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Ethical Dilemmas in Acute Care Geriatric Discharge:

An Exploratory Study

by

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With impeccable logic—once certain basic assumptions are granted—and with graceful prose, the ethicist develops his arguments.... Yet his precepts are essentially the product of armchair exercise and remain abstract and idealistic until they have been tested in the laboratory of experience.

F. J. Ingelfinger

## **ABSTRACT**

This exploratory study investigated how social worker discharge planners in Calgary's acute health care settings experience and deal with ethical dilemmas in their work with senior clients. It involved a purposive sample of six social workers with significant experience in acute care geriatric discharge planning in the Calgary Region. Each participant reviewed three fictional case studies and prepared a discharge plan for the client in each case. In semi-structured, open-ended interviews, discussion of the discharge plans initiated a discussion of ethical dilemmas encountered in real discharge planning situations.

The major dilemmas encountered by these professionals arose from two sources: (1) constraints imposed by the health care system; and (2) the commitment to the social work value of client self-determination. All of the participants showed a tremendous recognition of their ethical obligations but faced numerous challenges in meeting them, and developed various strategies to ease their ethical discomfort.



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One's family is always behind a time-consuming project like this. My mother and sisters probably don't know how their pride in me drives me to achieve. Finally, my husband—for all the dinners, the dishes, the "us" time sacrificed, the cheerleading—deserves an honorary degree in partnership.

## **DEDICATION**

To all loving families, who,  
like mine,  
only want the best for their members,  
and to the social workers who battle the odds  
to help them achieve that end.

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## LIST OF TERMS AND ABBREVIATIONS

**Beneficence** A moral obligation to act for the benefit of others. This entails both abstaining from harming clients and contributing to their welfare (Beauchamp & Childress, 1994).

**Calgary Region** That area of southern Alberta administered by the former Calgary Regional Health Authority.

**CASW** Canadian Association of Social Workers

**Community-based services** Services provided to persons living in the community to help them maintain or regain a maximum degree of autonomy and independence by addressing their physical, mental, or social needs.

**CRHA** Calgary Regional Health Authority (changed in 2001 to the Calgary Health Region, but referred to throughout by the former, which was the name of the body at the time of this study)

**Discharge planning** A systematic, organized, and centralized approach to providing continuity of care from the time a client is admitted to a health care facility through return to the community, or an interdisciplinary hospital-wide process that should be available to aid clients and families in developing a viable post-hospital plan of care. The focus is on continuity of care.

**Ethical dilemma** Ethical dilemmas arise where ethical reasons both for and against a particular course of action are present and one option must be selected.

**Ethical discomfort/ethical distress** Ethical distress occurs when health care professionals experience the imposition of practices that provoke feelings of guilt, concern, or distaste.



**Frail elderly** A term from social gerontology that refers solely to physical health status or function. Used to describe a person who has a number or certain type of chronic illnesses as measured by a variety of formal scales. Persons who are frail may require long-term care, either at home or in a specialized setting such as a nursing home (Rubinstein et al., 1992).

**Geriatric** Relating to persons over the age of sixty-five.

**Informal caregiving** Unpaid care provided by family, friends, and volunteers.

**NACA** National Advisory Council on Aging

**Senior** A person over the age of sixty-five

## **CHAPTER ONE:**

### **CONTEXT OF THE STUDY**

#### **INTRODUCTION**

The primary purpose of this exploratory study was to extend and refine the understanding of how social workers working as discharge planners in acute health care settings in the Calgary Region experience and deal with ethical dilemmas in their work with senior clients. A secondary purpose was to provide a foundation for the subsequent development of resources for dealing with these ethical dilemmas. As the majority of clients being discharged from acute care are over the age of sixty-five, this study addresses specific issues concerning this age group.

The research questions were:

- How do social workers in acute care discharge planning roles experience and deal with ethical dilemmas in their work with senior clients? and
- What contributions or changes, if any, could be made to social work education, ethical codes, or practice guidelines to increase the ethical comfort of social workers planning the discharge of senior clients at risk?

This qualitative study comprised two phases. The first phase involved providing a small sample of social work discharge planners with three fictional case studies and asking each to formulate a discharge plan for each of the clients. The second phase involved conducting a semi-structured, open-ended interview with each participant to: determine how each participant went about planning for the discharge of the client in each case study; engage each participant in a discussion of ethical dilemmas encountered

in discharge planning with the case studies and in their work; and elicit suggestions from each participant for changes in social work education, ethical codes, and practice guidelines to increase ethical comfort around discharge planning with senior clients.

## BACKGROUND

The focus of this study is the ethical challenges encountered by social workers working as discharge planners within the acute health care segment of the Calgary Regional Health Authority (CRHA)—now known as the Calgary Health Region—health care continuum. Discharge planning has consistently been recognized as a vital task within acute care environments, and it has gained in importance with increasing pressures to reduce operating costs. At the time of this study, discharge planning was almost exclusively within the mandate of the social worker on the multidisciplinary team, and made up a significant percentage of the work of this professional. Effective discharge planning is not one discrete intervention based upon a particular theory or model of practice. Instead, it is a complex collection of interventions that calls upon the gamut of a social worker's knowledge, skills, and values. Particularly in the context of the current health care system, it is also a process fraught with practical, political, and ethical issues.

### *The Calgary Regional Health Care System*

The body formerly known as the Calgary Regional Health Authority—the now Calgary Health Region—comprises a variety of services with the goal of providing continuous, integrated health care between its four acute care (hospital) sites and long-term care institutions or care in the community (home care, supportive living, clinical support services, specialized geriatric services, palliative care, and the seniors' health

program). This system is supplemented by two rehabilitation and recovery care units established to provide a bridge between the high-needs care provided in hospitals and the variety of community-based care services that do not require hospital beds (Calgary Regional Health Authority, 2001).

Hospitals are the most expensive part of the health care system (Foot, 1998). When health care reforms began focussing on curtailing hospital costs, any activity that contributed to this end was implemented. Limits were placed on the number of hospital beds, on the length of hospital stays, and on subsequent hospital readmissions. Hospital social work departments changed their focus from providing psychosocial support to the more “critical” institutional concerns of arranging for client transportation services, making referrals to community agencies, and planning client discharges (Andrews, 1986; Barker, Williams, Simmer, VanVuren, Vincent, & Pickrel, 1985).

Concomitant with these changes, the provincial government began to extol the virtues of community care. According to the National Advisory Council on Aging (NACA) (1995), “Community-based services are services which are provided to persons living in the community to help individuals maintain or regain a maximum degree of autonomy and independence by addressing their physical, mental or social needs” (p. 9). Hypothetically, says the Council, community-based services should be less costly substitutes for hospitalization and long-term institutional care, a more appropriate response to the chronic disabilities experienced by many seniors, and, most importantly, respectful of the wish of most seniors to age at home, or to “age in place” as long as possible.

While Alberta's Coordinated Home Care Program was introduced in the 1970s to provide both health care and support services to Albertans living at home, and while home care services have increased, "the need to serve people who have been discharged from hospital has put pressure on the amount of home care available for people with longer term, chronic health needs," of whom seniors make up the majority (Alberta Health and Wellness, 1999c, p. 47). Thus, informal caregiving—unpaid care provided by family, friends, and volunteers—became and remains the real cornerstone of community-based care. An increasing stress falls on this informal network to provide for highly complex chronic and acute post-hospital care needs (Armstrong & Armstrong, 1996; Blazyk, Wimberley, & Crawford, 1987; Chappell, 1999).

### *Discharge Planning*

According to an early definition, hospital discharge planning is "a centralized coordinated program to ensure that each patient has a planned program of continuing care and/or follow-up which meets his/her post-discharge needs" (Department of Health, Education, and Welfare, 1974, p. 4). Subsequent to this, Shulman and Tuzman (1980) stated "discharge planning is a systematic, organized, and centralized approach to providing continuity of care from the time a patient is admitted to a health care facility through return to the community" (p. 3). The American Hospital Association (1984) cites an alternate, but equally valid, definition of discharge planning as "...an interdisciplinary hospital-wide process that should be available to aid patients and their families in developing a viable post-hospital plan of care" (p. 1). A more recent definition was put forward by Feather (1993): "Hospital discharge planning is the process of assessing the

needs of hospitalized patients for post-acute care and developing a coordinated plan to provide the care needed” (p. 1). Another by Anderson and Helms (1993) reads, “Discharge planning is a process of identifying continuing patient needs and coordinating care with appropriate service providers at the next level of the health care delivery system” (p. 41). Regardless of the definition used, the foundational principle behind discharge planning is continuity of care.

#### Discharge Planning in Today’s Health Care System

Ideally, discharge planning should be the key to ensuring that all the appropriate supports are established to allow the elderly client to return home (Oktay, Steinwachs, & Mamon, 1992). Increasing technology and a climate of medical discovery have led to anticipation of high-quality medical care in hospitals and its continuation in the community.

Yet one of the most frustrating problems for clients, families, and social workers is the lack of continuity in services for hospitalized older adults who are discharged and return to community living. Unfortunately, community-based services for elderly people are highly fragmented, inadequate, and inaccessible in many areas. When families, the major providers of care, are unavailable, large numbers of elderly people with limitations in activities of daily living continue to go without the help they need (Oktay et al., 1992). Frequently this lack of continuity contributes to an older adult’s poor readjustment to community living, which may culminate in the client being readmitted to a hospital or admitted to a long-term care facility (Hubbard, Santos, & Wiora, 1978).

The current health care environment is far from ideal. Shamefully, little has changed since Cannon (1913) warned that leaving hospital care too soon or without convalescent plans risked “grievous results of an incomplete recovery” (n.p.), or since Bartlett (1957) reported that referrals to the social work department consisted “largely of requests to arrange removal from the hospital” (n.p.). As well, a statement of Shulman and Tuzman (1980) twenty years ago still rings true today: “...unfortunately, many political, economic, and social factors are frustrating social workers’ efforts in providing a professional level of discharge planning” (p. 3). The emphasis on expedient processing of clients continues to mean that elderly clients are discharged from hospitals “quicker and sicker”; in other words, with more numerous and complex needs for post-hospital care (Clemens, 1995; Meiners & Coffey, 1985; Reamer, 1985). As noted by writers in the late 1980s, “the emphasis of discharge planning appears to be more on meeting hospital administrative demands to facilitate speedy discharge than on providing comprehensive care for patients after leaving the hospital” (Wolock, Schlesinger, Dinerman, and Seaton, 1987, p. 71).

### The Clients

Statistically speaking, elderly persons in the hospital system constitute a prime target for cost cutting through efficient discharge planning. Reliance on hospitals increases sharply for individuals in their mid-fifties. By their late seventies, people use hospitals five times more than their lifetime average rate of use; by their eighties, twelve times more. In 1997-1998, persons over the age of 65 accounted for 44.8% of patient days in general hospitals and constituted 71.5% of clients served by the home care

program. Older people tend to stay longer in hospital. For people 75 years of age and older, the average length of stay is 12.6 days compared with 5.2 days for people under 65 (Alberta Health and Wellness, 1999b). In addition, persons who are hospitalized once are more likely to be readmitted (Boling, 1999).

What Fromstein and Churchill (1982) said still holds true, that “the elderly fall into a category that pose the greatest number of discharge planning [challenges] for the social worker” (p. 296). Acute care hospitals are organized around treating specific ailments, rather than dealing with the complex, multiple health problems common to the (particularly frail) elderly. Given their multiple health problems, the stress of caregiving on families, inadequate community resources, and a tendency among some health care professionals to paternalize the elderly, there is a high likelihood of physical, social, and emotional issues complicating the already complex process of discharge planning with this group. In summary, older clients represent greater challenges to post-acute care, and thus are among the clients who are invariably referred to hospital discharge planners (Morrow-Howell, Proctor, Dore, & Kaplan, 1998).

#### Social Worker as Discharge Planner

At the time of writing of this study, the social worker was the member of the multidisciplinary team responsible for planning the discharge of clients from the hospital setting. In fact, some of these social workers in this study spent virtually one hundred percent of their time engaged in this activity. Yet because of the system’s focus on cost containment and efficiency, the timing of discharge is largely beyond the control of the social worker planning it.



By the end of the time of writing of this research study, a relevant development had emerged. The Calgary Regional Health Authority had just established a committee to review the role of social work in the acute care segment of its health care delivery system. Preliminary recommendations at that time foreshadowed a removal of the role of discharge planner from the social worker's mandate and a possible move of more social workers from acute care to community-based service. The implications of this change are examined in Chapter Five, Discussion and Recommendations.

### *Ethics in the Context of this Study*

The individual members of the multidisciplinary team involved in consultation on a client's discharge have differing professional codes of ethics. An extended analysis of the varying professional codes is not the purpose of this section. Sufficient information about the ethical values and obligations of the usual members of the multidisciplinary team is given here in order to provide a context for the findings of this study.

#### Social Work Ethics Amidst Other Standards

The Social Work Code of Ethics published by the Canadian Association of Social Workers (CASW) (1994) lists seven ethical duties and obligations and three ethical responsibilities (see Appendix A). The codes of ethics under which the other, usual members of the hospital's multidisciplinary health care team practise differ little from the social work Code in the categories of values they espouse and obligations they demand of their members. In different ways, and with different emphases, all contain reference to respect for the client; integrity, competence, and professionalism in practice; avoidance of conflict of interest; non-discrimination; confidentiality (including informed consent);

and advocacy on behalf of the client (and sometimes society) (CASW, 1994; Canadian Association of Psychologists, 1991; Canadian Nurses Association, 1991; Canadian Occupational Therapy Association, n.d; Canadian Physiotherapy Association, n.d.).

At the same time, social workers are recognized, at least in theory, as possibly the strongest proponents of self-determination and make its realization, through advocacy, for their clients one of their major goals (Perlman, 1975; Burstein 1988).

This commitment is consistent with a philosophy that states:

The profession of social work is founded on humanitarian and egalitarian ideals. Social workers believe in the intrinsic worth and dignity of every human being and are committed to the values of acceptance, self-determination and respect of individuality. They believe in the obligation of all people, individually and collectively, to provide resources, services and opportunities for the overall benefit of humanity. The culture of individuals, families, groups, communities and nations has to be respected without prejudice.

Social workers are dedicated to the welfare and self-realization of human beings; to the development and disciplined use of scientific knowledge regarding human and societal behaviours; to the development of resources to meet individual, group, national and international needs and aspirations; and to the achievement of social justice for all (CASW, 1994, p. 7).

### Ethical Dilemmas

Numerous definitions exist in the literature for the concept of *ethical dilemma*.

Proctor, Morrow-Howell, and Lott (1993) state that an ethical dilemma is considered to be experienced when acting on one moral conviction means behaving contrary to another or when adhering to one value means abandoning another. Blumenfield and Lowe (1987) emphasize that not everything is an ethical dilemma: "Often when workers are faced with difficult decisions and the need to act, the problem is framed as an ethical or value conflict, when in reality it is a practice question" (p. 54).

The Canadian Association of Social Work Code of Ethics (CASW, 1994) provides a definition for neither an ethical dilemma nor ethical discomfort. It does provide a brief note on “professional practice conflicts,” which states that “Conflicts of interest may occur because of demands from the general public, workplace, organizations or clients. In all cases, if the ethical duties and obligations or ethical responsibilities of this Code would be compromised, the social worker must act in a manner consistent with this Code” (CASW, 1994, p. 7).

The Canadian Nurses Association’s Code of Ethics for Nursing (Canadian Nurses Association, 1991) provides the broadest, most general definition of an ethical dilemma. The Code states that “Ethical dilemmas arise where ethical reasons both for and against a particular course of action are present and one option must be selected” (p. 41). This same code provides a definition of ethical distress, which could be considered synonymous with the term used in this study, ethical discomfort: “Ethical distress occurs when nurses experience the imposition of practices that provoke feelings of guilt, concern, or distaste” (Canadian Nurses Association, 1991, p. 41). As nursing shares many of the same ethical priorities as social work, these definitions were chosen as those that were most appropriate for application to this study.

## RESEARCH QUESTIONS

The research questions again are:

- How do social workers in acute care discharge planning roles experience and deal with ethical dilemmas in their work with senior clients? and

- What contributions or changes, if any, could be made to social work education, ethical codes, or practice guidelines to increase the ethical comfort of social workers planning the discharge of senior clients at risk?

## RATIONALE FOR THIS STUDY

Ethics form the cornerstone of social work practice. By their very nature, the ethical principles promoted in the Social Work Code of Ethics (CASW, 1994), by which all Canadian social workers practise, are highly abstract. Without accompaniment by more concrete guidelines for implementation, they leave the social worker in the field with a task of interpretation tantamount to that with which human history's most notable philosophers (including Plato and Aristotle, Kant and Mill) have struggled over millennia. In fact, the quest to provide a rational set of principles that would enable us to separate right from wrong has been, without question, the most important and challenging problem of moral philosophy.

Take, for instance, the social worker's duty to "maintain the best interest of the client as the primary professional obligation" (CASW, 1994, p. 7). This obligation alone leaves vast potential for individual interpretation. In the context of discharge for a frail elderly client, is the best interest of the client a desired return to her home when an accident and subsequent readmission to hospital is almost certain? Considering "the values of acceptance, self-determination and respect of individuality" (CASW, 1994, p. 7) that underlie this ethic provides little clarification, and in fact may introduce further uncertainty for the practising social worker. Is self-determination in the best interest of the elderly client who, for example, wishes to give full power of attorney to an abusive

son? Examination of these questions, and guidelines for meeting these and the many more ethical challenges encountered by social work discharge planners on a daily basis, is more important now than ever before, for the ethical comfort of social workers, for the well-being of the clients they support, and for the benefit of all society.

The argument made by nursing scholars, Dash, Zarle, O'Donnell, and Vince-Whitman (1996), is equally applicable to social workers. That argument, specifically directed at the principle of an elderly client's autonomy, states that:

Discharge planning issues are among the major causes of moral and ethical concerns of nursing staff. Nurses are often troubled by the demoralization of older patients who fail to regain their readmission level of functioning. Nurses are also concerned about procedures that increase patients' dependence and relegate them to nursing homes.... Thus, a tension forms between the nurses' felt duty to do good and prevent harm to the patient and the patient's right to autonomy and self-governance. This tension of two opposing forces implies a dilemma and, as such, indicates that there will be trade-offs made in resolving that tension (pp. 151-152).

It is vital for social workers to continue to struggle with ethical questions if only for the fact that they will not go away. Again using the example of self-determination, back in 1928, when social work was in its formative years, Taft (1928) said, "the philosophy of participation is more easily understood than is the method of achieving it" (p. 103). Today, the debate continues, and has even reached the policy agenda, as is evidenced in the recent emphasis on decisions about cardiopulmonary resuscitation, do-not-resuscitate orders, euthanasia, and personal directives (Teaster, 1995).

Alberta Health and Wellness (1999c) recognizes that ethical issues will become increasingly complex and important with an aging population. Particularly for seniors' health and continuing care, the key ethical issues relate to promoting autonomy for

seniors and their right to make their own decisions while taking into account their decision-making capacity and role of others, especially family members, in helping with important decisions. The Policy Advisory Committee contracted by Alberta Health and Wellness (1999c) found that citizens across Canada are calling for an open, public debate and discussion of ethical issues in health. They have recommended the establishment of a forum to “explore ethical issues specific to seniors’ health; regularly communicate positions and policy advice on ethical decision making to assist the health system and continuing care providers in making decisions, delivering programs, and to establish appropriate policy” (p. 106). The Committee held as its first priority to “allow people to remain in their homes and other types of supportive living arrangements” (Alberta Health and Wellness, 1999a, p. 28).

