbalize my feelings to people who I feel it's safe to do that with or who I feel could maybe give me advice on where to go with something...mostly within the hospital.... I really find that, and I know that I'm not alone with this, with the work that I do and the work that social workers do here in the hospital, the stuff that we see is stuff that people on the outside don't see and don't have a clue about.

Another social worker spoke about the benefits of debriefing when confronted with an ethical situation. "Maybe if I debriefed more, that would all become clear". A third social worker also acknowledged debriefing as an important ongoing support. She

spoke about actively seeking out peers for debriefing but believed that debriefing should become more formalized into social work practice. "I think that informally we have our support systems of people that we go to when we have to debrief. I mean, we shouldn't have to seek for that. That should be there for us.... I think it should be mandatory though".

Although debriefing was identified as most helpful when done with a hospital colleague, one social worker also spoke of the benefits of debriefing with someone external to the hospital environment:

> The one thing else that I would say would be talking to a completely outside party.... Obviously, sometimes it helps to have a totally non-medical person listen to this and see if they would feel comfortable with it and what they would think or more of a debriefing so then I could maybe go with it at fresh eyes so I could help to solve the problem.

However, two social workers discussed the difficulties of debriefing with people who do not have hospital based experience. One social worker stated:

> I find that people who don't ever, don't work in social services sort of positions or have health care related experiences, their eyes tend to bug out when you tell them your experience...cause they can't relate...I find people that are in medical related fields can do that easier than someone who isn't.

If social workers seek support from a person external to the hospital environment then it must be with someone who can relate, either because of their own experiences or because of their professional background. Another social worker noted this when she said, "if it's outside the hospital then it's with people who are in similar kinds of disciplines,

disciplines to me or just someone who I have a feeling that knows instinctively what I'm talking about".

Two social workers spoke about formalized debriefing accessed through the critical incident stress management program. One of the social workers had been a participant, with her multidisciplinary team, and identified this as a useful resource. She stated that ensuring staff that this resource is available is a support in itself. "It's the most, it's the most helpful thing if that it's known that it can be accessed. Sometimes I find that the people who need it the most don't access it".

Interestingly, one social worker expressed a desire to engage in debriefing with professional colleagues but did not feel like she could adequately do this safely. "And you can't even debrief...here if you do then it's like you can't cope. It's very interesting". This social worker spoke about her desire to debrief about heightened clinical cases; however, because she felt that this was not adequately available from her social work peers, she fulfilled this need in a personal context by debriefing with her spouse. "...I need to do that because nobody else will listen. You know, so I'm breaking confidentiality probably daily". This social worker also believed that debriefing is a necessary component for social work practice. "...We're social workers and we need to talk about what is going on". Actively reflecting on a clinical case offers benefits as is described by a hospital social worker. "I can talk about what I said and what I did and be open to people commenting on that...and I think that helps me grow...".

Four social workers discussed the role of active supervision and how this may assist in providing guidance and an outlet for debriefing when involved with difficult cases and overall general daily social work practice. One social worker vocalized the

need to implement mandatory social work supervision to generate dialogue about practice-related issues and foster increased accountability to one's clinical practice:

> We provide clinical services and have absolutely no structured supervision. I think that's wrong because I think that that would offer a place to bring those issues and one as a department address them…and two, to learn better ways to address it personally…. Well, look at the child welfare system…. They have very, very, very strong supervision and that's there for them. I think they have weekly meetings with the supervisor and we might not be taking children out of homes, but we're watching people die.

She proceeded by saying:

> And how are we also accountable to the work that we're doing? Like, how do people really know what we're doing…and how we're engaging ourselves in really difficult situations. I mean, it's optional whether we talk to our director or not, it's not mandatory.

A second social worker also commented on how supervision would enhance her own ongoing clinical practice by providing validation and suggestions to improve her daily practice. "I need feedback…and someone to read my assessments and say, yes you get it or no you don't get it…. I want to have some interaction with somebody to let them know what I'm doing just in case it's not right". She did also testify that her social work manager was available to talk about clinical issues and had in the past proactively approached her manager when requiring that additional guidance.