With frail elderly people being cared for more frequently in the community, the social worker will inevitably be drawn into ethical debates, such as those around risk-taking. Who is taking the risk? What is an acceptable risk? Where is the balance between paternalistic acts intended to protect the elderly client from harm and respecting that adult’s right to self-determination? Social workers need criteria upon which to base the judgment that they have done the best they can for their clients and families (Blumenfield & Lowe, 1987).

To complicate matters, according to one of the foremost writers on the topic of ethical concepts in social work, Fredric Reamer, social workers are responsible for encouraging the activities that are most beneficial to clients, discerning the best uses of limited resources, and distinguishing just from unjust procedures and policies to guide

daily decisions. In other words, they are in a position between unlimited demands and limited resources. To increase the challenge, there is often a significant discrepancy between employer traditions and policies and professional social work standards (Reamer, 1982).

The need to define clearer positions on ethical issues can be taken to a universal level. Given the paucity of appropriate resources in most communities, the basic human right of choice is being usurped and public policy is imposing an “unintended tyranny” over the most vulnerable in society—elderly, ill, disabled, and poor people (Shulman & Tuzman, 1980). Says Spicker (1990), “It is precisely because such a potential exists that ethical principles are necessary to guard against it” (p. 235). Gewirth (1978) said:

In a century when the evils that man can do to man have reached unparalleled extremes of barbarism and tragedy, the philosophic concern with rational justification in ethics is more than a quest for certainty. It is also an attempt to make coherent sense of persons’ deepest convictions about the principles that should govern the ways they treat one another. For not only do the divergences among philosophers reflect different views about the logical difficulties of justification in ethics; the conflicting principles they uphold, whether presented as rationally grounded or not, have drastically different implications about the right modes of individual conduct and social institutions (p. ix).

Despite the importance of ethics to the social work profession and the attention directed toward developing theories of ethical choice, there is a lack of systematic studies of the specific nature, occurrence, and outcome of ethical dilemmas in social work practice (Proctor et al., 1993). Yet it is not enough just to identify the ethical challenges and the dangers inherent in them. Research is needed to determine whether and to what degree abstract ethical principles are realistically applicable in practice. “Never has a professional field been in greater need of painstaking research,” said Biestek and Gehrig

(1978, p. 40). Even less is known about how social work professionals identify, experience, and respond to moral and ethical issues encountered in their work, or what resources are used or needed for improving performance in this area (Holland & Kilpatrick, 1991).

Social work education needs to prepare us adequately to apply elusive ethical principles to practice. Clearer practice guidelines are necessary to specify the boundaries for professional behaviour in the face of ethical dilemmas encountered in specific contexts. In the early 1980s, Abramson (1983) summed it up best with this statement: “We are just beginning as a profession to talk about how to translate our ethical assessments into practice principles that can be used as guides for action....The discharge planning process is an excellent place to begin” (p. 51). This statement remains true today.

## SUMMARY

In theory, discharge planning has as its primary goal the provision of integrated, continuous care for—mainly elderly—persons leaving hospital for their homes or other living arrangements in the community. The expedient delivery of this function has been recognized as vital to the viability of the health care system in the area administered by the Calgary Regional Health Authority and beyond, in its capacity to release people from the most expensive part of the system—the hospital.

In practice, discharge planning, as conducted under the pressures of time and shortages of community resources, falls short of its primary goal. Families often end up



with the responsibility for providing continuing care, and seniors are often readmitted to hospital soon after discharge, often in worse condition than when they left.

Discharge planning is conducted largely by the social work member of the multidisciplinary hospital team. Social workers in the fast-paced, cost-driven environment of acute care are challenged to uphold their ethical commitment to provide dignified, egalitarian, and choice-rich service to their elderly clients. Discharge planning, then, is a source of ethical distress and ethical dilemmas for these professionals. With the exception of the abstract principles listed in the Social Work Code of Ethics (CASW, 1994), for the most part, the social worker lacks specific guidance on how to deal with these ethical dilemmas. In fact, even less is known about how social workers experience and deal with ethical dilemmas in their discharge planning work with elderly clients, or about what resources they find useful in their attempts to resolve these conflicts. The aim of this study is to contribute to the knowledge base in these areas.

## **CHAPTER TWO:**

### **LITERATURE REVIEW**

#### **INTRODUCTION**

The literature on ethics and ethical dilemmas is arguably the largest body of literature in existence. Writings on the debate between right and wrong date as far back as recorded human history itself. Fortunately, this chapter devotes itself to a miniscule portion of these writings—those pertaining to the role of the social worker in the current health care environment with the responsibility of planning the discharge from acute care of a predominantly geriatric client base.

There is no central repository of literature that speaks to the specific questions posed in this research study. This literature review, then, draws from the fields of philosophy, gerontology, medicine, social work, and nursing, to piece together a foundation for understanding the issues inherent in acute care discharge planning with seniors. It will also contribute to the rationale for this study by way of identifying the gaps in our knowledge in this area.

This chapter begins by introducing the existing literature on discharge planning, including its role in the acute health care system. It then presents the current state of our knowledge regarding the values espoused by persons over sixty-five. Within this section is a discussion of those social work values and ethical principles that directly address the values of seniors. Next, the chapter turns to a discussion of ethics in practice and the tools available for solving ethical dilemmas. Finally, it identifies the gaps in the literature that provided the impetus for this study.

## THE DISCHARGE PLANNING LITERATURE

The majority of the medical, social work, and nursing literature on discharge planning focuses on models to be applied in practice. Most are very akin to the practice models by which social workers are accustomed to operating. Some of these models are presented here, followed by a discussion of how their application in full in the current health care environment is impeded.

### *Models of Discharge Planning*

A model of discharge planning, according to one source, is “the formalized outline utilized by an institution to describe the basic components of its program” (Discharge planning models, 1983, p. 34). The literature highlights various models of discharge planning. McKeehan (1981) defined five steps of discharge planning: assessment, diagnosis, prescription, implementation, and evaluation. Proctor and Morrow-Howell (1990) define the discharge planning tasks as determining client needs and wishes; assessing family resources and preferences; facilitating communication between clients and family members; deciding on a post-acute care location; co-ordinating plans and paperwork among hospital personnel; and working with community agencies, institutions, and third-party reimbursement sources. Mamon, Steinwachs, and Fahey (1992) define four phases to discharge planning, including client assessment, development of a discharge plan, provision of services (including family and client education, and service referral), and follow-up evaluation.

Potthoff, Kane, and Franco (1997) suggest that discharge planning be based on a decision-making process with six key components: (1) screening; (2) assessing the

client's needs, preferences, expected prognosis, long-term care financial resources, and prior use of formal and informal care, as well as the family's ability to care for the client; (3) choosing the appropriate post-acute care modality (e.g., long-term care facility versus rehabilitation) based on the assessment data; (4) choosing the specific post-acute care vendor; (5) implementing the post-acute care plan; and (6) evaluating the post-acute care plan after discharge from the hospital to assess whether needs have been met and clients are satisfied.

A common model used in discharge planning is the case management approach. It resembles general social work practice in its phases: introduction (name of client, institution, and members of the discharge planning team), assessment, planning, implementation, evaluation, and conclusion (observations and recommendations based on the previous steps) (Dash et al., 1996). The aim of this approach is to match the client with appropriate community services. It also aims to assess necessary changes to the discharge planning process of the institution.

A second case management approach to discharge planning involves four basic steps: (1) contact with the client that begins during the institutional phase, as hospital discharge usually occurs within 24 to 48 hours after the physician's decision; (2) advocacy for and co-ordination of fragmented community services to address the client's physical, social, psychological, and spiritual needs; (3) construction of a support system network to provide socialization for the client and help in securing meals, transportation, home repair, and upkeep assistance; and (4) initiation of discharges based on community care plans versus transfers between institutions (Hubbard et al., 1978).

Some of the literature recommends integrating whatever model of discharge planning is used with family systems theory. Ideally within any setting, the client and family are viewed as the primary treatment units. Margles (1995) says "...assessment, diagnostic, counseling, concrete planning, and resource allocation efforts must focus on the impact of the illness not only on the patient but also on the immediate and extended family" (pp. 52-53). By incorporating the principles of family systems theory the discharge planner gains a broader perspective of client functioning (Johnson, Morton, & Knox, 1992) and a better blending of client and family care needs (Margles, 1995).

#### *Discharge Planning in Context*

The literature acknowledges that, even under ideal circumstances, discharge planning is a complex process requiring the collection of information on the functional status of the client and the resources available in the family and community. It invariably involves tradeoffs between preferences of clients, their families, and health care workers. Discharge planning with elderly clients often entails planning care for multiple chronic health problems (Kadushin, 1996), which are often accompanied by some mental impairment (Fromstein & Churchill, 1982). Added to this complexity is usually a degree of emotional distress for both the client and the family.

Studies have shown that, theoretically, effective hospital discharge planning can dramatically reduce subsequent readmissions and total hospital days for elderly clients and improve the ability of high-risk elders to cope with medical problems and disabilities (Andrews, 1986; Barker et al., 1985; Cable & Mayers, 1983; Fethke, Smith, & Johnson, 1986; Morrow-Howell, Proctor, & Mui, 1991; Naylor, Brooten, & Campbell, 1999;

Proctor & Morrow–Howell, 1990; Victor & Vetter, 1985). However, Anderson and Helms (1993) maintain that models aimed at encouraging effective discharge planning are not operational in the traditional sense. Feather (1993) agrees, and recognizes that hypothetical models of discharge planning are often adapted to maximize efficiency in environments where time and other resources are limited. The hospital is such an environment.

Dash et al. (1996) summarize the objectives that lie at the foundation of cost containment in the acute care institution:

The acute care institution has an obligation to ensure the rights of all clients. This includes an obligation to discharge patients with a safe and adequate plan. The institution also has obligations to regulatory and funding bodies. The foundation for institutional decision making is the utilitarian model, ensuring equal care, concern, and resources for all patients. Thus the interest of one patient may be compromised to serve the interests of all (p. 161).

An emphasis on expedient processing of clients makes the process of developing an appropriate discharge plan even more challenging than it would be ordinarily. Under conditions where expediency is the rule, discharge planners find themselves disadvantaged on several levels: making decisions based on prognosis instead of observation of performance; lack of ability to fully plan the transition to long-term care; and an inability to support client autonomy (Kadushin, 1996). Under the pressure of time, frequently, engagement, assessment, and intervention must occur in one session. Social work discharge planners are hard pressed to involve elderly clients and families in discharge decisions, or to explore choices that might threaten to delay discharge (Coulton, Dunkle, Haug, Chow, & Vielhaber, 1989).

Also under time pressures, families may overestimate their capacities for caregiving, which often results in the subsequent discovery that they cannot provide the care expected of them or planned at the time that their loved one left the hospital (Proctor, Morrow-Howell, & Kaplan, 1996). All too often, the family becomes so overwhelmed by the physical and emotional burdens the caregiving situation creates that they bring their loved one back to the hospital to be admitted, possibly as a “social” rather than a medical admission (Shulman & Tuzman, 1980). In short, “measures designed to lessen the number of expensive stay days, without taking into account the family and community supports needed by patients who have received sophisticated and costly medical care, result in poor discharge planning and inadequate health care” (Shulman & Tuzman, 1980, pp. 5-6).

The need for quick discharge planning in the high-pressure atmosphere of the hospital, combined with shrinking resources available in the community, has long been considered to be a factor in the high rates of burnout among hospital social workers (Oktay et al., 1992; Reamer, 1982). Hospital social workers complain that they are being forced to discharge clients from services more quickly, and clients are being returned to the community in a weaker state of rehabilitation than ever before (Bywaters, 1991). Also, these discharge planners receive little systematic feedback about the post-discharge implementation (Resnick & Dziegielewski, 1996; Simon, Showers, Blumenfield, Holden, & Wu, 1995).

As well, says Donnelly (1992),

Hospital social workers play to a number of audiences simultaneously: patients and their families, hospital administrators and nonprofessional staff, and other professionals in the treatment team. The consequences of neglecting this role defining task can be dramatic for the individual worker both in terms of burnout, declining morale and loss of influence and access to resources in a climate of fiscal constraint (p. 107).

There would seem to be a conflict inherent in the role of social worker as discharge planner. A small segment of the literature recognizes this conflict. For instance, Galambos (1997) states:

There is a fiduciary relationship to the agency or organization. Within this relationship, an expectation exists that the social worker will contain cost, and increase efficiency....The compelling interest toward the client is to provide services that the client needs....Situations occur where in honoring one promise, a social worker is forced to break another, competing promise (pp. 60-61).

Dash et al. (1996) note that the simultaneous obligations to employer and client conflict when:

- A client's decision conflicts with sound health standards
- Having worked to restore health, the provider must accept the client's decision to assume risks
- The provider has an additional obligation to public welfare and policy
- Providers view discharge planning as their medical decision rather than the clients' personal decision
- An institution faces financial pressures from delays in discharge (p. 160).

## INDEPENDENCE: A PRIORITY FOR SENIORS

Research has shown that the most important component of the quality of life for seniors is their independence (Galambos, 1997; NACA, 1995; Rubinstein, Kilbride, & Nagy, 1992). In fact, Rubinstein et al. (1992) discovered that what is most feared by seniors to be lost by ill health is independence. One study suggested a positive association between privacy, control, and independence and a senior's well-being (Timko



& Moos, 1989).

A review of the literature on independence indicates that this concept cannot be considered in isolation, as it is inextricable from a number of related concepts. Wigdor and Plouffe (1992) stated that “an appropriate understanding of independence is to be able to carry out life’s activities within a normal community setting, to be able to make choices about these activities and to have a degree of control over one’s life” (p. 3). Thus, it is on the more concrete concepts—community living, choice, and decision-making—underlying the abstract notion of independence, and the corresponding social work values, that this section focusses.

#### *At Home in the Community*

Rubinstein et al. (1992) stated, “the home is, in and of itself, an expression of the core value of independence” (p. 20). One elderly respondent in the Rubinstein et al. (1992) study stated, “As long as I can remain in my own home, I have a feeling of independence. But if I lost my home I would lose control over my life, probably. This is my last, this is the last thread I am hanging onto” (p. 132). The National Advisory Council on Aging (1995) maintains:

By remaining in their own homes, seniors retain their self-assurance and decision-making power; this sense of control reduces stress and provides peace of mind. Because the home is a normal life setting, it promotes the maintenance of valued contacts with family members and friends. By continuing to live in the same neighbourhood and cultural milieu, seniors retain a sense of security and of belonging that helps them feel socially integrated, despite disabilities (p. 10).

Rubinstein et al. (1992) found that, for many seniors, living independently, even alone, represents mastery and control of one’s life, continued competence, and a

resistance to decline, especially when a subjective sense of these may be compromised through illness or misfortune. This is why, this author maintains, elderly people may focus on the desire to continue to live alone, even in relatively wretched circumstances. The alternative—institutionalization—is culturally viewed as much worse in its potential to dehumanize and remove one's authority over oneself (Rubinstein et al., 1992). Many of the elderly respondents in the Rubinstein et al. (1992) study were willing to live in inferior conditions in exchange for the certainty of controlling their own space and use of time, or of knowing they would always have a roof over their heads. According to Rubinstein et al. (1992), “elders felt the domain of choice and decision-making to be within their homes....[home] environments were still perceived as ‘choiceful’ and ‘choice-rich’” (pp. 82-83).

Rubinstein et al. (1992) reported that a large number of older adults with significant physical impairments continued to maintain homes in the communities where, by and large, they had always lived. According to one Canadian study, about 68% of seniors live in their own homes and an additional 19% live in self-contained rental accommodations (Alberta Health and Wellness, 1999b). “People dislike long-term care institutions, not necessarily because the care is bad and the staff uncaring (although they may be), but more for what they represent: the diminution of the social self” (Rubinstein et al., 1992, p. 81). In a study by Boyajian (1991), “fear of institutionalization, with the result of *losing control* over one's life, is the greatest fear to citizens polled about long-term care and dying” (p. 314). Given the symbolic significance of independent living, it

is easy to see why the large majority of elderly clients discharged from hospital wish to return to their homes, regardless of associated risks (Rubinstein et al., 1992).

The vast majority of older people living alone manage with little or no help when faced with some type of health or functional limitation (Rubinstein et al., 1992). At the same time, living at home comes with the expectation of support from the community. Even in a decrepit and untrustworthy neighbourhood, “there is always some opportunity for good neighborliness, for helping and being helped, watching out for others and being watched over” (Rubinstein et al., 1992).

In terms of more formal community supports, a study by Hollander (1997) showed that it was important for seniors to know that community services were available when needed. Unfortunately, Hollander’s (1997) participants also noted that there was inadequate monitoring after an illness. One senior interviewed commented, “I have not received any services since a month after my discharge from hospital. Since then I have not seen anyone. No visit, no telephone call....In case of complications I have to go to the emergency at the hospital” (Hollander, 1997, p. 27). In short, seniors express a need for continuity in service provision, a vital requirement to their continued independent living in the community.

### *Choice and Decision-making*

Rubinstein et al. (1992) say that, in the Western democratic view, independence does not exist without choice. In fact, choice may be “culturally viewed as independence operationalized” (p. 3). These authors maintain that people enact their independence through making choices. A lack of independence reflects a lack of choice.

Rubinstein et al. (1992) point out that, as we age, the domains over which we have control and can make choices diminish, thus the choices that remain to us (such as the choice of how to use personal time and space) increase in importance. It is generally accepted that senior clients have the desire to govern their own lives. Rubinstein et al. (1992) says, "the ethos of independence, operationalized through choice making, does not dissipate, disappear, or diminish.... People do not suddenly switch to some alternative framework of evaluating themselves or some alternative key symbols that give meaning to their experiences.... independence and choice making remain important" (pp. 8-9).

According to some writers, it is our need to participate in making and carrying out plans for our lives—in other words, the process of decision-making—that distinguishes us from other beings (Richmond, 1922; Bernstein, 1975). Numerous writers defend the right of clients to exercise choice and make decisions in their daily lives (even if this involves taking risks) as requisite to the intellectual, moral, and ego development of the individual. The rationale here is that we learn about ourselves and about responsibility from our own mistakes, failures, and successes (Biestek & Gehrig, 1978; Perlman, 1975; Soyer, 1975; Ten, 1971; Weick & Pope, 1988).

The position of the National Advisory Council on Aging (1995) is that "Seniors have the right to be autonomous while benefiting from interdependence and to make their own decisions even if it means 'living at risk'" (p. 4). Introduced by Soyer (1975), the concept of the "right to fail" is a direct reflection of the exercise of choice. Rubinstein et al. (1992), speak of "infirm elders living in impoverished row houses.... By and large, these people feel themselves to be maintaining their independence, not being a burden,

making choices about their daily life and activities, and comparing themselves favorably with those with less independence and fewer choices” (p. 146).

In conclusion, choice includes the option to reject a negatively perceived option, the decision *not* to choose, or “the choice allowed to each individual to choose damnation” (Spicker, 1990, p. 230). Says Mill (1962), “To be able to choose is a good that is independent of the wisdom of what is chosen” (cited in Beauchamp & Pinkard, 1983, p. 81).

### *Corresponding Social Work Principles*

By virtue of the Social Work Code of Ethics (CASW, 1994), and with very few exceptions, social workers are obliged to respect and defend the values and wishes of their clients. The social work principle that embodies the senior’s primary value of independence is self-determination. The application of this principle in practice, and the ongoing debate regarding its limitations, is presented here.

#### Self-determination

Abramson (1985) calls self-determination “one of the most enduring ethical principles in social work practice” (p. 387). . . . and “the value that gives the profession [of social work] its distinctiveness among the helping professions” (Abramson, 1989, p. 105).

Numerous definitions of self-determination are found in the literature. Most focus on action, unhindered by interference or coercion, taken for one’s own reasons (Stalley, 1977), according to one’s own values, goals, and personal choices (Nicholson & Matross, 1989), based on one’s own decisions and one’s own power and freedom to enact them

(Spicker, 1990). Self-determination has been regarded as a basic human need, a supreme ethical precept, an ideal, an ethical principle, a value, a technique, a cultural assumption, and a fact, as well as a working principle in social work (Bernstein, 1975; Biestek & Gehrig, 1978; Ejaz, 1991; Rein, 1982; Spicker, 1990). Many philosophers, including John Stuart Mill, agree that the capacity for self-determination is “either the most valuable or, at least, one of the most valuable characteristics of human beings” (Stalley, 1977, p. 40).

Like independence, self-determination cannot be considered apart from a number of other, related concepts. Ejaz (1991) says about self-determination: “the fundamentals of the principle stem from the broader philosophical issues of autonomy, respect for the individual and the belief that individuals have the right to make their own decisions in life” (p. 127). Bernstein (1975) argues that “...self-determination is *not* king....Most basically, the supreme social work value is human worth, an enormous idea, probably the greatest discovery in human history” (p. 40). Even so, Biestek and Gehrig (1978) would argue that self-determination “is essential to the implementation of the supreme value; without self-determination, human dignity and worth are meaningless” (p. 4).

Many sources recognize the principle of self-determination as rooted in the Western emphasis on freedom and independence (Agich, 1990; Beauchamp & Walters, 1994; Rubinstein et al., 1992). In the democratic view, freedom is not only a basic political right, but also a personal goal or desire. “Self-determination, then, is the expression of our innate drive to experience the self as cause, as master of one’s

self...Self-determination is based upon a realistic view of freedom” (Perlman, 1975, p. 79).

Numerous writers maintain that the social work principle of self-determination equates to, or at least supports, the exercise of choice (Biestek, 1975; Perlman, 1975; Rubinstein et al., 1992). Biestek (1975) states, “The principle of client self-determination is the practical recognition of the right and need of clients to freedom in making their own choices and decisions in the casework process” (p. 19). Decisions—no matter how large or small, according to Rubinstein et al. (1992) that are based on the client’s values, goals, and conception of a meaningful life support the client’s right to self-determination. Similarly, Perlman (1971) stated that although “self-determination is nine-tenths illusion [and] one-tenth reality” (p. 125), it should nonetheless be defended in social work practice:

Self-determination...is the very essence of mature humanness; that man’s exercise of choice rather than his coercion by his own blind impulses or the power of others is what builds in him his sense of effectiveness, of identity and selfhood, and of responsibility....Whatever fraction of self-determination is given to us should be exploited to its fullest, for ourselves and for anyone in whose lives we intervene (pp. 131-132).

Beauchamp and Childress (1994) posit that self-determination implies that there are alternatives from which an individual can choose, and that, in order to act autonomously, the individual must be made aware of these alternatives and be free from undue influence or coercion in choosing between them. Vladek (1989) points out the difference between this scenario and the one in which a person is discharged to the first available long-term care bed irrespective of its convenience, suitability, or desirability, or

the scenario where a person must be institutionalized because of a lack of comprehensive home help.

Rubinstein et al. (1992) say that, besides “health limitations, low incomes, characteristics of the home environment and of the neighborhood, and fear [, c]ertainly, choices have other limits that are significant. These include the lack of supportive others or appropriate guidance, the lack of the knowledge of choices, and the effects of ageism” (p. 25). Similarly, Vladek (1989) argues that when discharge decisions have to be made quickly, one wonders about the issue of influence and coercion. It is interesting to note that although a great deal has been written about the importance and necessity of full knowledge (informed consent) in research and treatment, there is little mention of the need for informed consent concerning discharge from the hospital. “Why is knowledge of and participation in transfer or discharge different than consent for treatment?” asks Abramson (1981, p. 37).

Often used synonymously with self-determination is the term *autonomy* (Beauchamp & Walters, 1994; Biestek & Gehrig, 1978). Rooted in our liberal Western tradition of democracy, autonomy focuses on independence of action, speech, and thought. Agich (1990) says,

The ideals implicit in this concept include independence and self-determination, the ability to make rational and free decisions, and the ability to identify accurately one’s desires and to assess what constitutes one’s own best interests.... According to this view, to be a person is by definition to be capable of free and rational choice.... So long as these individual beliefs and desires do not directly cause harm to others, anything goes (pp. 12-13).

According to Beauchamps and Walters (1994), being autonomous and being



respected as autonomous are two different things. To be respected as autonomous is to be recognized for one's "capacities and perspective, including his or her right to hold certain views, to make certain choices, and to take certain actions based on personal values and beliefs" (p. 23). To those who, like Kant (1971), would adopt autonomy as the term that expresses the supreme ethical value, to treat someone as if he lacks autonomy is to treat him as less than human. For these theorists, the burden of moral justification rests on those who would restrict or prevent a person's exercise of autonomy (Beauchamps & Walters, 1994).

#### The Autonomy–Paternalism Debate

A vast body of literature exists across the disciplines of philosophy, ethics, and social work that deals with the long-standing debate between the right of clients to retain control over their lives and their decisions and the need to safeguard their well-being. Much of this literature is framed within what is known commonly as the "autonomy–paternalism debate."

Murdach (1996) calls paternalism, "an approach to treatment typified by an attitude of parental concern toward the patient" (p. 27). In a more detailed definition, Buchanan (1978), a philosopher concerned with medical ethics, describes paternalism as "interference with a person's freedom of action or freedom of information, or the deliberate dissemination of misinformation, where the alleged justification of interference or misinforming is that it is for the good of the person who is interfered with or misinformed" (p. 372).

Justification for paternalism is based on an assertion that dates back to the fourth

century B.C., when Aristotle argued that some degree of paternalism is defensible in a society in which certain elite individuals are clearly more informed and wiser than others. According to the writings of various authors (Abramson, 1985; Beauchamp & Pinkard, 1983; Biestek, 1975; Buchanan, 1978; Carter, 1977; Dworkin, 1968; Edge & Groves, 1999; Mappes & Zembaty, 1986; Murdach, 1996; O'Neill, 1984; Reamer, 1983; Strasser, 1988; Ten, 1971), throughout the history of social work, paternalism has been argued as justifiable under a variety of conditions which have as their end goal the protection of the welfare of the client or others or the maintenance of the client's autonomy in the long run. In some cases, paternalism might be practiced as temporary interference with liberty, meant to ensure future freedom and autonomy (Abramson, 1985). This is what Strasser (1988) called the "you'll-thank-me-later criterion."

Proponents of autonomy or self-determination have warned us against any tendency to become excessively intrusive in the lives of our clients, or to use paternalistic acts as camouflage for actions that in fact are inspired by individual or organizational self-interest (Reamer, 1990). Numerous writers have proposed that, as well as providing the context for positive change, the social worker–client relationship can be a context for influence, even coercion. They argue that, unavoidably, the social worker, by the very act of establishing a trusted relationship with a vulnerable client, provides the basis for exercising influence and/or authority (Rothman, 1989, p. 608) and directing the client to accept the social worker's assessment of what should be done (Abramson, 1985; Hollis, 1964; Spicker, 1990).

As Wetle (1985) noted, there is a tendency among those serving the elderly to assume a paternalistic approach when there is a perception that the client might be putting herself at risk. The right of older or disabled seniors to choose to live “at risk” is sometimes questioned in a way that would never be acceptable in the case of younger adults. Although this paternalistic approach may be due, in part, to society’s wish to protect its older citizens, it may also be based on motivations that have less to do with the good of the individual than with some perception of the good of the institution, the care providers, the family, or society in general.

Although social workers claim that they do not impose their values on their clients, Siporin (1975) says “social work talk is full of normative and prescriptive statements and of moral judgements which seek to guide clients in their choices of right behaviour in deciding what they do about resolving their problems” (p. 65). Abramson (1985) says that, through the medium of the social worker–client relationship, we use the client’s trust to “cajole, persuade, or manipulate the client into accepting the social worker’s assessment of what ought to be done” (p. 391). Such beliefs prompted Salzberger (1979) to say: “either respect client self-determination, give up social work practice, and become mere paper-pushers or give up the idea of a client’s autonomy and actually help the client” (p. 399).

#### The Competency–Self-determination Connection

In extreme cases, professionals and family members alike may be tempted to question a client’s competency when her decision is not irrational, but merely incompatible with what others think is in her best interest (Campbell, Charlesworth,

Gillett, & Jones, 1997; Nicholson & Matross, 1989). For health care professionals and families, it often is easier to question a patient's competency than to recognize a legitimate conflict of values (Nicholson & Matross, 1989).

Nicholson and Matross (1989) say that "*Competency* can be defined broadly as an individual's capacity to understand and appreciate the nature and consequences of his or her actions....The ethical principle of autonomy and the social work value of self-determination underlie this position [i.e., upholding the right of competent people to make decisions]" (p. 234). By far the exception is the person who has permanently lost the capacity for autonomous decision-making. More common are less global deficits in decision-making capacity. One client can indeed be expected to come to an informed and autonomous (if idiosyncratic) decision; another may be too confused to take in what his options are. A third may be able to understand the issues but too dependent, or too distraught, to make decisions. A senior who is not mentally competent today may be competent next week and vice versa (O'Neill, 1984). Moody (1998) argues that "...we live in a 'hyper-cognitive' culture, so much so that any deviation from full mental capacity, from complete rationality and autonomy, is regarded as a fall from 'personhood,' from human dignity" (p. 125).

Says Moody (1998), "...every day in countless ways we treat elderly people as somehow less than competent, as children, to be seen but not heard, not addressed directly. Whatever our intentions, we violate their dignity..." (p. 112). For example, failure to involve the older person in the decision-making process may be based on the ageist assumption that to be old is to be incompetent. The National Advisory Council on

Aging (1995) believes that “the rights of seniors to choose to live ‘at risk’ should be respected as long as the senior is mentally competent and is not likely to harm anyone else” (pp. 1-2). The Council’s argument proceeds: “...when caregivers defer to the senior’s choice, they are, in fact, protecting those values and beliefs that give meaning and purpose to the senior’s life and which are so dear that the senior is prepared to make considerable personal sacrifices to uphold them” (NACA, 1995, n.p.).

The National Advisory Council on Aging (1995) warns against deciding on a person’s freedom to make personal decisions on the basis of a single assessment. Even when a person is declared mentally incompetent, because of the importance of autonomy, we are obliged to act in such a situation as we think the client would have wanted, and justify that in some way (Campbell et al., 1997). As well, “...a periodic review of our justification for treating her as incompetent is ethically demanded of any professional or team of professionals who act to override the autonomy of the patient” (Campbell et al., 1997, p. 11).

The National Advisory Council on Aging (1995) urges that “If a senior’s decision or behaviour appears irrational to you, try to understand the perspective of the person and what matters to him or her before questioning the senior’s mental competence” (n.p.). Perlman (1975) points out that “there are few perfect solutions in life, and that, therefore, compromise and tolerance for some frustration are inherent in choice—it is this repeated exercise that builds what, in professional shorthand, we call ‘ego strength’” (p. 75). “One of the things we must learn and face about self-determination...is that choice always involves some compromise, some renunciation.

And it always involves, too, the possibility of its being a poor choice, of yielding an unhappy outcome" (Perlman, 1975, pp. 69-70).

Soyer (1975) cites two reasons for supporting self-determination, even when a client's decision may seem irrational. "The first reason is simple: the client might be right, the worker wrong....The second reason for backing the client's aspirations is that only through life itself can the client really try, test, and temper his abilities, his fantasies, and his goals....This is how all people grow, how they gain a more mature view of themselves and the world. They succeed and fail and through success and failure they learn" (p. 61).

The tolerance of risk, whether by client, family, or worker, carries with it acceptance of the inherent anxiety (Rowlings, 1981). For the social worker his is the feeling that, whatever the support offered by senior staff, in the final analysis responsibility lies with him. Sprung (1989) adds, "the worker's need to see the elderly person in a hospital, fed, bathed, medicated, and cared for is not wholly a rescue fantasy. Rather, the countertransference issue may be fear of oneself eventually living in such sordid conditions or the fear of one's parents or grandparents deteriorating" (p. 600). As well, "...when people will not accept help, the worker may feel like a helpless observer of a tragedy" (Burstein, 1988, p. 521).

In response to this anxiety, social workers may encourage an older person to enter long-term care because they regard the risks of remaining in the community as outweighing the risks of institutionalization, disorientation, and possible death after readmission (Rowlings, 1981). Campbell et al. (1997) point out that "Care should be

taken that we do not become so averse to the idea of death in an older person that we deny that person the right to take the sort of risks that are generally allowable in younger people purely for pleasure” (p. 144).

“The risks to which people are exposed or to which they expose themselves may be emotional, psychological, or physical. As a general rule, these three types are placed in a hierarchy, with physical risk assuming the greatest importance, possibly because it is easier to assess and the preservation of life is a fundamental concern” (Rowlings, 1981, p. 86). The concept of well-being must be defined by the client to include those other aspects of self that might be more important to her than the physical. As Rowlings (1981) puts it, “...if the purpose of intervention is to help the client survive, care must be taken to ensure that he is not destroyed in the process” (p. 92).

## ETHICS IN PRACTICE

If independence (and all of its implications) is the most highly valued ideal of seniors, and respect for self-determination is the means by which this ideal is operationalized in practice, then, presumably, one of the priorities of discharge planning with elderly clients should be to maximize self-determination. Certainly, the ethical literature tends to view self-determination as an unquestioned goal. Yet seldom is life so clear cut.

### *Practice Realities*

As theoretical concepts, terms like self-determination and autonomy pose little practical problem. Safe within the social work classroom, the values that guide our professional conduct ring noble and clear. Yet not long into practice, the social worker

realizes the claim of Biestek and Gehrig (1978), that “The social work profession is a complex mix of idealism and realism” (p. 1). The attempt to apply conceptual ideals to real practice situations educes harsh ethical dilemmas. As Rehr says in Abramson (1981), “Even a firmly adhered to code of ethics does not protect one from daily confrontations with ethical and value dilemmas, particularly in health care settings where crises, diminishing resources, and rapidly advancing technologies highlight competing interests” (p. 34).

Not only does the literature on self-determination ignore the reality of practice in health care settings. For the most part, it also ignores the social reality of most peoples’ lives. Feminist thinkers encourage us to be critical of contemporary theories dominated by abstract principles that view autonomous individuals as separate from all of their essential moral relationships, like those with family and friends. These critics charge that current theories downplay the social context of self-determination (Freedberg, 1989; Jecker, 1991; Wesley, 1996). They argue that a sense of community potentially both challenges and supports one’s self-determination. Community values and needs can act to constrain individual action (Rubinstein et al., 1992). However, a degree of dependence can be positive and appropriate; for instance, when the aging process or a life-threatening illness impairs one’s capacity to be a judicious consumer of medical services (Barker, 1991), or when a decision requires others for its implementation (Barker, 1991; Beauchamp & Childress, 1994).

In the past decade, many writers began to recognize, and sometimes even defend, paternalistic behaviours of social work professionals. Defenders of paternalistic or



protective acts argue that sometimes paternalism in social work is appropriate. Murdach (1996) states that despite their view of paternalistic or protective acts as arrogant, coercive, and controlling, “social workers today find themselves increasingly required to intervene protectively in the lives of clients, many of whom are unable to fend for themselves without extensive assistance” (p. 26).

Beginning in the 1990s, the concept of universal, unquestioned autonomy began to be argued as not only unattainable, but dangerous (Glick, 1997; Hamel, 1995). Numerous writers have urged a re-examination of the totalitarian interpretation of the concept of client self-determination for all clients in all situations (Biestek & Gehrig, 1978; Freedberg, 1989; Gilbert & Specht, 1967; Reamer, 1990; Reynolds, 1934; Weiss, 1985; Whittington, 1975). Moody (1998) cautions, “in relationships and in caregiving in particular, non-interference can serve as a mask for indifference or the detachment of a stranger” (p. 121). Biestek (1975) cautions that the principle of client self-determination can become a meaningless cliché without regard for the realistic limitations on that right. The predominance of autonomy has been described by one of its critics as verging on the “tyrannous” (Hamel, 1995). Glick (1997) says, “I do think that the issue is much more complex than is suggested by the politically correct view that feeding hunger strikers by force is always unethical” (p. 956).

As Stalley (1977) once said, “...even the most enthusiastic advocates of self-determination do not believe that people should always be left to do exactly what they want” (p. 41). Beauchamp and Childress (1994) argue that “Many autonomous actions could not occur without the material cooperation of others in making options available”

(pp. 126-127). Says Jecker (1991), "...dominant ideas, such as individual autonomy, pose the risk of creating conventional categories of thought to which society becomes wedded. Such categories may ignore central aspects of moral experience. Thereby fostering illusions that become difficult to dispel" (p. 199).

The more recent approach is based on the assumption that help in making decisions that are to the benefit of client welfare can be given without affecting a client's autonomy (Edge & Groves, 1999, p. 44). These writers would encourage clearer, more calibrated practice guidelines for a guiding concept that has so many practical limitations. Nicholson and Matross (1989) believe that social workers can play a leading role in developing self-awareness in themselves and others regarding the value biases inherent in establishing interventions that contribute to the client's well-being. "Recapturing the hidden meanings of the concept [of autonomy] can help us better understand our roles as social workers" (Weick & Pope, 1988, p. 12).

### *Theories for Ethical Decision-making*

Blumenfield and Lowe (1987) state that "Ethical theories and reasoning do not solve [ethical] dilemmas, but they do suggest ways of structuring and clarifying them" (p. 49). Dash et al. (1996) describe two approaches aimed at helping providers resolve ethical dilemmas: the "balancing approach" and the "philosophical approach." In the balancing approach, the interests of each party involved in discharge planning are examined and balanced before determining their roles in the decision-making process. According to this approach, the rights of the client are paramount.

Otherwise termed utilitarianism, the philosophical approach seeks "the greatest

good for the greatest number.” According to this approach, moral decisions are based solely on the consequences of actions, not on the inherent right or wrong of the actions themselves. Hospitals and communities often use this approach when making decisions about how to provide (whether they actually achieve it or not) equitable, appropriate, affordable, and accessible services for individuals.

Formalist theory states that an action is right if it is in accordance with a moral principle or rule (e.g., “Do unto others as you would have them do to you”), and wrong if it violates such a rule. The consequences of the act do not matter. Features of an act that make it right include such things as truth-telling, promise-keeping, and abstract justice and beneficence. Rules and principles are related to the decision, not the consequences. The principles apply to all situations. This approach is often used to judge individual acts.