Furthermore, a third social worker also discussed her perception of the role of formal supervision. This social worker indicated that she has not been involved with

formal social work supervision; however, would actively seek out advice from her manager if she were struggling with a clinical situation. This social worker did indicate that she would benefit more from case consultation with peer social workers than consultation with a manager. A fourth social worker also stated that she recognizes the available knowledge and guidance that her discipline director could offer; however, had never felt that she needed this support in the past. She did note that she would feel comfortable in approaching her social work discipline director if she encountered a clinical difficulty or ethical dilemma in the future and required additional support. Supervision is helpful but perhaps it may be more valuable to explore clinical issues with someone working within a similar clinically based area.

All of the social workers interviewed indicated that peer support from their hospital social work colleagues is a valuable resource for overall collaboration, encouragement, and insight when faced with a difficult clinical situation. The Health Sciences Centre's social workers have an accumulation of existing body of knowledge. One social worker referred to the valuable resources in colleagues when she stated, "I can't imagine not too many situations coming up that haven't come up before. Like not many times where it's like, wow I've never heard of that before. So people can relate".

When faced with difficult clinical situations and ethical conflicts, social workers have found it valuable to informally consult with their professional colleagues. "I think that informally we have our support systems of people that we go to when we have to debrief". Further, a different social worker spoke about the guidance that she obtains from her social work colleagues. "I do have very good colleagues to call on to ask their opinions. Having someone who has good clinical skills and know the system

knowledge...". Informal settings, like the lunchroom, were also referred to by social workers as an opportunity to informally discuss difficult situations and obtain advice.

To reach out for support and initiate contact with other social workers can be difficult if there is limited pre-established relationships. One social worker discussed the difficulties that she had with having to seek out informal peer consultation when she initially began working within Health Sciences Centre. She recognized that social workers were knowledgeable and a good source of information but because social workers are often physically isolated from one another within the hospital and have limited opportunities to see one another, it was intimidating for this social worker to approach someone that she did not know nor have a relationship with:

> I think it was nice knowing you guys were out there but again you guys weren't in my little office so again it was kind of intimidating to contact you.... I mean, informally that support was there too but because of the spreadness, spread out everywhere and that makes a difference".

Another social worker discussed being resistant to seeking out informal support, not because she did not have established relationships, but because she described feeling inadequate for requiring the support and guidance in the first place. "I might not have sought it out either as I say, because you think that you should know this stuff".

Though social workers actively take the initiative to request support and guidance from individual social work colleagues, an overall awareness of how clinical situations are addressed within the hospital is not established. A social worker reviewed her lack of knowledge pertaining to the overall interventions utilized by professional colleagues:

> What are social workers doing here? How are we dealing with all these difficult situations, I don't really know. I mean, I don't know how my colleagues deal with all of these situations. I know how some of them deal with them but not all of them, or if they deal with them at all.

Though social workers routinely approach their professional colleagues when requiring additional support and guidance, a more formal venue to address complicated psychosocial issues and situations would be advantageous. Social workers spoke about the benefits of having regular cases and issues forum where social workers could regularly come together, not just at times of clinical conflict. The following segment evolved from a social worker's discussion regarding the benefits of having ongoing case consultation in a cases and issues forum:

> I think it would be a very good learning opportunity for many people and just kind of sharing of different kind of information of what worked and didn't work in certain situations, you know. Cause why reinvent the wheel if you have something that is really helpful, why not share it?

Another social worker also described the benefits that would be inherent in having a forum to regularly discuss psychosocial cases and issues:

> …It probably would be very interesting to hear what other people say cause I think that I'm still developing all these thoughts with how to do it and how not to do it…so it would be interesting to hear what other people say. I think, how they look at things differently.

Two social workers spoke about how the social workers within the Child Health program used to meet on a regular basis to discuss clinically oriented issues; however,

this no longer occurs due to time constraints. Both social workers identified this forum as a beneficial mechanism to gain support, suggestions, and education.

> We had a thing there at children's for a while, this has gone by the wayside, but we did this lunch and learn thing…where people came together to talk about challenges like families and cases and stuff like that to sort of brainstorm about how to try and figure a different way that you might approach this issue or working with that team….

Upon reflection of these meetings, a social worker depicted some of the topic issues that were discussed. "Like we did one on attachment and talking about how to use attachment interventions or theory when assessing parental relationships with their children…we did one on working with families with complex kids". Regular meetings to discuss cases and issues can be valuable to review social work interventions, techniques, and skills that are specific to working within the hospital setting. Establishing regular formalized psychosocial discussions was expressed as a desire of the social work staff. "I think that would be very good. Weekly meetings. Bi-weekly meetings about different things, cases and issues".

Several professionally oriented resources were identified by social workers as a possible resource or outlet for the provision of support, education and guidance in the resolution of ethical dilemmas. A social worker conversed about the benefits of incorporating professional social work tools and intervention techniques into practice. She believed that by establishing a more empirically oriented clinical practice, this might prevent some conflicts as well as provide underlying guidance when conflict arises. She spoke about the benefits of "scales and more empirical and better assessment tools, I

guess. And I think that there can be a very good tool that's something that I can refer to that has some empirical meat to it. It's not just up in the air".

A different social worker spoke about the need for social workers to approach these issues as a professional body. She identified the Social Workers in Health Network as one possible professional group. "It would be nice if we had more of, maybe through the Health Network, know sort of different ways to handle those issues as a collective and have a voice, as well as individually".

A third professionally based resource that was identified as a possible tool when confronting ethical issues is the social work code of ethics. Although no social worker had identified the social work code of ethics as a tool to aide in the resolution of any past clinical conflict that they had been involved in, two social workers believed that the code of ethics could be used as a helpful guide. "I think definitely knowing, remembering your code of ethics an following that guideline…".

Additionally, having a general understanding of the hospital organizational structure and policies can provide social workers with a sound foundation of knowledge. One social worker spoke about the importance of being aware of the underlying policies as this can be used to guide practice and assist in the resolution of conflict. She stated:

> …being guided by the policy of where you work. And if you don't necessarily know the details of a certain policy, going to your supervisor or somebody who knows the policy really well. I think that is very important to know and helps you know what your limits are too to providing service and knowing what's within your right to do and not do. It helps you make those hard, you know it relieves you from having to make some hard decisions sometimes.

Chapter 5

DISCUSSION

In the exploration of hospital social workers' experiences with ethics and ethical decision-making, a plethora of information was obtained. One goal of this research study was to explore hospital social workers' knowledge base regarding ethics. Interestingly, not all of the social workers initially recognized that they had ethically related knowledge and experience in the resolution of these complex issues. However, the majority of the participants did describe their experiences using language and terms inherent to ethics and ethical decision-making. It seems that social workers that had participated in ethics oriented education and training had incorporated the appropriate ethics related language and ability to readily identify ethical issues.

All of the social workers interviewed had encountered ethical issues and dilemmas in their clinical practice within the hospital setting with most social workers indicating that ethical issues are frequently confronted within this type of health care setting. Participants described encountering a wide range of ethical dilemmas in direct and indirect practice. Social workers reported encountering ethical dilemmas in clinical practice related to communication and decision-making processes, client decision making abilities, self-determination and patient autonomy, boundaries, disclosure of patient information, confidentiality, resource allocation, personal values conflicting with professional responsibilities, end of life issues, and paternalism. The types of ethical issues encountered by social workers were consistent with those outlined by Reamer (1999). Participants discussed their involvement in confronting various ethical issues associated with the above categories. Although most participants readily described

situations in which they perceived there to have been an ethical issue, some social workers were unsure that they had encountered an ethical issue until they were either prompted by one of the above categories or the category was explained to them.

Exploring the types of ethical issues encountered in social work clinical practice and whether social workers recognize clinical ethical issues in practice is encouraged by the established theoretical framework developed by Jansson & Dodd (1998). Jansson & Dodd (1998) described this knowledge obtained in research as "Ethical Deliberations and Outcomes" and proposed that emerging data of this type will assist in the preparation of social workers for practice by alerting them to the possible ethical issues that may be confronted. A significant amount of data emerged pertaining to this particular category.

Social workers did not only identify the encountered ethical issue but also spoke in depth about some of the associated influencing characteristics. As illustrated by Jansson & Dodd (1998), "Contextual Features" includes information about the clinical practice environment as well as the micro, meso, and macro level forces that influence the environment. Examples of these contextual features that participants described as influences include time, fiscal realities, organizational factors, and external mandates. Exploration of these contextual factors was necessary in order to identify the factors that shaped the process of ethical deliberations, the choices that were made and eventual outcomes to the clinical situation.

As well, some of the participants spoke about the process of ethical deliberations, the decision-making process, and the consequences associated with their course of action in an attempt to resolve the ethical conflict. This type of data that emerged is considered "Ethical Outcomes" within the framework developed by Jansson & Dodd (1998). If all

of the participants had an underlying foundation of ethics education and training, it would facilitate exploration of the three different areas outlined by Jansson & Dodd (1998). Ethics education would provide a common language as well as the skills to be able to actively identify ethical issues and thus actively reflect on the associated influences and decision-making processes. Some social workers with limited hospital experience and ethics specific education had more difficulties in identifying more of the meso and macro level contextual forces as well as the active processes and outcomes that occurred during the resolution of ethical conflict.