Gewirth’s criteria for resolving ethical conflicts proclaims that:

An individuals’ right to freedom takes precedence over his or her own right to basic well-being. In general, this guideline suggests that someone who chooses to engage in self-destructive behavior should be allowed to do so if it can be established that the individual is making an informed, voluntary decision with knowledge of relevant circumstances and that the consequences of the decision will not threaten the well-being of others. Temporary interference with an individual who threatens to engage or actually engages in behavior which results in basic harm to him- or herself is justifiable in order to determine whether the conditions of voluntariness and informed choice have been met. The guideline requires, however, that if these conditions have been met, further interference must be discontinued (Reamer, 1990, pp. 61-64).

The few studies that comment on the approach of social workers to ethical dilemmas paint a rather unethical picture. Biestek and Gehrig (1978) said that “the supreme value of social work is largely nullified by the manner in which the principle of client self-determination is practised. On the one hand, social workers have been accused

of interpreting client self-determination so liberally that it amounted to license, to unlimited freedom; while on the other hand, critics have claimed that self-determination in practice is nothing more than seductive manipulation, deceitful authoritativeness, over-all double dealing” (pp. 3-4).

Spicker (1990) speaks of the influence and authority that social workers exercise in order to control client behaviour. Hollis (1964) equates talk of self-determination to a “strategy for weakening the client’s capacity to hold to a self-determining course” (pp. 607-608). Spicker (1990) goes on: “Social workers may try, in the spirit of self-determination, to establish not just what people seem to want, but what they ‘really’ want....The idea of self-determination is being watered down, I think necessarily, because it would otherwise be impossible to reconcile it with what social workers actually do” (p. 223). Spicker (1990) maintains that social workers cannot avoid influencing the decision-making processes of their clients. He states that “The essential condition which would have to be met for a client to remain self-determining would be that the client must voluntarily accept the intervention of the social worker—not only at the beginning of the social work contact, but throughout the process” (Spicker, 1990, p. 228).

The surface solution to these ethical dilemmas is, as various writers suggest, for social workers to consistently seek to enhance the power of their clients to make choices, to whatever degree possible (Beauchamp & Pinkard, 1983; Spicker, 1990; Wesley, 1996). Sprung (1989) suggests social workers ask themselves the following questions when faced with an ethical dilemma concerning client self-determination: “Is the client at

risk? Does this risk pose life-threatening conditions? Does the risk justify taking away the client's right to live freely and to determine his or her life-style? Does the client have the right to refuse treatment for his or her illness? Are the worker's recommendations based on the client's as opposed to the worker's needs?" (p. 600). In addition, O'Neill (1984) reminds us to consider each person, and that person's capacity for self-determination, individually, rather than applying a universal principle across all clients.

#### GAPS IN THE LITERATURE

We are relatively well informed on numerous elements of the questions under study in this research. This chapter has compared the literature addressing the process of discharge planning in theory and the obstacles encountered in practice situations. It has presented some of the literature on seniors' values and the highly abstract social work ethical concepts designed to match them. Again, the difficulties in translating abstract principles to practice situations is discussed.

Despite the size of the body of literature addressing ethical dilemmas, this literature search revealed nothing about ethical dilemmas encountered by social workers in any particular context. Ethical dilemmas, apparently, arise in a vacuum. The social work profession suffers from a lack of systematic studies of the application of professional judgment to ethical concepts in practice (Alberta Health and Wellness, 1999c; Holland & Kilpatrick, 1991). Social work education accents certain values, yet there is little education focused on applied ethics that would help social workers better integrate client-centred philosophy with practice patterns (Rothman, Smith, Nakashima, Paterson, & Mustin, 1996).

Our professional ethical codes do not reflect the ethical dilemmas social workers encounter in contemporary practice (Clemens, Wetle, Feltes, Crabtree, & Dubitzky, 1994). Our profession must identify the needs of the social worker in the area of ethical conflicts, define problems, and provide clearer guidelines on resolving the ethical dilemmas encountered in real practice, in order to provide practitioners with as much “ethical comfort” as possible (Abramson, 1991; Clemens et al., 1994; Ejaz, 1991; Kane et al., 1994; Rothman et al., 1996).

## SUMMARY

The literature that provided background for this research study is fragmented across various disciplines and topic areas, with minimal overlap. In other words, the literature on discharge planning tends to be restricted to the mechanics of the process, with minimal empirical data on the outcomes of comprehensive or inadequate discharge planning for elderly clients or for the discharge planners who attempt to serve them.

The effect of discharge planning that downplays the rights and abilities of elderly clients to exercise choice and make decisions for their futures is inferred from the literature that addresses the importance to seniors of maintaining their independence. A parallel must be drawn between the literature that discusses this desire for independence and that which discusses the social work ethic—self-determination—that supports this value. A few recent studies reflect a direct recognition of the effect of dichotomous obligations to employer and client on the discharge planner, and of the effects of systemic constraints on the choices that social work discharge planners are able to present to clients. And, of course, a vast literature exists that addresses the ethical dilemmas

inherent in the challenge of upholding the client's right to self-determination against the tendencies to paternalize (particularly elderly) clients.

Where the literature really falls down is in its usefulness to practitioners who encounter such ethical dilemmas daily. Nowhere are all of these factors tied together to present a picture of *how* social work discharge planners experience and deal with ethical conflicts in their work with senior clients. Ethical principles are presented as abstracts well apart from practice realities. There is a need for research that addresses the application of ethics to practice situations and for guidelines that allow for the satisfactory resolution of ethical dilemmas like those encountered in discharge planning with elderly clients. When the social worker with this responsibility can rest comfortably with discharge planning decisions, then it would be reasonable to assume, given this professional's focus on the well-being of clients, that client welfare will be better served.

## **CHAPTER THREE:**

### **RESEARCH METHODOLOGY**

#### **INTRODUCTION**

The primary objectives of this study were:

- to extend and refine the understanding of how social work discharge planners experience and deal with ethical dilemmas in their work with senior clients, and
- to provide a foundation for the subsequent development of resources for dealing with these ethical dilemmas.

Correspondingly, the primary research questions were:

- How do social workers in acute care discharge planning roles experience and deal with ethical dilemmas in their work with senior clients? and
- What contributions or changes, if any, could be made to social work education, ethical codes, or practice guidelines to increase the ethical comfort of social workers planning the discharge of senior clients at risk?

This chapter outlines in detail the methodology used to conduct this study. It begins by acknowledging the researcher's impetus for choosing the research topic, a potential source of bias in interpreting the findings. It then leads the reader through a step-by-step description of the methodology, from the choice to follow a grounded theory approach to the writing of the research report.

#### **RESEARCHER'S POINT OF VIEW**

Before delving into a description of the methodology utilized in this study, it is important to acknowledge the researcher's potential biases. The impetus for this study



was a four-month practicum experience during the Master of Social Work program. The researcher was fulfilling the role of student social worker at a local hospice and was surprised to discover that almost half of the workload comprised planning discharges for stabilized, usually elderly, clients.

The researcher noted immediately that no discharge was ever achieved without controversy. Invariably, these clients wished to return to their homes, almost always against the advice of the multidisciplinary team that they would be at risk in the home environment without extensive (often 24-hour) support. Thus, sometimes the controversy was framed as a conflict between the desire of some multidisciplinary team members to protect the client from harm and that of others to grant that client an unquestioned right to self-determination. At least at this point in her development as a social worker, the researcher admits to possessing an indisputable belief in the right of individuals to self-determination. Because of this conviction, the researcher was particularly sensitive to (always well-meaning) tendencies toward paternalism in herself and other members of the multidisciplinary team, and watched with interest the means by which these tendencies played out in each individual discharge. At the same time, this researcher watched in wonderment how the choice to respect the right to self-determination simplified discharge planning and admonished health care professionals from further action to protect the client.

Discharges of frail elderly persons were almost always a source of uneasiness for this researcher, who quickly became fully aware of the lack of both formal and informal community networks available to support the client's right to return home and live in

safety. A source of literal distress at times was the need—due to pressure to free up the hospice beds to make room for others more appropriately matching its mandate—to ask well-settled families to make alternative plans for housing their loved one in his or her final days. Too often, the news would have to be delivered, always by the social worker, on the day of one's first meeting with the family.

Because of an early sensitivity to the area of ethics, the sense of dis-ease these controversies caused, and without having yet researched the concept of ethical dilemmas in social work practice, the researcher framed these controversies as ethical dilemmas, rather than as practice challenges. A strong curiosity was borne in the researcher as to how more seasoned social workers experienced and resolved so-called “ethical dilemmas” in their discharge planning work. Following consultation with a potential thesis advisor and a research methods professor, a researchable topic was defined. The eventual research questions underwent some revision prior to becoming those that formed the basis of this study.

Before leaving this section, it is important to acknowledge the researcher's bias toward participant responses that reflected an untainted idealism. It was entirely instinctive for this researcher to feel rewarded by responses that indicated the social worker had maintained an uncompromising dedication to their primary professional obligation—the “best interest of the client”—whether that translated to the strict adherence to the ethical principles in the Social Work Code of Ethics (CASW, 1994), or to their adaptation through the seasoned practitioner's professional judgment, and even if it meant bending or breaking the rules or jeopardizing one's professional position to do

so. It was by way of this research that the researcher came to respect the varying ways in which social work discharge planners adapted to their conflicting obligations.

### CHOOSING A METHODOLOGY

A qualitative method was deemed the most appropriate for approaching the research questions in this study. Qualitative methods allow researchers to uncover and understand what lies behind any phenomenon about which little is known (as was the case with this study), to gain a fresh angle on a phenomenon about which much is known, and to give the intricate details of phenomena that are difficult to convey with quantitative methods (Strauss & Corbin, 1990). The specific qualitative method chosen for this study was grounded theory methodology. Following is the rationale for this choice.

According to Ingersoll and Ingersoll (1987), the intent of the originators of grounded theory methodology, sociologists Barney Glaser and Anselm Strauss (see Glaser & Strauss, 1967), was to “free sociologists from the old positivistic goal of verifying an established hypothesis and to help them apply their energy to a more creative goal of generating personal hunches and gradually shaping them into more coherent hypotheses for interpreting findings in the course of gathering and examining field data” (p. 91). The current study had no *a priori* hypothesis; only a desire to generate knowledge.

The major difference between grounded theory methodology and other approaches to qualitative research is its emphasis upon theory development, with the belief that theories represent the most systematic way of developing, synthesizing, and

integrating scientific knowledge (Guba & Lincoln, 1994). Grounded theory methodology inspires creativity in fieldwork, allowing researchers to pursue leads and ideas as they develop. Grounded theory methodologists perform inquiries in natural settings, and *ground* their theories in observation. Because grounded theory is a general methodology, a way of thinking about and conceptualizing data, it is also highly flexible, and is easily adapted to studies of diverse phenomena across various disciplines, including education, nursing, and social work (Strauss & Corbin, 1994).

A grounded theory is one that is inductively derived from the study of the phenomenon it represents, rather than from findings of previous studies. One does not begin with a theory, then prove it. Rather, one begins with an area of study and the substantive concepts and hypotheses that are relevant to that area are allowed to emerge. Grounded theory draws no dividing line between empirical research activity and the process of theorizing. Instead there is a continuous interplay between simultaneous, systematic data collection and analysis. The researcher actively shapes the research process. Rather than following a series of linear steps, the investigator works within a matrix in which several research processes are in operation at once. In other words, the researcher asks questions all along the course of the study, examines data as they arrive, and begins to code, categorize, conceptualize, and write the research report almost from the beginning of the study. The researcher may even collect further data near the end of a study, to close a theoretical gap.

Grounded theorists begin with general research questions rather than tightly framed, preconceived hypotheses. The research question is usually a statement that

identifies the phenomenon to be studied. The initial question is progressively narrowed and focused during the research process, as concepts and their relationships are discovered to be relevant or irrelevant. Grounded theory questions tend to be oriented toward action and process. Typical research questions, then, begin with “How do...” types of statements (Strauss & Corbin, 1990). By starting with data from the lived experience of the research participants, the researcher can, from the beginning, attend to how they construct their worlds. That lived experience shapes the researcher’s approach to data collection and analysis. In other words, throughout the research and writing, grounded theorists follow interests, leads, and hunches that they identify in the data.

Because it represents the everyday reality of the area of study, a grounded theory should also be comprehensible and make sense both to the persons who were studied and to those practising in that area. If the data upon which it is based are comprehensive and the interpretations conceptual and broad, then the theory should be abstract enough to include sufficient variation to make it applicable to a variety of contexts related to that phenomenon. Finally, the theory should provide control with regard to action toward the phenomenon. This is because the hypotheses proposing relationships among concepts—which later may be used to guide action—are systematically derived from actual data related to that (and only that) phenomenon.

Finally, Charmaz (1990) argues that grounded theory methodology meets the criteria of sound research. “The rigor of the grounded theory method depends upon developing the range of relevant conceptual categories, saturating (i.e., filling, supporting, and providing repeated evidence for) those categories, and explaining the

data. Similar to quantitative studies, or any other research, the quality of grounded theory studies varies according to the methodological thoroughness, the significance of the research questions, and the incisiveness of the analysis" (p. 70).

## REVIEWING THE LITERATURE

The literature review in a grounded theory study serves slightly different purposes than it would in other methodologies. It may stimulate questions to be researched. It supports the importance of the study's focus. It may serve to validate the eventual findings. It also suggests linkages between events uncovered during data collection and analysis. It may help to develop theory by providing theoretical constructs, categories, and their properties that can be used to organize that data and discover new connections between theory and real-world phenomena (Marshall & Rossman, 1999).

A researcher generally approaches a grounded theory study with some background in the technical literature, but not so much as to stifle creativity. The literature can be used to determine what other researchers have said about what the study is uncovering but should not be used to validate everything the researcher is seeing (Strauss & Corbin, 1990).

One of the main purposes of the literature review according to grounded theory methodology is to develop theoretical sensitivity in the researcher. Theoretical sensitivity refers to "the attribute of having insight, the ability to give meaning to data, the capacity to understand, and capability to separate the pertinent from that which is not....

Theoretical sensitivity can derive from the literature, from professional experience, from personal experience, and from taking part in the analytic process itself" (Strauss &

Corbin, 1994, pp. 41-43).

## SELECTING THE RESEARCH SITES

Though the researcher's curiosity about the research topic was generated in the environment of hospice, the researcher deemed this environment less appropriate than hospital settings for the research sites. First, there was not a sufficient sample size of hospices, or of discharge planners within hospices, since there are only three hospices in the City of Calgary, with a total of fewer than forty beds. Second, the hospices are not administered by the same management, and thus generalizations across settings may have been limited by the philosophy of their administrations. Third, hospice operates under a different philosophy than hospital, so that to generalize from a study conducted in a hospice to one undertaken in any other health care environment may not have been valid, either.

Hospitals provided a large number of discharge planning experiences, a larger sample of participants (social work discharge planners) from which to choose, and a common administrator (the CRHA). As the study focused on the experiences of discharge planners with geriatric clients, the Alberta Children's Hospital was eliminated from the study. Participants were chosen from the three Calgary hospitals serving adults—Foothills Medical Centre, Rockyview General Hospital, and the Peter Lougheed Centre.

## OBTAINING ETHICAL CLEARANCE

Since this study involved Calgary Regional Health Authority staff as participants, application was made to the Centre for Advancement of Health (CAH) in the South Tower of the Foothills hospital site. The Centre conducts reviews of scientific, client

safety, ethical, and administrative aspects of the proposed research by the Conjoint Scientific Review Committee, the Foothills Hospital Research and Development Committee, and the Conjoint Medical Research Ethics Board at the University of Calgary's Faculty of Medicine. This process required completing the CRHA's Application for Scientific and Administrative Review of Clinical Trials/Health Research, and acquiring approval at the administrative level of the Department of Social Work. Clearance was received without reservation within a matter of weeks.

All efforts were made to ensure the confidentiality and/or anonymity of individuals on which case studies were based and of research participants. The case studies used were fictional. As details were based loosely on those of real clients, names, genders, and other details were changed. Confidentiality and anonymity of any clients discussed in interviews with participants were assured by, when necessary, a reminder from the investigator to use similar disguising criteria.

Confidentiality of research participants was ensured by: (1) using number codes to identify subjects, rather than names or other personal information; (2) limiting access to data, even in coded form, on a need-to-know basis; and (3) ensuring that no identifying data were included in any published material resulting from the study. Research participants were informed of these procedures and their consent was requested prior to the collection of any data.

Hard copies of data were securely stored in a locked filing cabinet in the researcher's private home office. Upon completion of the study, data on the researcher's private home computer was transferred to floppy disks, which will be kept in a locked



filing cabinet for seven years, according to University of Calgary policy. Signed consent forms are being kept in a separate, locked cabinet in the researcher's home office.

Potential risks and benefits of the study were described to the ethics committee providing clearance for its conduct. The research posed no physical risk to the participants. It was anticipated that the participants may have experienced some discomfort in disclosing crises of conscience encountered in their work and describing ethical "compromises" made within the context of systemic constraints. It was stressed that participation was voluntary and that no specific responses would be tied to any particular individual. The researcher considered the risks of participating in this study as minimal. The only cost of participating was the respondent's time.

Being given an opportunity to discuss ethical dilemmas encountered in practice was thought to have more potential benefits than risks. The case study exercise and interview process could have contributed to the self-awareness of the participants regarding their own value biases and their application of social work values and ethics to their daily practice. Participants were offered a copy of the final research findings. These findings could provide information on how colleagues deal with ethical dilemmas in their work.

## SELECTING THE SAMPLE

Due to the relatively lower level of academic research, and the desire to complete the study in a reasonable amount of time, the selection of the sample for this study varied somewhat from the strict guidelines laid down by the founders of grounded theory methodology, Glaser and Strauss (1967). According to these founders, after gaining an

initial familiarity with the phenomenon under study, the grounded theorist seeks further participants with the right characteristics to stimulate a more critical, comparative perspective on the primary sample of participants under study. The researcher should spend just long enough with the new sample to generate new insights for application to the study of the original group. Glaser and Strauss (1967) call this strategy theoretical sampling.

Theoretical sampling begins quite early in a field study and can be repeated, as needed, from time to time during the study. For the purposes of a Master of Social Work thesis, this process was truncated. The researcher did, however, transcribe each interview prior to the next, so that new insights gained in the previous interviews could be applied to subsequent interviews.

In this study, six participants with the “right characteristics” were chosen up front. The criteria that each participant was expected to meet were:

- At least two years experience in discharge planning within the CRHA acute health care sites in Calgary.
- A large proportion of this experience being with geriatric clients.
- A desire to participate in research on this particular topic and a willingness to discuss the topic openly.

The social work department supervisors from the three research sites were contacted for a list of the social workers in their departments. Supervisors were asked to identify each social worker’s current area of practice and number of years of experience. Those with less than five years of experience and no exposure to geriatric clients were

eliminated immediately. The rest were sent the standard introductory memo found in Appendix B. Each was then interviewed over the phone to determine their suitability according to the three criteria listed above. Six highly suitable participants were identified and all agreed to take part in the study. The final participant identities were known only to the researcher and her thesis supervisor.