Social workers described mechanisms used in the resolution of past ethical conflicts as well as discussed the strategies that they might use in the future when ethical issues arise. This sample described social work's contribution to addressing ethical issues and participating in ethical decision-making with the hospital setting. This included providing an alternate ecological perspective to a clinical situation, particularly by giving a situation contextual meaning and explanation. This is consistent with the study by Landau (2000) whereby he cited that the person-in-environment perspective was one of the attributes of social work that contributes the most to ethical decision-making within a hospital setting. The participants also believed that their underlying communication skills combined with the roles that they held on their multidisciplinary teams enabled them to actively participate in ethical decision-making.

Social workers did provide insight into the various supports and mechanisms used to assist in addressing ethical issues and difficult clinical situations. The participants described the importance of maintaining good working relationships with colleagues including effective reciprocal communication amongst the multidisciplinary team

members to provide a strong foundation for overall sound ethical decision-making processes and also to facilitate the resolution of difficulties when they do arise.

The social work profession's Code of Ethics was scarcely cited in these interviews other than a few comments about participants reviewing the Code of Ethics within university education and a few social workers that have on occasion reviewed the Code of Ethics. Participants recognized that the social work profession is guided by underlying ethical principles outlined in social work's Code of Ethics. However, as is consistent with the study by Holland & Kilpatrick (1991), participants generally did not offer the professional Code of Ethics as a resource for assisting to deal with complex clinical and ethical issues. As well, few social workers identified the social work Code of Ethics as a tool for addressing any future complex issues that may arise.

During many of the interviews, I was struck by the level of stress that participants described to me and the significant personal impact that their clinical work has had on them. The personal impact associated with addressing ethical issues is not only restricted to social workers but affects various health care professionals, as per the study by Hamric (2000). Hamric (2000) described how moral distress was a powerful factor in critical care nurses' decisions about continuing on in their position whereby 13% of the nurses within the sample had left nursing positions because of moral distress. Interestingly, one social work participant had reported leaving a position with moral distress cited as one of the significant reasons. Therefore, this study is comparable to Hamric's (2000) report whereby 10% of the social work sample had left a position due to moral distress that arose from difficulties associated with the resolution of an ethical issue.

Participants described past clinical situations that evoked a heightened state of anxiety and stress. The social workers had reported experiences that resulted in a residual stress state and two had even articulated their experiences as inducing moral distress. It is important that social workers along with all health care professionals maintain a sense of personal well being in order to ensure that they can provide competent assistance and interventions with others.

Ensuring that social workers are aware of their role and the various strategies with which they can intervene combined with having existing clinical supports and accessible consultation with colleagues is essential to empower social workers to their fullest capabilities. Participants indicated that having access to necessary supports, resources, and accessible clinician expertise was also inherently important not only to the resolution of ethical conflicts but also to overall good clinical social work practice and ethical decision-making. Supports for social workers for ongoing case consultation and collaboration particularly during times when confronting a difficult clinical situation is imperative for the overall personal well being of the social worker. This is important because "the issue of powerlessness surfaces repeatedly in the literature as both a central cause and key element of moral distress"(Hamric, 2000, 200). Along with ongoing support, adequate training and education may diminish the experience of moral distress in social workers who may be compelled to participate in a decision-making process or formulate a conclusion that they do not feel is appropriate.

Chapter 6

RECOMMENDATIONS

There are numerous recommendations that arise from this study. It is clearly evident from the research that ethical issues are frequently confronted in all hospital areas. Health care staff would benefit from an underlying knowledge base on ethics and ethical decision-making. As well, it is apparent from this study that social workers would benefit from forums to discuss ethical issues that arise in clinical practice as well as learn from peers regarding possible solutions to difficult situations. Increasing overall support for social workers is essential to prevent and reduce the experiences of stress, anxiety, and moral distress that may accumulate when confronted with an ethical situation in practice.