### CONSTRUCTING THE DATA COLLECTION METHODS

In grounded theory methodology, data collection can include interviews, observation, or documents, or a combination of these sources. The chosen mode of data collection for this study was the semi-structured, open-ended interview. In other words, the questions were pre-formulated but the researcher was open to any and all relevant responses, with no preconception of the “correct” answer. This interview strategy was aimed at inducing theory grounded in observation of the lived experiences of the respondents with discharge planning for senior clients.

To provide a starting point for an in-depth discussion of ethical dilemmas in discharge planning, the researcher devised three fictional case studies, based on composites of real cases. The case studies were pre-tested by three social workers with experience in acute care discharge planning, but who would not be taking part in the study. These pre-test respondents provided feedback about the realism of the cases and the relevance of the questions. The questions were also piloted in a presentation to the researcher’s research methods class. The professor and classmates were invaluable in redirecting an initial set of more specific questions toward open-ended questions more conducive to inducing theory.

The interview consisted of seven open-ended questions (see Appendix C). These questions addressed the case studies first, and then branched out into a more general discussion of ethical dilemmas encountered by the participants in their discharge planning work with real clients. Given that the study was based on grounded theory methodology, the aim was to build theory and ground that theory in observation. The researcher thus pursued leads and ideas as they developed, so that any individual interview may have taken an unanticipated direction, and so that ideas not anticipated by the researcher but offered by participants could be introduced into subsequent interviews.

Accordingly, question 4 was disregarded in all interviews after the first. Questions that were added to interviews as appropriate included:

- How would you define “the system”/“self-determination”/other terms introduced by the participant which could have had varying meanings?
- What is the greatest single source of ethical dilemmas in your work?
- How have things changed for you over the years that you have been practising within the acute care system?
- Have you ever found yourself in head-on conflict with the system?
- What would you say are your core values and beliefs?
- What questions do you ask yourself when you are attempting to resolve an ethical dilemma?

## COLLECTING AND TRANSCRIBING DATA

Respondents were sent an identical package containing a cover memo (see Appendix D), the consent form (see Appendix E), and the three fictional case studies (see

Appendix F). A follow-up phonecall about a week after sending the packages ensured that each participant had received the package, and established a date for the interview. Once an interview date was set, the researcher sent a final package to the interviewees with a confirmation of the interview date and a list of the interview questions (see Appendix C).

Interviews lasted between one and two hours. Prior to starting the tape recorder, the researcher invited the participant to discuss any concerns regarding the study or the consent form. Both researcher and interviewee signed the two copies of the consent form, and each retained a copy for their records. The researcher briefly explained the interview process and again offered the participant the opportunity to discuss any questions or concerns. Then the researcher gathered basic demographic data on the participant, by asking the questions in Appendix G. The tape recorder was started and the researcher began with Question 1 of the interview questions.

Grounded theory differs from other qualitative approaches in its approach to collecting data. Other qualitative approaches stress collecting large amounts of data before leaving the field and beginning the analysis. In contrast, grounded theorists use their emerging theoretical categories to shape their data collection while in the field. Accordingly, during the interviews, the researcher pursued leads and ideas as they developed. If themes or issues recurred during data collection, according to grounded theory, the researcher took an unanticipated direction to follow up on them. For instance, Question 4 was deleted after the first interview, as it was deemed to be “leading,” and various other questions, as cited earlier in this chapter, were added based on participant

responses. As well, in any individual interview, the questions were often pursued out of order, or skipped altogether, depending upon the direction of the information the participant offered. As long as the discussion remained relevant to the main thesis questions, the interviewees were allowed to proceed in unanticipated directions.

According to grounded theory methodology, the general guideline for data transcription is to transcribe only as much as is needed. The first interviews or fieldnotes were entirely transcribed before going on to the next interviews or field observations. This process gave guidance to the next field observations or interviews. In the case of a researcher's first study or a small-scale study, it is best to transcribe all of the field observations. In this case, the researcher transcribed each of the six interviews herself, directly after conducting them, and prior to the next.

## ANALYSING THE DATA

Two major processes dominate data analysis in grounded theory methodology: theoretical coding and memo writing. In this study, both functions were performed simultaneously using ATLAS.ti software.

### *Theoretical Coding*

Coding was initiated after all six interviews had been transcribed. The data were considered line by line and examined, and the themes within the data were identified. This stage of analysis entailed reading the data very carefully and noting in writing what was happening or being said in each line. Each discrete incident, idea, or event was given a substantive code, something standing for or representing a phenomenon. These codes often replicated the very words used by the subjects themselves. Once the data for all

interviews were coded, the researcher returned to the first interview and read through each interview again, adding the incidence of any new codes to previous interviews.

A central feature of the grounded theory approach is a general method of constant comparative analysis. Coded data were compared with other coded data and assigned to categories according to obvious fit. This process is called reduction, as it is done to reduce the number of units with which the researcher had to work. Categories are simply coded data that seem to pertain to the same phenomenon but which are more abstract than the specific codes that comprise them. They were produced using ATLAS.ti's Merge Codes function. Automatically, the ATLAS.ti program transfers all associated quotations and memos from all merged codes under that one category. In the end, three strong categories emerged—competency, client choice, and systemic constraints.

### *Writing Memos*

Grounded theory methodology is designed to guide researchers in producing theory that is “conceptually dense”—that is, with many conceptual relationships (Strauss & Corbin, 1994). ATLAS.ti's Memos feature is a tool for conceptualizing data.

Conceptualizing data is the central process by which theories are built from data. Raising a term to a conceptual level means making a series of decisions about it. The researcher attempts to discover the main problems in the social scene from the point of view of the subjects participating in the study, and how these subjects deal with the problems. At the same time, the researcher discovers his or her own ideas about the data after interacting with it.

Using ATLAS.ti, the researcher can write memos all the way through the data analysis process, beginning with coding. Memos are a way of preserving the meaning of codes, elaborating on codes, and recording any emerging hypotheses and hunches. Basically, writing memos gave the researcher a tool for engaging in an ongoing dialog with herself. The finished memos formed a repository of ideas about the data, which the researcher could then rethink, revise, discard, organize, and present in varied ways. According to grounded theory methodology, this final step is done while the researcher is still in the field. This way, it is still possible to fill in some of the gaps by gathering final information and testing ideas. This final step is called “densifying” one’s theory. This researcher did not take advantage of further trips to the field, as any identified gaps in knowledge were left for future research studies.

#### WRITING THE RESEARCH REPORT

The writing of the research report became a write-up of memos. The research report for a grounded theory investigation presents theory substantiated by data from the investigation. References from the literature were woven into the theory. Concepts were supported in the report by examples from the field data. “Concepts must earn their way into the theory by virtue of their relevance to the empirical world. The use of data in the report ensures this” (Stern, 1980, p. 23). The researcher gained further insights and created more ideas about the data during the writing. Hence, writing and rewriting actually became crucial phases of the analytic process. Further, the writing process gave the researcher the opportunity to link her work with other theories.



## SUMMARY

In hindsight, grounded theory methodology was well suited to this particular exploratory study. Little is known about how social work discharge planners experience and deal with ethical dilemmas in their work with senior clients, and though it provided a straightforward set of steps to guide the researcher, grounded theory allowed maximum flexibility and creativity in the inquiry process. Since grounded theory research questions are oriented toward “how” participants approach the phenomenon under study (in this case, ethical dilemmas in discharge planning), the findings could be directed more toward concrete action, rather than adding to the already highly abstract knowledge base.

The literature review conducted by this researcher went well beyond the extent needed to develop theoretical sensitivity. Nevertheless, a significant amount of time was allowed to pass between the literature review and the analysis of the data. In this way, theoretical sensitivity evolved in a way that the originators of grounded theory methodology would consider more legitimate. It was as much a product of personal experience and interaction with the data itself as of a familiarity with previous studies. It was only when the researcher returned to the literature following data analysis that data were confirmed as consistent with the recognized aspects of the phenomena under study, and in fact extended the state of knowledge in this field.

ATLAS.ti provided an efficient tool for the collection and coding of the data, particularly when the time came to combine codes into categories to derive themes. None of this implies that the researcher recognized no limitations in her approach. The limitations of the methodology are addressed in Chapter Five.

## **CHAPTER FOUR:**

### **FINDINGS**

#### **INTRODUCTION**

For the sake of simplicity, the findings arising from this research study are organized according to the interview questions found in Appendix C. Although some of the findings confirm the theorized experiences of social workers planning hospital discharge for geriatric clients, this study is unique in that such experiences are articulated directly by practising professionals.

It is relevant here to match the study's findings to the research questions. Again, the research questions were:

- How do social workers in acute care discharge planning roles experience and deal with ethical dilemmas in their work with senior clients? and
- What contributions or changes, if any, could be made to social work education, ethical codes, or practice guidelines to increase the ethical comfort of social workers planning the discharge of senior clients at risk?

Questions 1 through 6 were directed at determining how social workers experience and deal with ethical dilemmas in their work. Question 7 addressed the changes participants would recommend to help social workers deal with ethical dilemmas in their discharge planning work. Questions 5 through 7 were the source of the majority of new knowledge that emerged from this study.

No attempt is made in this chapter to interpret the findings. The interpretation of findings is left to Chapter Five.

## INTERPRETATIONS OF “ETHICAL DILEMMA”

The term “ethical dilemma” was purposely not defined for the participants. Neither did any participant ask the researcher to provide a definition of the term. This implies that each participant had an intuitive definition of an ethical dilemma. Intuitively, the definition of ethical dilemma that was used as a foundation for designing the fictional case studies was that given previously in this document, and again here:

Ethical dilemmas arise where ethical reasons both for and against a particular course of action are present and one option must be selected (Canadian Nurses Association, 1991, p. 41).

The majority of participants recognized as such the ethical dilemmas that had been “planted” in the fictional case studies by the researcher. Participant 2 constructed the planted “ethical issues” in the case studies as “clinical practice issues,” and assigned another definition to the concept of ethical dilemma:

*Participant 2: I guess when I think of an ethical dilemma, I'm thinking of one whereby...it forces me to sort of make decisions, or to sort of, um, modify my practice in a way that is out of the ordinary or usual.... it's not just a case that is tough. [use of roman typeface within italicized quotes indicates speaker's emphasis]*

Nevertheless, Participant 2 did describe numerous encounters with ethical dilemmas in discharge planning, which are discussed in this chapter.

## PARTICIPANT DEMOGRAPHICS

In a few preliminary questions (see Appendix G) preceding the interview questions, the researcher determined the participant profiles shown in Table 4.1. It is interesting to note that, despite the challenges of the work, all participants had chosen to remain in the acute care system for significant periods of time, from five to twenty years.

These participants spend from 50 percent to 100 percent of their time planning discharges. Despite the fact that not all participants worked in seniors-specific units (e.g., geriatric assessment unit), an average of 74 percent of their discharge planning work was being conducted with persons over the age of sixty-five.

**TABLE 4.1: PARTICIPANT DEMOGRAPHICS**

<b>Participant Number</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>Average</b>
Time practising as a social worker (in years)	10	14	5	13	20	16	13
Time in acute care (in years)	8	12	4	13	20	16	12
Percent of time spent in discharge planning currently	100	50*	75-80	90	75-80	90	71
Percent of discharge planning conducted with persons over 65	96-97	100	95	40	90-95	80	74
Seniors-specific unit?	Yes	Yes	No	No	Yes	No, but clientele are predominantly geriatric	Split about equally between yes and no

\*Participant revised original estimate of 30% after thinking about how seemingly unrelated activities conducted during the course of a day are in fact related to the eventual discharge of clients.

## RESPONSES TO INTERVIEW QUESTIONS

The reader is advised to review the case studies (see Appendix F) and interview questions (see Appendix C) prior to reading this section.

### *Question 1: Discharge Planning for the Fictional Clients*

Question 1 read: *How did you go about planning for the discharge of the client in each case study?* The responses to this question are given here within the context of the individual case studies, in the order in which they were discussed with the participants.

Participants were invited to discuss related cases and dilemmas encountered in their real work, and such data are also presented in this chapter.

Prior to engaging in a discussion of the separate fictional case studies, it is important to present a commonality across all three cases and across all participants. This commonality is summed up by Participant 2:

*Participant 2: Mr. Chan is competent. Everything turns on that....*

The participants were unanimous on this point. None of the social workers denied the obligation to determine the competency of persons who make decisions that put them at risk. Nor do they deny their tendency to want to protect such persons from harm. Yet, like Participants 1 and 6, they all agreed on the right of a mentally competent person to self-determination as indisputable:

*Participant 1: ...as long as somebody understands their rights and can explain to whoever has the expertise to evaluate that, can explain that they understand the risk and they're willing to take that risk, it's not my choice.*

*Participant 6: When you start to make decisions that are putting yourself at risk, then that needs to be challenged as to how competent is somebody. And if they're competent, then one of my mottos is that they have every right to live at risk, even though they might be making decisions that the treatment team does not support.*

#### Case Study 1: Ethan

Case Study 1 was very familiar to the participants. They acknowledged that, like Ethan, the vast majority of elderly clients admitted to hospital for the purposes of stabilization after a crisis event wish to return to their homes. This wish is, more often than not, unaltered by the protestations and recommendations of family and health care professionals, whose inclination is to protect the client from risk of accident or further

health crises. In the case of Ethan, all participants were committed to respecting this competent client's wish to return home. Four statements of this commitment are given here:

*Participant 1: ...if he really was intact, then it was his right to determine to live that way.*

*Participant 2: ...if the patient is saying, "I will, I don't care if I'm at risk or not, I want to go home," then my role becomes very clearly in my mind, I must now assist this patient in finding as much support to make going home possible.*

*Participant 4: ...in case study 1, I would um do everything I could to get this man home again, because if ah, he's clearly competent.*

*Participant 5: ...we're in this dilemma a lot on our unit....At risk for falls, at risk for, if they're not eating properly, proper nutrition, just generally at risk health wise. But does that really mean we can stop them from making a decision that we consider is poor judgment and is a risk for them? I don't think so....to get back to Ethan here. He is considered competent, so you do have to let him make his own decision. To return home.*

This is not to say that the social workers in this study would undertake no form of intervention with Ethan. On the contrary, they described extensive attempts to educate Ethan of the potential risks of his choice to return home, and his alternative options for housing. Not only was education considered an advisable intervention with a mentally competent client in the absence of other options (like institutional placement), but also as a safeguard against the inaccurate assumption that Ethan or any other client is *aware* of available housing options and community support services. In addition to the means inferred in the following quotes, one of the common ways of providing this information is through accompanying the client on a visit to an available facility:

*Participant 2: ... so you try to provide the support and education process when you're dealing with a competent patient.*

*Participant 3: ...it's very important, well it would be important for me, to at least make sure that that person's aware of everyone's recommendations, the risks that we see in his going home.*

*Participant 6: And sometimes clients just need to know that, we need to be able to say, what you're planning really does put you at risk and these are what our concerns would be....*

Failing a change in the client's decision, participants would try to place available formal supports in the home to increase Ethan's safety, as Participant 5 suggests:

*Participant 5: ...if somebody is refusing placement, and I couldn't convince them otherwise by my work with them, then there's nothing else I could do but facilitate a safer discharge plan.*

A few of the participants, like Participant 2, identified the dilemma inherent in the team's *expectation* that the social worker arrange discharge to a long-term care facility:

*Participant 2: ...here's the dilemma, you see, is where when we have a patient where I think the patient is competent... but the team feels differently, it puts me in a dilemma because you see the team now expects, sometimes it's almost like compelling the patient to do something that the patient doesn't want to do.*

But participants were still prepared to defend their moral commitment to respect the client's wishes over those of the team. Participant 5 stated this commitment most clearly:

*Participant 5: I would have to defend that because if I couldn't work with him to convince him that this is what he needs to look at, then I would have to say that he has the right to make a decision to return home, regardless of the team's expectation.*

The client was often not the sole target of the social worker's efforts to educate. Case Study 1 was one of the numerous contexts in which participants found themselves acting as educators of the multidisciplinary team, reminding them of an ethical principle that may not have been as prominent in their minds as it was in the mind of the social

worker. Participants 1 and 5 provide two excellent examples of the social worker's educator role amidst her multidisciplinary colleagues:

*Participant 1: Um, so in our next rounds or whenever we met to discuss his case, I would say, "you know, lookit, we can't prove that he's incompetent, this is where we stand, these are the people I've talked to, this is what I've learned. Ethan's gonna go home [softly but very clearly], and we can recommend Home Care, and we can recommend that the social worker at Home Care follow up, but the bottom line is Ethan's probably gonna fire Home Care again and he's probably gonna die in his home, and that's Ethan's choice."*

*Participant 5: Then when you're dealing with issues such as, you know, nursing home placement, um, adjusting to having a stroke, you know loss of independence, loss of control, it's a tremendous amount of time in doing that kind of support work with people. But that is not seen as necessary, by some members of our health care profession. It doesn't matter; they can walk, they can go home! So they don't look at the whole picture, and they don't look at the psychosocial needs of older people.... Um, so with that kind of attitude, by some members of the health profession, not all members, in terms of the elderly, you know, it gets very frustrating, because your job becomes more difficult when you're trying to explain to somebody that you know, a decision to go to a nursing home is a very traumatic experience for some people.*

Three participants also identified an ethical dilemma in the obligation to respect the confidentiality of third-party information from the brother and the landlady. This information represented knowledge that was vital to the client in making an informed decision regarding what he could expect in the way of support if he remained steadfast on his choice to return home. Participant 5 summed up that dilemma:

*Participant 5: Um, so, it does present some dilemmas in that you know that there may not be the support in this case when he goes home, from the landlady, which he is expecting obviously. But you're not able to share that information with him. So that's a real dilemma, because you have that piece and you're not able to do anything with it.*

Participant 6 suggested a solution to the dilemma of maintaining confidential information that is vital to the client's decision-making process on the issue of returning



home. This participant would try to get these third parties to recognize that they were participating in Ethan's failure by not sharing with him:

*Participant 6: ... what I often say to families or friends who may phone in, is that "You've given me a significant piece to the puzzle, and if this person [the client] is not aware of that, then we're setting them up to fail, cause they're going home with different expectations. And I don't want to be a part of their failure, and it would really help if I could share this with them." Or try to get them to come in for a meeting and help them share it with the person.*

Participant 3 neatly sums up the dilemma inherent in the case of Ethan as triangular, with the three points being the team/system, the client's safety, and the client's wishes:

*Participant 3: ...it's balancing the system and the team that I'm working with, and you know their recommendations, and of course, the person's safety, but also what...they're wanting and what their wish is.*

#### Case Study 2: Mr. Chan

The issue of financial and possibly physical abuse that was assumed to be taking place in Case Study 2 presented an ethical dilemma for all participants. The dilemma created by the knowledge or suspicion of elder abuse was described by participants as having the potential to take two different forms: one legal and one ethical.

In Alberta, social workers are aware of their obligation to report even their suspicions of child abuse or neglect. With seniors, this obligation is not so clear cut. The Protection for Persons in Care Act (Alberta Community Development, 1998) obliges persons witnessing the abuse by a staff member of a person in a publicly funded care facility to report that abuse. It does not apply to abuse in the home or by a family member. This ambiguity creates a dilemma for the social worker. Participant 6 referred to

the “horrendous” task of disclosing and pursuing a claim of elder abuse by a family member, particularly when evidence may not be corroborated by others, or even by the client:

*Participant 6: ...unless he [the client] was prepared to give consent to further intervention, it's a very sad case, but I'm not sure we have legally any grounds to stand on... so there's lots of abuse that goes on out there undetected, that we have strong suspicions about, but our hands are often tied.*

Three participants pointed out that a social worker may be prevented not only legally but ethically from directly intervening in the case of elder abuse. In fact, addressing the abuse directly may result in an even less favourable situation for the client, such as when an elderly person becomes alienated from a significant source of informal support. Even raising the issue of abuse with a senior may be seen as threatening to that individual. This is how the three participants expressed the dilemma:

*Participant 1: And certainly we see a lot of this kind of abuse where the family members [the abused senior] are very reluctant to, um, push their relationship with this person, that, you know, they need this person in their life, they're their only lifeline to family or whatever.*

*Participant 3: And I think that that's pretty common as well, for elderly people. The thought of going to the police and charging a son or a daughter is very difficult.*

*Participant 5: I think a lot of it has to do with the lack or loss of control as you get older. Um, when you're losing control of things in life that were important to you, you wanna hold on to what you have. You become protective of your possessions. You become protective of your family.*

Again, in no case was a participant apt to walk away without attempting some form of intervention. The most common intervention that any participant identified as being willing to take on was educating the client, as expressed in the following quotes:

*Participant 1: ...but if she's gonna sneak around behind his back, I'd want him to be aware that she's asking those questions...and that there be somebody there to advocate for him...when I discharge him.*

*Participant 2: So the first thing I probably would want, in talking to him about is to find a way of where he can have the powers of attorney reviewed, and that's kind of the easy, nice way out. I think it certainly would be within his jurisdiction without causing any difficulty....I would tell him that this is not uncommon, and the way that people have done it in the past to protect themselves and maintain that closeness with their niece, is to do this.*

In terms of intervention intended to protect the presumably mentally competent client in Case 2 from abuse at the hands of a family member, a few participants suggested setting up some form of monitoring when Mr. Chan returned home. Suggestions for monitoring included a community social worker, the private caregivers hired to assist Mr. Chan in his home, and the Seniors' Liaison at the Calgary Police Service. Four participants had taken advantage of the services of the latter and spoke very highly of these individuals and their work.

One participant had accessed the toll-free number established in accordance with the Protection for Persons in Care Act (Alberta Community Development, 1998), but noted that this Act does not address abuse of seniors by their own family members, only by persons working within the health care system.

Participant 2 pointed out the importance of "treading very very lightly" in terms of interventions on the issue of elder abuse:

*Participant 2: And I think a lot of times as social workers, we gotta be careful, because we can easily alienate the patient from the very thing that we're trying to protect them from, and we have nothing better to replace it....You go so much after the justice that you forget the relationship, you forget that this is the most important thing for this man, this is the most significant thing that he has available.*

In the end, with a mentally competent, abused senior, because of the responsibility to respect their right to self-determination, a social worker's hands may actually be tied. Participant 5 identifies this as another dilemma:

*Participant 5: So the dilemma for you is, you know this may be going on, but you can't do anything about it, because you don't have enough proof, there is not enough disclosure from Mr. Chan that he's concerned for himself or for his future. He hasn't disclosed that for you, but you're still concerned about what's going to happen to him. And you feel, I mean I think as a social worker you might even, and a lot of times in those cases you almost feel powerless, in terms of not being able to fix it, not being able to change it. Um, you know, and sort of your value is, you know, you want to protect the person, you wanna keep him safe, you want to solve the problem. I mean you're there to solve a problem, but a lot of times you can't do that.*

Had Mr. Chan been incompetent, there could have been different handling of the case. As Participant 6 put it, "that would be a whole different ball game." More specifically:

*Participant 5: ...you might be more apt to perhaps move him out of that situation and into something more protected, if he wasn't competent.*

*Participant 6: With incompetency, you'd have a right to be looking at the lack of confidentiality in terms of getting more collaborative information. So perhaps talking to the caregivers who look after him in the home. You know, consulting with the Public Trustee/Guardianships office regarding the situation and potential for abuse, talking perhaps to the niece about the allegations. So, it opens up the guidelines much more.*

All participants recognized the presence of a cultural element in Case Study 2, and the need to take into account that, coming presumably from a non-Western culture, Mr. Chan may have values that differ from those of the individual planning his discharge. Specifically, participants pointed out the recognition of the importance of family to Mr. Chan, and the possible tendency to want to deal with family problems without outside

intervention. Also recognized was the possibility that a more effective intervention for Mr. Chan could be delivered within the context of his own cultural community. These social workers showed a willingness to involve such persons in providing resources for their clients.

### Case Study 3: Elizabeth

Case Study 3 was cited as the case among the three that was most likely to cause the social worker to “lose sleep.” In each case, it was because, although participants had dealt with family “pacts” in the past (usually a pact promising that the family member would not be placed in a nursing home or other institution), none had practice experience with a pact involving euthanasia.

Case Study 3 prompted all the participants to identify the *family* as the client in need of intervention. The preferred discharge plan was institutionalization for the severely compromised family member, Elizabeth, in order to reduce the caregiver burden and restore some quality to the lives of her informal caregivers, her husband and her two adult children. The dilemma inherent in this case was interpreted as the family’s dilemma, with the social worker working to help them resolve it.

All participants recognized the obvious ethical dilemma inherent in the highly controversial issue of euthanasia, and in possessing such important information as knowledge of a pact to participate in euthanasia. The principle of the right of self-determination did not extend, in the ethical standpoint of these participants, to assisted suicide. In fact, Participant 1 argued that Elizabeth was not in fact self-determining, but instead having her decisions determined for her by her family.

Despite personal beliefs, the primary focus of the participants, as with Participant 5, became preventing the act of euthanasia:

*Participant 5: And that in itself presents a huge issue, in that if these people are actually thinking like this, um, you know, how do you go about changing that? How do you go about stopping them from doing that, because that is not legal. It's not legal to do this, and you know this, and they've told you this. So the dilemma is you've been told that this is what they'd be planning to do at that time.*

Prevention of the execution of this illegal act would be attempted through discussions with the family. The second focus of intervention was convincing the family that institutionalization for Elizabeth could be a palatable goal. Again, education became the social worker's most valuable tool to accomplish this end. Failing a change in the family's determination to take the client home, the social worker would attempt to provide further in-home supports for the family. Lengthy excerpts from the interviews are provided for this case study, as the researcher was impressed by the degree of expertise and certainty with which the participants indicated they would handle this case:

*Participant 1: "I know you've made this pact, I know why you've made this pact, you want to respect that you committed to your mom. First of all I can't help you do that. But secondly, um, do you think if your mom knew it was going to ruin three other lives, do you think she would still have wanted this? Are you sure? I know you've made this pact, but have you looked at it that way? Is that something she'd want to do to you? I know you're willing to do it to her. You're willing to do this for her, but do you think that when she made the pact or even before she made the pact, do you think that the woman your mother was, would she have wanted this for you?"*

*Participant 4: I find that in a lot of cases when you get the whole family in the room, um, you're able to appeal to, you know, that they've been having thoughts and they've been wishing for solutions and worrying about each other and you know you as a social worker have...a good ability to convince families like this that something has to change....I've written that um I need to give them all permission to forget the pact, and urge them to consider their father's health and their own futures. Ah, I of course, I'd strongly advise against the euthanasia and*

*push as hard as I can for uh, long-term care. And failing that, I would arrange for tons more respite than they're already getting.*

*Participant 6: Like we can't support euthanasia, because the system would never support it....So I think on this one we would have needed to have a team-family conference and review all of the issues presenting to them, with, I think some predictions. I'm not sure they have a real clear understanding of the progression of her disease, and that it's going to only get worse, and that they don't have a right to euthanasia because she could live in a care centre and still have quality of life.... I think the recommendation that they need to go and talk to somebody around this pact, too. Like this pact is going to come with future guilt, and I'm not sure that they appreciate that.*

Case Study 3 was recognized as unique from the other two in that the client was depicted and thus interpreted by the participants as mentally incompetent. Participants thereby assumed a liberty to protect this client from neglect or harm at the hands of her caregivers. This is how two of the participants expressed their reaction to this increased power to act for the client:

*Participant 5: Um, but when you get into the level of caregiver burden that paralyzes people, you get to be very concerned about neglect going on. And so it's it's a big dilemma for you, because you want to protect the person.... If there is an indication that it is unmanageable, then I would want to make sure that you have um some kind of professional help involved, in terms of the decision-making.*

*Participant 6: ... they don't have a right to euthanasia because she could live in a care centre and still have quality of life. So, it's again that whole ethical dilemma of now what is "quality," I mean, now you know, if she progresses we're just going to end her life.... there's lots of dilemmas in here around quality of life issues and who gets to decide what someone's quality of life is.*

### *Questions 2 and 3: Ethical Dilemmas Encountered in Discharge Planning*

The three fictional case studies were introduced to encourage the participants to think about ethical dilemmas in discharge planning. They were intended as a jump-off

point for a discussion of actual ethical dilemmas the participants had encountered in their practice. Questions 2 and 3 reflect these intentions, and are reproduced here:

*2. What ethical dilemmas did you encounter in planning these [the fictional] discharges?*

*3. Please describe the most challenging ethical conflict you have encountered in a real discharge planning situation with a geriatric client.*

Questions 2 and 3 are dealt with together as they are closely related. The findings are categorized around two major themes: dilemmas arising from working in the health care system, and dilemmas arising from the belief in self-determination.

#### Dilemmas Arising from Systemic Constraints

As professionals, we tend to allude to abstract concepts in the belief that a common profession provides us with a common interpretation of our jargon. One such abstract concept that arose in this study was “the system.” Participants very clearly identified “the system” as the source of the majority of the ethical dilemmas encountered in discharge planning with geriatric clients. Here are three representative comments to that effect:

*Participant 1: [when asked for the major source of ethical dilemmas] Because of the job, the discharge job I'm doing now, it would have to be systemic.*

*Participant 5: ...if I think of the challenges I face, I mean there are those around, um, you know the end-of-life kind of treatments and all that that comes...lots of ethical dilemmas there, but in terms of discharge planning on a geriatric unit, it's probably coming from those system constraints of policies and procedures that you have to face.*



*Participant 6: ...your ethical dilemmas encountered in planning discharges. There's many but I think they they centre on systemic issues, you know, the demands of the system versus client wishes.*

### "The System" Defined

When asked to define the term in their own words, "the system," by the participants in this study, was equated with politics, policy, and procedures that share the commonality of dictating to the social worker, and to the client, the restrictions on their options:

*Participant 3: I think it's people, but I think it's policy as well... because a lot of the policy for discharge planning in the CRHA there's not a lot of choice for patients and for families. So that creates a lot of stress, as well, for people.*

*Participant 5: And so I guess when I say system I say you know, long-term care system, CRHA kind of system, policies, procedures, I mean they're huge kind of systems that we work within, but it's all dictated by um the people who make those decisions. It's like politicians who make decisions for us. You know it's the same kind of thing with CRHA administration or um you know, supervisors who make policies and procedures that we have to face.*

As a group, the participants painted a picture of this system, based on the description of some of its main characteristics. For instance, this depiction by Participant 1 gives an impression of the system as large, elusive, and bureaucratic:

*Participant 1: I respond to another supervisor who takes her stuff from the guy who's in charge of care in the community and he takes his stuff from, you know whoever who reports to [names current Minister of Health and Wellness].*

Participant 2 characterizes the system as a master with different moods, which place changing expectations upon its servants:

*Participant 2: I think that the system is fairly self-serving. You see when we have lots of beds, people are not pushed out, and they're probably, we don't talk about that, we're all just so smug and we're happy, right? ...But when there's a there's a*

*push on the system, then we all pretend that we really need to be efficient and get people out.*

Participant 3 speaks of the system as if it has its own definition of a plan for its clients who are no longer among those requiring the most acute level of care:

*Participant 3: ...but ultimately there needs to be a plan, staying in hospital is not, not considered a plan.*

The system presents as the major source of ethical dilemmas for social work discharge planners, seemingly due to two factors: (1) dichotomous obligations and (2) limitations on client choice.

#### Dichotomous Obligations

The strongest and most prevalent theme around ethical dilemmas described by these social work discharge planners was the dichotomy created by serving two masters: the client and the system. "The advocate versus administration" is the way Participant 4 put it. It was Participant 4 who lent the term dichotomy to the description of the social work discharge planner's major dilemma:

*Interviewer: I think it's interesting that in the last five minutes or so you've defined "good" in two different ways.*

*Participant 4: Is that right?*

*Interviewer: Mm hm. A few minutes ago you said good was something like doing what you're expected to do according to the administration, and then you just said you hoped you had a situation that was that strong because good meant being a good client advocate.*

*Participant 4: Ya, well, there's the dichotomy that I think probably every social worker that you talk to in health care would express.*

Ethically, the social worker is committed to respecting the client's rights. In a practical sense, as an employee of the acute care segment of the Calgary health region, the worker obliged to enforce the associated policies and mandates. Among the social

worker's obligations to the system is to empty acute care beds as quickly and efficiently as possible. The two mandates of respecting the client's rights and accommodating the system are often incompatible. Indeed, many hospital discharges occur at the expense of client rights, including the right to choose, and even client welfare. All social workers recognize that individuals with compromised health, and the families that care about them, are rarely amenable to, and often hurt by, being treated like pawns in a fast-moving game of chess. Participant 5 sums up the dilemma:

*Participant 5: You have to follow those procedures. But it's not always necessarily the best for the patient.*

The dichotomy between the two obligations of the social worker as discharge planner was identified as the single greatest source of ethical conflict encountered on the job. Participants described daily encounters with the strong incongruity between social work values, which puts the welfare of the client foremost, and system policies, which the findings herein would indicate do not. This reality made advocating for the client a visible and essential aspect of their daily work:

*Participant 2: ...what gets the social worker in a dilemma, is they're supposed to advocate for the resource that is, there's not a lot of it, but you're also to advocate for the client.*

*Participant 4: You know, the big thing in hospitals is that you're here to, you're here as an advocate and you're here to ah to discharge, and so you ah you know that's a that's a real moral conflict all the time.*

Balancing these simultaneous commitments to client and employer caused tremendous discomfort for the participants in this study, as well as the clients they serve. Participant 1 described as the most challenging ethical conflict the issues arising from

closing down a hospital-based long-term care unit to make room for psychiatric patients.

The distaste of the participants in this study for the tasks associated with meeting system requirements is evident in the following quotes:

*Participant 1: So we do need inpatient Psych beds, absolutely. But do you kick people out of their nursing home homes, because they have settled here? And now to say, "Okay, you did settle. We told you you would and you did. Now we're gonna turf you again...." It's yucky.*

*Participant 2: Where the social worker is really caught in a quandary, in terms of from an ethical dilemma situation, is when the exact case scenario, where the patient says, "I'm staying" and we're saying, "but it's time for you to go."*

*Participant 3: And there is definitely pressure that comes, and where that comes from sometimes I'm not even aware of, but there's people waiting in emergency. That trickles down to, you know, getting people out of the beds in acute care, but then there's also wait lists, you know there's wait lists everywhere, people waiting everywhere. So there is a lot of pressure....*

*Participant 4: Like, say the person is palliative, and they're, they've got cancer and they're weakening, and they're not looking good and they the unit needs the bed. And so we're looking at transferring this woman to a nursing home bed when you just have a hunch that she's going to die in transport. You know, like why can't we just give her a few more days? That sort of thing happens all time....*

Especially frustrating for the participants was the situation when the pressure to meet employer expectations jeopardized the social worker's relationship with the client. Every good social worker will attempt to operate from a position of trust. The establishment of a trusting worker-client relationship is the foundation for future interventions. For the social workers in this study, this relationship was not just a matter of professionalism, but a matter of morality. Too often in the role of discharge planner in the acute care system, these social workers were placed in a position in which employer expectations to plan discharges quickly and efficiently restricted their ability to establish

rapport. In fact, the first encounter with the client was sometimes the one in which the worker needed to address the issue of discharge. This made for client–worker encounters that were ethically uncomfortable for the social work discharge planners, and often traumatic for clients. It even resulted in clients—and the social workers themselves—perceiving the discharge planner as the system’s “bad guy,” as evidenced in the following quotes:

*Participant 1: And I have felt on several occasions that I am sort of like the one appointed to carry out their dirty deeds. And so, ya, I lose sleep over it, I lose sleep because these are the people I care about, not the people making the decisions.*

*Participant 3: And they saw me I think as "the" discharge planner. I think they'd see me coming and they'd want to run the other way, and that was not. And that was not even. I mean I'd just be coming to say hello, but I think that that's really what they viewed my role as. And it got to a point where the one daughter said to me that I was putting a tremendous amount of pressure on the family. And at that point I realized, you know, I can't do this, I mean, although, yes, it's my job to do. ... And, um, because really in that case it was very evident that that supportive role and that relationship that I had was lost through that process. ... Because just when she said that I was putting, that I, she said "you" are putting this pressure on us. Ya then it, then it becomes, it's not the system, it's you, you're the person that's coming and bringing us that that message.... Well, it doesn't always feel good.*

*Participant 4: Um, but um he doesn't want to talk to me. So every time I go and see him, because I'm the bad guy, cause I ask all kinds of nosey questions. He's fine with everybody else, he hates the social worker.... despite being told [by the client] to "Get out of my room, I hate you," more than once, several times....*

*Participant 5: So they oftentimes are the messengers of the information. And a lot of times the message is not the information that the patient or the family member want to hear. Um, they can then be the bad guy, or take the fall for that information that the person doesn't accept.*

*Interviewer: Shoot the messenger.*

*Participant 5: Ya. Exactly....So she was feeling that obviously social workers, you know, she didn't want to talk to them, she didn't want to be involved with the*

*social worker because she um you know was placed in this home and left there, basically....*

Since the social worker cannot follow a client through the continuum of care, even when a relationship is established, it cannot be maintained. In cases where the relationship was characterized by strife, there is no opportunity for the damage to be repaired. The ethical social worker, like Participant 1, must prepare the client for this termination in services:

*Participant 1: ...cause I can only help you while you're here in the hospital. Once you go out [voice tone rises], I can't provide that support to you anymore.*

A minor theme related to the dichotomous obligations to client and system revolved around the issue of confidentiality. The Social Work Code of Ethics (CASW, 1994) obliges social workers to respect the right of the client to confidentiality. Half of the participants mentioned experiencing ethical discomfort due to the lack of restrictions on confidentiality of client information within the acute care system. In contrast to other environments in which social workers may find themselves employed, the hospital team necessarily shares information in order to make decisions around client care. Sometimes, though, participants noted that the assumption that sharing of client information is necessary in this environment can result in a failure to extract formal client consent for release of information, or even rampant gossip among professionals. A related dilemma mentioned by a few of the participants, including Participant 1, was around charting:

*Participant 1: ... one of the ethical dilemmas I find in cases like this one [referring to Case Study 3] is how much do I chart in the medical record.... Cause he might come back at the system, and that can be an issue for me as a professional. You need to be really careful about how I document.*

This sub-section discussed the ethical dilemmas arising for the social work discharge planners in this study as a result of the dichotomous obligations to client and system. The second factor inherent in the system that tends to present ethical dilemmas for the social worker discharge planner in this study was the limitations it places on client choice.