6.1 University Education

The first recommendation pertains to social work university education. Hospital social workers require an educational foundation to prepare them for complex work environments and skills to effectively and confidently interact within a multidisciplinary setting. Incorporating a university social work curriculum into existing health classes that encourages the development of social work skills transferable to doing effective psychosocial assessments and intervention within a hospital and health care setting is required. Educators are also advised to make certain that courses will promote social work ethics understanding and skill, and to provide opportunities for students to expand and challenge their ethics knowledge. The inclusion of more comprehensive ethics education with the social work university programs is indicated by this research.

6.2 Organizational Supports

The second recommendation pertains to organizational education. The inclusion of a more comprehensive orientation process for new social work staff as well as staff moving into different care areas is necessary. Developing a more enriched orientation process for social work staff new to the hospital setting is strongly indicated by this research.

The establishment of a social work mentor program is recommended to be incorporated into the hospital social work's orientation process. Social work staff new to the hospital setting would benefit from being paired up with a senior social worker to aide in the orientation process as well as establishing relationships and providing necessary support. The new social worker and the senior mentor could contract to meet one time per week for the initial six months to ensure opportunity for the new staff person to ask questions, review clinical issues, and debrief as necessary.

Additionally, ongoing training sessions for hospital social workers is encouraged with focus on the various components to overall clinical skills required for the hospital setting as well as ethics related training. Optimally, clinical skills and ethics oriented training will be tailored for social workers.

It is also recommended that where ethics oriented education and training exists, social work staff be encouraged to attend. This includes in-hospital opportunities such as speakers and presentations. All hospital-based social workers would benefit from attending the Health Sciences Centre's ethics education course and should be supported by management in doing so.

It is recommended that regular social work psychosocial cases and issues rounds be established whereby social workers can meet on a regular basis to discuss clinical issues or topics. This would provide a forum with social work colleagues to brainstorm and share around ethical and clinical issues as well as an opportunity to obtain necessary peer support.

6.3 Social Work Role

It is important that the social work role is well defined. It is recommended that appropriate social work indicators be used within all areas of the hospital setting with indicators dispensed to the various departments. Indicators need to be current with an underlying consistent social work approach, although, the specific needs of the varying hospital areas need to also be represented.

As Health Sciences Centre is a teaching facility, it is recommended that social work be incorporated into the training curriculum and orientation process of the various multidisciplinary disciplines to provide an overview of social work's scope of practice. This could be done in small information sessions or in a one on one session as necessary.

Naturally, it is also essential that the Health Sciences Centre's social workers actively contribute to the social work university programs and foster relationships with the faculty. The existing hospital social workers are recommended to be active with the University of Manitoba social work program by contributing to the social work curriculum and training. This will enhance the knowledge and skill base of social workers that will be pursuing careers in health care.

6.4 Research

Further research focusing on social work and ethics is necessary. Further research could delve deeper into the various areas associated to ethics including ethical deliberations and outcomes, contextual factors, and ethical outcomes. It is necessary that social work become more present in the literature focusing on ethical and overall health related issues.

6.5 Summary

Ethical issues and the process of ethical decision-making is a common occurrence and frequently encountered within all areas of the hospital setting. Social work has an underlying ethical foundation with hospital social workers involved in the identification and addressing of ethical issues along with the multidisciplinary patient care team. The social work profession can enhance the process of ethical-decision making that occurs within a hospital setting by presenting a broader contextual understanding to the situation.

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Appendix A

JOINT-FACULTY RESEARCH ETHICS BOARD APPROVAL CERTIFICATE

19 May 2004

TO: **Rachelle Ashcroft**
(Advisor D. Bracken)
Principal Investigator

FROM: **Karen Duncan, Interim Chair**
Joint-Faculty Research Ethics Board (JFREB)

Re: **Protocol #J2004:080**
"Hospital Social Workers: Experiences with Ethics and Ethical Decision Making"

Please be advised that your above-referenced protocol has received human ethics approval by the **Joint-Faculty Research Ethics Board**, which is organized and operates according to the Tri-Council Policy Statement. This approval is valid for one year only.

Any significant changes of the protocol and/or informed consent form should be reported to the Human Ethics Secretariat in advance of implementation of such changes.

Please note that, if you have received multi-year funding for this research, responsibility lies with you to apply for and obtain Renewal Approval at the expiry of the initial one-year approval; otherwise the account will be locked.