#### Limitations on Client Choice

The literature review recognized that inherent in the concept of self-determination is a right to choice. As well, defending the right of clients to make their own choices is an operationalization of the ethic of respect. Within the current acute health care system, there are major limitations on client choice; namely time and resources. Logically, then, the participants in this study experienced ethical dilemmas and discomfort around the inability to respect client choice. Some of their frustrations are evident in the following quotes:

*Participant 1: Because in everything else it's also violating people's ability to make good choices [voiced with a questioning tone]. Like, they can still make a choice.... It's sort of the which-is-the-lesser-of-two-evils thing.*

*Participant 5: So that to me ah is a huge issue in terms of having to work within that rule. Because you would think that what palliative care means is that it's the end-of-life care and regardless of where you are, if you choose to stay there, you should be able to stay there. That's no longer the case.*

*Participant 6: ...you know when families say "My mother does not respond well to multiple moves. She's not the type of person that can have a roommate." And yet we give her multiple moves, cause she goes to the first available bed, goes to a transitional unit, and she's going to have a roommate.*

Lack of client choice was indicated as resulting from two systemic factors: a lack of resources to support clients in their preferred environment, and discrimination. The following discussion deals with these factors in turn.

### Resource Shortages

The system is characterized by shortages of resources—beds, people, community supports, and time. At the time of this study, Participant 1 was attempting to find beds for approximately ninety more people than the system could absorb. This participant pointed out that, although new beds were being established, the reported number of new beds did not reflect the number that had previously been closed. Neither did it reflect that these are not all beds that could or would accommodate clientele with complex needs. And of course there is a shortage of qualified staff to allow the administration to open the beds.

Another participant spoke of the lineups in Emergency of people waiting for beds. Some of these people ended up being sent up to the units to wait in stretchers in the hallways, while beds were being located for them. One participant spoke of the fact that, because discharges are being performed more quickly than ever before, a client who had public guardian involvement and assessment for low IQ, and who needed group home placement, was sent back out to the street to be homeless.

For clients who wish to return to their homes in the community, and the social workers who attempt to put the appropriate community supports in place for them, there are systemic obstacles, one of which is presented by Participant 1:

*Participant 1: Plus, the system doesn't have enough, lots of times....I mean that's the biggest challenge of all, I mean finding [formal] caregivers [who will work in the client's home] is a a a [searching for the right word] nightmare now.*



This lack of choice for clients is stressful for clients and their families, of course. But these findings indicate that it is also a source of stress for the social workers planning discharge into another part of the system, as can be seen in these quotes:

*Participant 3: It's a struggle when there's no choices for people, and we are giving them this information that basically states, "You're not going to have really any choice." ... The patient and families. They struggle with it. Because there's really very little choice for them.... So that creates a lot of stress, as well, for people.*

*Participant 4: ...and we tell them and we tell the family that the hospital policy is that you must go to the first available bed and wait there for your choice. And the family says, "How long will it be?" and you say, "I don't know, maybe three months, four months" you know. And and you kinda you don't know for sure but you kinda half know that that's probably a lie, that's probably a lot short of the actual time it's going to take for them to get to where they wanna go. You know. But you you do it to sort of convince them, you know get them to sign the papers and agree to go, and maybe you'll get lucky, and maybe he'll move to his choice in two weeks' time, and a lot of times you don't, those are you know, that's a real moral dilemma.*

The second reason for a lack of client choice is discrimination.

### Manifestations of Discrimination

One of the greatest barriers to choice for any individual is discrimination. Because of the emphasis on gerontological clients, this section deals with two categories of discrimination the participants cited as occurring within the acute health care system: ageism, and other double standards.

Participant comments indicated that ageism is a belief and a practice that is commonplace in the hospitals and that affects the process of discharge planning. Without prompting, five out of six of the participants identified and described evidence of ageism in their working environments. Here are two examples of such comments:

*Participant 1: The hospital tends, whether they'll, we never say this, but seniors get discounted. If somebody's a senior they have less rights than a younger person. Not necessarily legal rights, but um, less investment from the people who make decisions.... And as trite as it sounds, that's what I fight a lot with the system is negating somebody. It's ageism, really, negating somebody for their age.*

*Participant 3: I think especially in working with elderly clients where you know I hear it over and over again, I don't feel like they, I mean they lose that independence, and don't feel like they're able to make those choices, and that's a pretty pretty hard thing...and all these decisions and choices are being made for them and they have really very little say.*

One of the subtler forms in which discrimination appears in our society is stereotyping. Participants described instances of stereotyping of seniors within their institutions. Participant 4 described a situation with an elderly client who, because of one episode of presumed confused behaviour, was deemed cognitively impaired:

*Participant 4: ... but essentially he was perfectly fine, and everybody had just sort of left it at that... at the first suggestion that he was confused.*

*Interviewer: If he were fifty-five and acting exactly the same?*

*Participant 4: No. Would never have happened.*

*Interviewer: What would be the explanation in that case?*

*Participant 4: Ageism. Ya, I think so.*

*Interviewer: And what would be the explanation for the fifty-five year old acting exactly the same way?*

*Participant 4: Mm, strong diabetic reaction, or they'd have been on their toes trying to figure out what was causing it.*

*Interviewer: Mm hm. But they don't if there's a certain age?*

*Participant 4: Um, you know, I...think not. You know, they're doing sort of slower tests and eliminating this and that but not looking for any serious cause.*

Two other participants provide further examples of ageist attitudes in their hospitals:

*Participant 5: Many people look at the elderly as non-productive, you know, um, not valued as individuals, people who, it doesn't really matter, we can't fix them anyway so why bother. If they can't fix it, in the health care system, in some people's minds, not all people, some people's minds it doesn't matter, we don't want to deal with you.*

*Participant 6: But what what tends to happen is you get people in their late eighties, early nineties, and the thought process becomes these people need placement.... [paraphrasing the attitudes of non-social work co-workers]: "She's 91 years old. What are we going to do with her?" "Well, you know, what should we expect, they're 94, they're depressed, so what?" ... Um, so it's those kinds of things all the time that you hear, it's always quantified by age.*

Nevertheless, all of the social workers interviewed in this study cared very much about their elderly clients. Beyond creating an ethical dilemma for these participants, most described the experience of personal pain in watching the way the system treats the elderly. Participant 1 was particularly eloquent on this point:

*Participant 1: I've been given so many gifts from these people, and um I'm sure any population is that way but this is the one I'm attached to, and you know they've put so much into making Calgary a home for so many people, ah, and they've raised their families and they've raised good citizens and they've done good work and contributed to their communities and now we're saying "Well, I need a place for this psych patient, and you don't seem as important to me, I'm going to move you somewhere else." Moving isn't that big a deal, when I know it's their whole world. Their world has gotten very small already, through no fault of their own usually, I mean, most of their disease processes they didn't choose, with a few exceptions, um and, ya, I lose sleep.*

Three of the participants made reference to other bases of discrimination that are manifest in their hospitals. These discriminatory practices were referred to by one participant as “double standards,” founded on personal connections, personality, race, and income. Some of the social workers in this study admitted that they were not immune to applying double standards themselves. For example:

*Participant 2: If it's a nice, pleasant, sweet little old lady or little old man, you know what, we'll pull out, everyone will pull out all the all the um exceptions and make it happen for them. On the other hand, when you're dealing with this type of person [referring to clients who, like Ethan, are “angry, negative, and downright rude”], it's almost punitive... you do exactly what the procedure says.*

*Participant 6: ... as soon as that family becomes difficult to deal with, the discharge is rushed. So, a senior does not benefit if the family becomes difficult to manage and to deal with.*

Participant 1 goes on to describe how policy has been applied disproportionately for or against different people. Clearly, persons who are of a visible minority, poor, homosexual, or unequipped intellectually to advocate for themselves are at risk of being “compelled” by the system to accept the rules. In the face of a challenge from a mainstream family with resources, this participant claims, “the system *always backs down*.” Participant 3 points out that money can actually work against a client, but that financially secure people are better equipped to retain their right to choose:

*Participant 3: ...people that can afford to go to private facilities versus the people that can't and you know we have a situation now where a person's waiting to go to a private facility but basically they've been told that they can't wait in the hospital, whereas we've got many people waiting for public facilities, you know.... And yet I see there's choice, like they're choosing to go there, with others there's no choice where they go.*

Apparently the current acute health care system in Calgary imposes restrictions on client choice by way of not being able or willing to accommodate certain clients.

Participant 1 speaks of the difficulty in placing clients with complex physical and psychosocial problems, like those with “trachs,” tube feeds, or disease processes that cause them to deteriorate very severely and very rapidly; or those with dementing illnesses that cause them to be highly anxious, disruptive, or dangerous to other clients. These are some of the clients that Participant 5 agrees “do not fit” the system. Such situations in themselves can be a source of conflict and discomfort for the social workers performing discharge planning, as indicated in this comment from Participant 6:

*Participant 6: So the system can't accommodate with all of these things that, so you're constantly in conflict between families and the system and what the system can do....*

This concludes the discussion of the first major theme in this study: dilemmas arising from systemic constraints. Now the discussion turns to the second major theme: dilemmas arising from the belief in self-determination.

#### Dilemmas Arising from the Belief in Self-determination

The second major category of ethical dilemmas the participants in this study identified encountering in their work were those that arose from the uncompromising belief in the right of the individual to self-determination, even if that individual is at risk.

Participant 5 encapsulates this dilemma:

*Participant 5: I mean the same kind of dilemmas for you when you want to protect the person and you can't do something about it. That's a real dilemma.*

The participants in this study were unwavering in their belief in the right to self-determination for mentally competent clients. Yet, as discussed earlier, the commitment to defend this right, and to avoid its antithesis—paternalizing a competent adult who chooses to exercise that right—is far more clear-cut in theory than in practice.

#### Self-determination and Paternalism Defined

First, it is important to present any descriptions or definitions of the terms *self-determination* and *paternalism* offered by the participants. Participant 1 provided a lengthy description of self-determination:

*Participant 1: ...for me, self-determination means each one of us is given this lifetime as an opportunity to make choices for good or for bad. When we make bad choices, we can learn from them or we can keep making them over again or whatever. But each one of us has permission to decide what's best for us. And*

*unless something organic or whatever could cause, you know, the kind of destruction we see that causes people to become incompetent, would be the only exception to that, no matter what somebody's choices are. No matter how hard they are to watch as a fellow traveler in this life. That's their choice....I mean if they're starting fires in their kitchen in an apartment building, that's not cool. But if they're starting fires in their kitchen in their ranch and they understand it may one day burn down with them inside it, there's nobody within fifteen miles of that ranch, I really think they can be allowed to make that decision. ...the favorite case example was a guy who lived in his car, all year long, and he'd have frostbite and everything was rotten, but he could tell you (short pause) what his risks were, that he'd chosen them, it was his own business—leave 'im alone.*

Participant 6's description of paternalism was multifaceted:

*Participant 6: Because I feel sometimes in hospitals we become very paternalistic. We get people in hospital who are elderly, you reduce them to being children, and want to take over, make decisions for them....we don't give enough assessment of people's skills that they came in with....I think it's all those issues and feeling that we know best....We strip them of their rights when they come in. You know, we're going to do X, Y, and Z, and whether they wanna do it or not. And we get lots of refusals to go to long-term care, and then it becomes a battle that, again we've recommended it, so therefore it must be right....Um, you know so often you get seniors who come in, and before the staff has really gotten to know them, they're letting family take over through phonecalls and whatever.*

### Self-determination versus Paternalism

As noted in the discussion of the participant responses to fictional case studies, the social workers in this study expressed the belief that a mentally competent client has the right to self-determination. Nevertheless, there were practice situations in which participants were willing to compromise on that principle. As seen above, in the example of the senior at risk of burning down an apartment building, Participant 1 drew the line on self-determination in the case of a client who was a danger to others.

Participant 2 would bend to systemic pressures:

*Participant 2: Because the other dilemma is, for instance, whereby you may get a grandma sittin' down there for eighteen hours, also in Emerg, trying to get in, to*

*a situation whereby we've got a patient who really does not need to be here anymore. But that grandmother down there, or that young family, they need this bed desperately. So...*

Participant 3 was regretfully resigned to situations created by resource shortages, where self-determination was simply not feasible:

*Participant 3: You know, ya, there's self-determination but, for people to make choices, but first of all, I mean, I've had people who their wish is to go home, let's say to die but the care's not available, the resources aren't there, I mean it's just not feasible. You know that might be their wish, but you know whether the other, um, the other pieces of the puzzle are there is another story.*

The rationale used unanimously by the participants in this study to determine whether to advocate for a client's right of self-determination or direct efforts toward paternalism—competency—provided one of the only clear guidelines available to social work discharge planners for decision-making in the face of ethical dilemmas. Nevertheless, competency turned out to be a double-edged sword. Believing in the right of the competent individual to self-determination does not necessarily equate to ethical comfort for the social worker who must watch frail individuals leave the care of the institution to return to potentially risky lifestyles. Below are a few of the internal struggles faced by the participants in this study:

*Participant 1: And so, it was very hard for me, you know, you don't go into social work or any caring profession because you like to walk away from somebody in an uncomfortable situation. It feels horrid....*

*Participant 5: And so it's very difficult, and you feel badly if something does happen in the future and what were you able to do about it?*

*And I remember it from a few years ago when there was a concern about about a lady in terms of end-of-life care and treatment and her wishes and concerns about the fact that we weren't respecting her her rights. ...she was refusing to eat and she was refusing to respond to us and she wouldn't have treatment and so forth*

*and we felt she was still competent and all those things. So it was a huge dilemma because she was slowly basically wasting away. And it became a huge dilemma in terms of do we let this lady die? Are we slowly killing her?*

By the same token, exercising the necessary paternalism to protect an incompetent client from harm could be equally ethically uncomfortable for the social worker, as these comments from Participants 4 and 5 demonstrate:

*Participant 4: Okay what I wrote down was that one of the challenging ones was that sick man on the mattress on the floor who didn't want to leave. And I had to struggle with my decision to call GAU [Geriatric Assessment Unit] and have them go in and I had to say to the geriatric people, the GAU people, I had to say, "Find a way to get in. Find a way to convince him that you're going. Lie if you have to." You know, to get in because this man is on the floor and there's something very wrong with him, and he can't even get food for himself. Ah, so, you know, that was a bad one.*

*Participant 5: So we ended up getting an ambulance, um, they came to take her, she fought with them, they had to sedate her quite heavily, and um, they almost had to kind of bundle her up and wrap her so tightly in the blankets that she couldn't move her arms. And they escorted her off to the nursing home. So that was a very difficult process for us who were involved, and for the nursing staff who had to actually sedate her, and sort of, you feel like you're taking away all the rights of the person. It was a very difficult situation.... It doesn't make you feel good.*

It is important to note at this point that paternalism and ageism go hand in hand.

The social workers in this study recognized the tendency of colleagues to paternalize someone because of their age and deny them their right to self-determination:

*Participant 1: Other times it's been our physio, you know, who says, "I know he tests competent, but he doesn't behave competent, this isn't competent." You know, our OT has told people "You cannot go home."*

*...sometimes, you know you see stuff when they're in the hospital. You see the stuff they do to themselves, you know it's so hard to watch. But they don't qualify to be a dependant adult, and if they don't they don't.*



*Participant 6: People come into hospital, they need diagnostics. Somehow that's interpreted that we have every right to take over their life and to look into every facet of it. Um, so that people come into hospital, referrals are made to social work, they're very rare do I get a case that the patient has been made aware that the social work consult has been ordered. So to me that says something right there about the statement of strength that we see in people, and capabilities to cope, that somehow this is being seen as something horrific by the person assessing them, without any consult to them about "do you want to see the social worker?", I get a consult.*

#### *Question 4: Satisfying All Parties*

Question 4 read: *In your discharge planning work, what ethical challenges have you encountered in devising a discharge plan that satisfies all parties?* As noted in the methodology section, question 4 was omitted from all interviews after the first as the researcher became aware that it potentially biased participant responses toward an approach that has as its aim to satisfy all parties.

#### *Question 5: Resources in Support of the Discharge Planning Role*

Question 5 read: *Do you find certain resources helpful in situations where you encounter ethical dilemmas in discharge planning? Please elaborate.* After stating the question, the researcher described resources as not only collateral community agencies, but people with whom the participants consult, and personal values and beliefs that the participants draw upon, when faced with ethical dilemmas in their discharge planning work. The resources cited are listed in Table 4.2.

By far, the first choice of resource of these participants for solving ethical dilemmas was to consult with colleagues, most often other social workers on or off site, but also with other health care professionals. These participants described taking advantage of colleagues to debrief on decisions as well as feelings:

*Participant 4: Ah, you know but other coworkers, certainly we do spend a lot of time hashing out stuff and over coffee and lunch and that sort of thing.*

*Participant 5: My geriatric team colleagues, as well as my social work colleagues. And so I often use them as a resource for myself in terms of processing my feelings, and talking about the situation and the issues that I'm facing.*

*Participant 6: Colleagues, of course, to debrief on very difficult, challenging cases.*

Medical and nursing colleagues were consulted not so much for their input on ethical issues but as a means of gathering information on medications and prognoses of clients the worker was attempting to help. Not just experienced social work colleagues, but in the case of these participants, students, clients, and families, were useful in reminding the participant of basic social work values underlying practice, as is evident in the following examples:

*Participant 1: Students, I have students and one of the things students remind me of over and over again is, "Shut up and sit down and listen," because I get so involved with being the professional that I don't even realize that I've slipped back into it again and so all those things are resources. Families and residents and our patients and students who remind me of what our roots are as social workers and what are the basics.*

*Participant 2: ...when I'm caught in a situation that I clearly don't understand, I sometimes try to play the role of the patient....And so that's when I try to empower the patient and/or family to...guide me....And when you let people know you don't know, sometimes they will help you.*

In the vast majority of cases, collateral agencies were involved not for the purposes of "passing on" the responsibility for the client to others, but in order to determine the intervention that was most in line with client welfare and wishes or to broker needed services.

**TABLE 4.2: RESOURCES USED BY PARTICIPANTS IN SOLVING ETHICAL DILEMMAS**

Participant Number	1	2	3	4	5	6
<b>Resource</b>						
<i>Individuals</i>						
Colleagues on or off site (social work, psychiatry, occupational therapy, physiotherapy, nursing)	X	X	X	X	X	X
Families and residents	X	X				
Practicum students	X					
<i>Community Agencies or Associations</i>						
Alzheimer Society						X
Bethany Lifeline		X				
Chinese Cultural Centre	X				X	X
Family Caregiver Centre	X					
Home Care program staff	X		X	X	X	X
Hospital ethics committee		X			X	X
Kerby Centre	X				X	X
Legal Affairs department of hospital	X					
Meals on Wheels		X				
Office of the Public Guardian	X	X				X
Protection for Persons in Care toll-free number	X					
Senior's Liaison at Calgary Police Service	X	X		X	X	
<i>Personal/Internal Resources</i>						
Experience	X		X			X
Humility		X	X			
Reading			X			
Self-awareness, intuition			X			

The most interesting resources to this researcher were what might be grouped as “personal” or “internal” resources, like experience, intuition, humility, and knowledge.