Appendix B

RESEARCH PARTICIPANT CONSENT FORM

Title: Hospital Social Workers: Experiences with Ethics and Ethical Decision Making

Researcher: Rachelle Ashcroft

This consent form is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more information about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

You have agreed to participate in a study about hospital social workers' experience with ethics and ethical decision-making. This study was developed to explore the experiences of hospital social workers as it pertains to ethics. If you decide to participate, you will be asked a series of questions that will explore your knowledge, experiences, and opinions in areas relating to ethics. Your participation is voluntary and you may at any time choose not to answer any of the researcher's questions. You can refrain from answering any question you would rather omit and will able to withdraw from the study at anytime without consequence.

Your participation will not be revealed to anyone, including Health Sciences Centre, so that your privacy will be respected. If you decide to participate, any information that could identify you will be changed or will not appear in the study. All information that you reveal will be stored in a locked drawer off of the Health Sciences Centre's premises and will be destroyed after the study is complete. Despite assurances of confidentiality, an informed reader may be able to identify some of the participants in the study.

You will be asked if the interview can be tape-recorded and if the researcher can take notes. It is hoped that the information to be covered will be completed in only one visit taking no longer than two hours. The outcome of the study will be made available to you and will also be on display at the University of Manitoba.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researcher from her legal and professional responsibilities. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation. The researcher is Master of Social Work student Rachelle Ashcroft who can be reached at . Her thesis advisor, Denis Bracken can be reached at 474-9264. This research will allow the researcher to complete her thesis.

This research has been approved by the University of Manitoba Research Ethics Board. If you have any concerns or complaints about this project you may contact any of the above named persons or the Human Ethics Secretariat at 474-7122, or e-mail

. A copy of this consent form has been given to you to keep for your records and reference.

I have read the above information and agree to participate in the study exploring my experiences as a hospital social worker as it relates to ethical issues. My confidentiality will be respected and I can withdraw from the study at anytime.

_____ _____

Signature of Participant Date

_____ _____

Signature of Researcher Date

Appendix C

INTERVIEW QUESTION GUIDE:

Possible interview questions:
Please note that these questions are optional:

1. Please indicate your age category:
   20-29, 30-39, 40-49, 50-59, 60+
2. Please describe your educational background, particularly education that is relevant to your current position.
   Probe: BSW, MSW, PHD, other degree(s)?
3. How many years have you been employed as a hospital social worker?
   Probe: Current position, other Health Sciences Centre's social work positions, other hospital settings.
4. Tell me about your role in the hospital and your area of practice.
   Probe: What does a social worker in your area do on a daily basis?
5. Tell me about your understanding of ethics.
   Probe: What comes to mind when you hear the word ethics?
   Probe: How would you define ethics?
   Probe: Are there any words you associate with ethics?
   Probe: Are there any situational events that come to your mind when you think of ethics?
6. Where did you acquire most of your knowledge about ethics?
   Probe: Formal education, workshops, reading, life experiences, direct work experiences, etc.
7. What is your knowledge and/or use of social worker ethical guidelines?
   Probe: ie. CASW Code of Ethics, NASW Code of Ethics.
8. Describe any ethical issues that you have encountered within your role as a hospital social worker.
   Probe: Have you ever been involved in a case where there were conflicts regarding confidentiality, self-determination (when patient/client wants is different than the care team), professional boundaries, conflicts of interest, professional vs. personal values, resource allocation? Please explain.
   Probe: Have you ever felt that the 'right' thing to do in a situation is different than what you've been expected to do in your social work role? Please explain.
9. What has been your involvement in the resolution of ethical issues in the hospital environment?
   Probe: Discussions with care team, formal assessment regarding the presented issue, consultation, mediation, actively participating in decision-making process for resolution, ethics committee participation, etc.
10. How has your experiences with ethical issues shaped your clinical practice?
    Probe: Do you feel more/less competent in identifying or addressing ethical issues now than five years ago? Please explain.
    Probe: Have you become more active/more reluctant in addressing ethical issues because of your clinical experiences?

11. What do you think are the most important ways to resolve ethical dilemmas within the hospital context?
    Probe: Multi-disciplinary team discussions, ethics committee, social work/physician/nurse led decision, formal patient representative involvement, lawyer, etc.? Please explain.
12. What skills or supports do you think are required to effectively address ethical issues?
    Probe: Facilitation, mediation, negotiation, medical knowledge, clinical supervision, debriefing, etc. Please explain.
13. Do you feel that you have the necessary skills and/or supports required to recognize and/or address ethical issues that you encounter?
    Probe: Education, time, professional support, clinical support, debriefing, training, etc. Please explain.
14. Is there anything you would like to ask me and/or additional comments you would like to make?