Participant 3 refers to the intuition aspect:

Experience was mentioned as a valuable asset by half of the participants. They referred to drawing upon analogous cases when they were providing solutions to the fictional case studies, like Participants 2 and 3 do here:

*Participant 2: But I do believe that a lot of ethical dilemmas are, I I had a lot more dilemmas when I was a young, inexperienced social worker [laughs]. I don't have as many ethical dilemmas [now].*

*Participant 3: I rely on, you know, the knowledge that I've gained through school and experience, and you know readings that I've done, I mean that's a piece, that theory piece.*

Lack of experience in dealing with a particular ethical dilemma was a source of stress for these participants. A few of the participants made reference to the confidence they felt as experienced social workers in approaching a specific ethical situation that would have troubled them as new social workers. The following comment from Participant 1 reflects this sentiment:

*Participant 1: But I would lose sleep over this one because because I haven't done it before. Once I've done them once, then I have something to go back to, to learn from, to do better the next time, all those things, but this first time would be really tough for me.*

#### *Question 6: Processing Ethical Discomfort*

Question 6 read: *How have you processed your discomfort with the ethical dilemmas you have encountered in discharge planning?* The means of processing ethical discomfort uncovered in this study could be grouped into the following general categories: determining mental competence, establishing priorities, and defining one's alignment with the system.

### Determining Mental Competence

For the social workers in this study, competency provided a very clear-cut variable in an almost mathematical equation for determining a client's rights around self-determination. Specifically, mental competence was accepted by these social workers as licence to defend the client's right to self-determination; mental incompetence was accepted as licence for paternalism. Below are only a few of the many statements of certainty on this point:

*Participant 1: ...if I find out somebody's incompetent, I am the first person to whip off an application to the Guardian's Office, because they can't make those choices anymore.*

*Participant 2: ...the first issue I'd say I'd be thinking about is if the patient is competent. ...the reason I'd say I'm even a little bit fixed on the competency issue is that I think it's very clear in our policies what my job would be regarding competency. So that for instance, if a patient is competent, ...there's a different, clearly demarcated options that I must now pursue.*

*Participant 4: Well, basically I think incompetency negates the self-determination. I feel that, you know if a person is not competent and doesn't have a reliable caregiver to look after their needs, then we have an obligation as social workers to protect them, even from themselves, you know.*

*Participant 5: ... if she is [competent], then you have to let her go home. If she isn't, then you can take away her right to decide and place her in a nursing home.*

If needing to paternalize or restrict the self-determination of a client causes discomfort for the social worker, it would seem a logical adaptation for an ethical professional, like Participant 1, to find ways to justify this necessity:

*Participant 1: But to me, if somebody can live a happy day with other people around who truly care that they're happy, a place where families can come and meet other families who provide support to them just because they're going through the same thing, that to me doesn't sound like a bad existence.*

### Establishing Priorities

A very basic means for these social workers of dealing with ethical dilemmas in their work was to remind themselves of their basic values; for instance, whose interests were foremost. The comments of these participants are directly reflective of their recognition of their primary professional obligation—the well-being of the client:

*Participant 1: So I think what you have to do is decide who's the most important priority, and it's the client [with a tone as if to say, of course].*

*Participant 3: I mean really my client in this case is the patient, and I just always have to keep that in mind.*

A few of the participants, as was the case with Participant 4 here, acknowledged the family as client:

*Participant 4: And so, um, you know, I equally support the self-determination of that family member or you know to um so that they don't burn out. I mean the caregiver is my patient in almost every...case as much as the patient is.*

Helping the client to maintain a high quality of life was deemed a priority by

Participant 6:

*Participant 6: ...I feel they have every right to anything available and possible that gives them quality of life.*

The ethic of beneficence was another guiding principle in helping the participants resolve ethical dilemmas, as is evident in the following comments:

*Participant 4: Who am I doing this for, or who is benefiting from this, you know?*

*Participant 6: Whose benefit am I doing this for? You know if I've got a patient who clearly does not want anything else done with the situation. If I choose to go off on my high horse and take it on, then whose needs are being fulfilled here? I think that's an important one to ask. Um, you know, what will be the final outcome if this goes much further? Is there going to be benefit to the patient or further harm?*

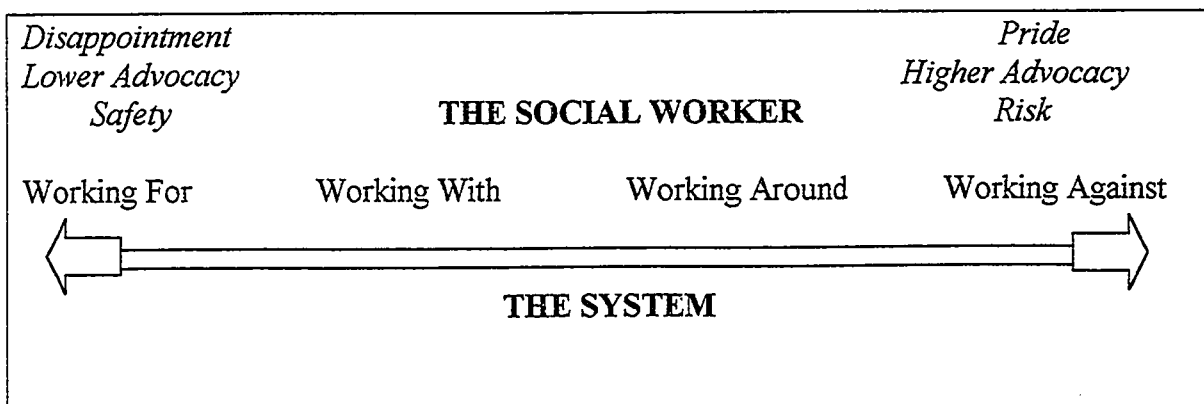
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It has already been noted that the social work discharge planners in this study faced the challenge of balancing their obligations to the client with their obligations to their employer. An extension to the establishment of priorities, then, would be some kind of soul-searching in terms of one's relationship to the system.

#### Defining One's Alignment with the System

The system, as defined by the participants, extends across a range, from other members of the multidisciplinary team to the rules and policies of the CRHA. The approaches of social work discharge planners in this study toward resolving ethical dilemmas arising from systemic constraints also sit along a continuum. This continuum is depicted in Figure 4.1. Major points on this continuum are termed "working for the system," "working with the system," "working around the system," and "working against the system." An example of each of these approaches is given following the figure.

**FIGURE 4.1: THE SOCIAL WORKER AND THE SYSTEM**



Working for the system:

*Participant 4: You know, you feel for the patient and the family but...it doesn't help your profile to spend a lot of time arguing for them.*

Working with the system:

*Participant 2: ...once you get to know the system like I think I do, you know how to work it. I must tell you, I work it for my clients.*

Working around the system:

*Participant 5: But yet you were doing what you needed to do to help facilitate change.*

*Interviewer: And you made big change.*

*Participant 5: Big change. Huge, it was huge. But in order to do that, um, I really had to go way above and beyond what my job description was.*

Working against the system:

*Participant 1: ...but I almost lost my job, and it's still going on, and it's going to the commissioner in charge of the FOIPP... and it may go to court. It almost assuredly will go through the commissioner of the...inquiry.*

One's choice of alignment with the system is, in turn, a source of professional identity. For the social worker, alignment at the far left end of the continuum is associated with a safe, low profile; alignment at the far right end is associated with potential risk to one's career in the health care system. Internally, at the far left end is a sense of disappointment in oneself, as reflected in this comment:

*Interviewer: ... can you think of one where you met the administration head on and found conflict, because you felt so strongly about a certain issue?*

*Participant 4: Oh, I hope there is at least one in my career.*

*Interviewer: [laughs] Why do you say you hope there is?*

*Participant 4: [pause] Well, because I wanna believe I'm that strong an advocate and that good a social worker, you know. That's what social work is....*



At the far right end of the continuum is a sense of pride in oneself as a professional, as reflected in this comment:

*Participant 1: Um, so when I realized that I actually can stand up to the system, even though it's horrid, I'm willing to do it. And that makes me feel really good.*

This observation is not included as a criticism of any of the participants, but as an indication of the types of adaptations that social worker discharge planners have made to the extremely challenging environment in which they all attempt to uphold social work values. All participants acknowledged the need at times to “fight” the system in order to uphold their values. The following comments from three of the participants suggest the prudence of compromise on the position of fighting the system:

*Participant 2: Because you see some fights you have to know when. You can't take on all the fights.*

*Participant 4: Pick your fights, you know, you pick your fights. The ones that you feel the strongest about you go to bat for, and then you let a few slide.*

*Participant 6: You've got to fight the system sometimes. And you can't do that just as yourself.*

#### Providing an Ethical Conscience

“...it's hard sometimes, to be the outlier,” commented Participant 1. All of the social workers in this study work closely with a multidisciplinary team comprising medical doctors, nurses, occupational therapists, physiotherapists, psychiatrists, and fellow social workers. All participants spoke of the individuals on their multidisciplinary teams with respect and even fondness. Yet, although two of the participants in this study acknowledged times when they took advantage of an alliance with other team members for the good of the client, more often they identified their fellow team members

collectively as part of the “system” that works for the efficient discharge of clients above all else. This resulted in the social workers being self-described outliers, the sole defenders of ethical principles respecting client welfare above all else.

The following comments are indicative of the ways in which the participants distinguished themselves as social workers from the other members of the multidisciplinary team:

*Participant 1: I think ultimately it's the social worker who, at least in my experience, in most cases, who says "This person has a right to be who they want to be, like it or not. You guys [colleagues on the multidisciplinary team] may not like the choices they're making, but short of putting someone else in danger, they can make their own choices." ...in this work with these people part of my job is to... make sure that I understand their rights and then interpret those for the people around them who are also trying to care for them or who have a stake in their discharge....*

*Participant 2: Because you see people will sort of say, "I support, I support, I support, I support" but, and then they'll back off, and you don't have the whole arsenal of the hospital and hospital administration. For instance, with the lone social worker in the middle trying to reinvent the wheel.*

*Participant 3: Working with the team, and I see that as a very important part of what we do and, working well together with the other team members. But also, being a voice for a person that's often lost in the whole medical type of system. Like that system, in a hospital, often the person's wishes are overlooked and their voice may not be heard. So I really see that as a big role for social work, is bringing those wishes and decisions to the rest of the team.... our role is to bring forth that voice, it's also to encourage that self-determination, and respect that....*

*Participant 4: Ya, well, you know, when the unit wants the bed, and you're the one who keeps coming back all the time and saying, "Hey, let's just try for another couple of days," you know that isn't what they see as needing to happen.*

*Participant 5: And that's my continuing struggle; it's my continuing challenge, within um a very fast-changing, evolving kind of system that doesn't necessarily take into account what the patient wants, or what the rights of the patient are, or what's best for the patient.... Whereas social workers come from a place of psychological and social support, and empathy, and all of those things. And so we*

*are the ones that often run into these kinds of dilemmas because of you know, just that whole scenario, of ah you know the politics and system issues, and all those kinds of things.*

**Participant 6:** *And you're working against the team, you know, who want people out right away.*

Social workers come from a slightly or vastly different standpoint than any other member of the multidisciplinary team, because of differences in training, but also very much because of their ethics. The Social Work Code of Ethics (CASW, 1994) emphasizes the obligation of the professional to *advocate* for client rights and social justice. Thus, these social workers, in their acute care environments, often find themselves advocating for the client or educating the team on the pieces of the picture of the client situation that may otherwise go unseen or neglected. Participant 6 describes—with a tone of pride—a particularly poignant example of advocacy within the team environment:

**Participant 6:** *[stated by another, non-social work member of the multidisciplinary team:] "If she aspirates and dies, who cares? She's 91 years old." And I said, "Well that family cares. And that's their mother. And they don't care that she's 91 years old. They want all stops pulled out for her." So I said, "Do we not have an ethical/moral issue here, to get her assessed properly again? It's been two weeks. If the family are seeing improvement, let's go with that. Otherwise, they're going to have that guilt on their heads, by feeding her, and if she aspirates and dies, then she's died at their hands. So let's do this, put everybody's minds at rest. Maybe there has been improvement." Well she hemmed and hawed about it, but she was very upset and very angry. So anyway we ended up getting a second opinion consult for a swallowing assessment, and she had improved. So we did put her on the start of a pureed diet. Well she went home two weeks later and she's still alive.*

A few of the participants expressed an experience or an impression of lack of support that was or would be received from the system in the event that the social worker,

by upholding the best interest of the client, brought unfavourable attention to the hospital.

Participant 1 described a very trying point in an exemplary career where this lack of support actually almost resulted in firing:

*Participant 1: So if you ask do I have regrets, my biggest regret is um that the disillusionment of being less than supported by these people that I work for....*

Participant 2 expressed anticipation of such non-support in the event of a controversial event:

*Participant 2: I'm not a person who wants to necessarily identify the issue, but have no way of dealing with it, but is not empowered to do squat about the issue, or, alternatively, put myself professionally at risk....And I do believe that the social worker doesn't have the protection of the system, if push comes to shove. If it ever hits the newspaper.*

#### Maintaining Compassion

One of the greatest frustrations of the social workers in this study was the treatment by “the system” of its clientele. As stated earlier, the system was at times anthropomorphized as a beast that shows a definite lack of respect for clients and their wishes. Consider the language alone. Clients within the medical system who question the medical or social recommendations of the treatment team are labelled “non-compliant.” Often the clients who do go home at risk come back into hospital, sometimes more than once. The system has a label for such clients—“frequent flyers.” Such language portrays the consumer as a nuisance to the system. The respondents in this study had a more humanistic perspective on what’s behind multiple admissions, for instance. The following comments are reflective of greater compassion and understanding:

*Participant 5: “If we let him go home he'll be back in a couple of weeks,” which may be true. But sometimes people have to go home, come back several times*

*they have, can have multiple admissions or visits to the emergency room, before they realize that "Well, maybe I'm not doing so well and I need to, you know, do something different."*

*Participant 6: Like the one fellow who was newly diagnosed with cancer and really wanted to go back to his home. I think we all would believe in our heart of hearts it would be short-lived for him to go home, but sometimes people need to go home to start the grieving process, and then build up from there.*

Participants confirm the practice of placing sick clients in hospital corridors, given the lack of availability of hospital beds for them, and the need to move new, more acute admissions from Emergency into the available beds. Participant 5, for instance, sees this situation from the viewpoint of clients and families:

*Participant 5: You know what about, um, you know, the policymakers? What about their parents or their spouses or their family? Would they want them to be sitting out in the hallway where everybody's gawking at them, and they're sick and they're not well, and...?*

Participants speak of the ease with which team members suggest long-term care institutional placement for certain clients, without regard for the resulting trauma for the client and family. The decision to give up one's lifelong independence cannot be an easy one. Yet the system shows very little awareness, let alone consideration or patience, with this process as experienced by seniors:

*Participant 5: I would say, "Are you aware that the doctor has asked me to look at [long-term care placement for you]? Often you get "No." That the doctor's had no conversation with them about this at all.*

In such an atmosphere, the social worker faces a tremendous challenge in ensuring the client is not totally demoralized. But the social workers in this study were determined to maintain compassion within the system. Participant 5 speaks with notable passion on this point:

*Participant 5: ...and for me this second case I was just talking about it illustrates how social workers within the health care system can make a difference, in terms of maintaining the compassion within the system. And that's my continuing struggle; it's my continuing challenge, within um a very fast-changing, evolving kind of system that doesn't necessarily take into account what the patient wants, or what the rights of the patient are, or what's best for the patient.*

### *Question 7: Needed Changes*

Question 7, in combination with question 5, was intended to address the second objective of this study: to provide a foundation for the subsequent development of resources for dealing with the ethical conflicts encountered by social worker discharge planners. Question 7 read: *What contributions or changes, if any, would you make to social work education, ethical codes, or practice guidelines to increase the ethical comfort in planning the discharge of elderly clients at risk?* Participants identified a need for changes in three areas: attitudes, education, and resources.

#### *Changing Attitudes*

One of the oft-cited needed changes was that around the attitudes of health care professionals toward the elderly. The comments of participants on this topic were indicative of their commitment to social change and advocacy for a group of persons who are discriminated against by health care professionals and society in general. Two such comments are reproduced here:

*Participant 1: And we need to look at not just what are their needs, cause I find that bandied around all the time. "Separate their needs from their wants" [said as if mimicking someone giving an order]. Excuse me, when you buy a house, you buy a house and you say, "What's the exposure," you know, "Which way does this window face?" You know, "Am I gonna get the southern exposure or am I gonna be stuck with a northern exposure and freeze my buns off in this Cal... Calgary climate. And my plants are gonna shrivel up and die because they don't have enough sun," or whatever. Somebody in long-term care says "What's the*

*exposure?" and we say, "You don't get to ask that question. You don't even get to pick who your roommate is. Take the bed or don't take it." You know, and so, we have a long way to go in what we do with seniors, and with discharge planning.*

***Participant 6:** [speaking of social work students and practicing social workers] I really think people need to take... some kind of attitude test and assessment developed for assessing your attitude toward the elderly. Because people come into this thinking, "Oh yeah, they can do the work." And yet they fall very quickly into this paternalistic framework of dealing with the elderly. And they're not comfortable, they're truly not comfortable with older people.... And I think unless you have a comfort zone for the elderly and the issues that they come with, then you have no business doing the work. You know, cause we have lots... on our unit who could care less about working with the elderly, they do not treat them with respect. Um, I think you need to be aware of your own issues where that comes from to really do a good job of it.*

#### Changing Social Work Education

Participants were generally critical of the role of the Social Work Code of Ethics in helping to resolve ethical dilemmas. The Code itself was seen as very esoteric, and none of the participants referred to the Code upon encountering an ethical dilemma in discharge planning work. It was also pointed out that the Code could be strengthened if accompanied by a set of practice guidelines. Below are two of the comments that emerged in the context of question 7:

***Participant 1:** Practice guidelines would be nice... you know, things like case studies that explain how you would function within the guidelines of Canadian ethics.*

***Participant 3:** But I think that it's one thing to read through that Code of Ethics, and another to be faced with a real situation and have to make decisions. They're quite different.*

Participants felt that social work ethics and values needed to be emphasized more in social work education. At present, one participant noted, social work values and ethics are taught "by osmosis." Another noted that, during her education, the Social Work Code

of Ethics (CASW, 1994) was made available, but was unaccompanied by any discussion of how these ethics are encountered, interpreted, or operationalized in practice.

Participants noted that any theoretical knowledge of ethical values needs to be combined with opportunities for open discussion about ethics and ethical dilemmas, and practical experience in resolving ethical conflicts. These participants are, in effect, identifying a major shortfall in the curriculum of a profession that bases its practice on the interpretation of ethics:

*Participant 2: ... I don't have a lot of confidence in just sort of leaving it up to the social worker, or any profession for that matter, to just saying that "Here it is, take a read." I think, though, if we make, to make it important, if it becomes a required course, so that we develop a course that that also that goes deeper than our core social work values, so that we can sort of expose our our um graduates to the debate.... We need to at least expose them to these discussions, these debates, these possibilities, that may come at you.*

*Participant 3: I mean, ya again, there's not going to be a definite answer, but just having that discussion. And I didn't have that in my education.*

*Participant 5: So I think what's lacking within I think the school of social work or the teaching component is, you're not going to find the answers to your dilemmas within the books that you read. The real world of social work is dealing with people. And I think that's where most of your learning is.... So I think there needs to be more emphasis on practice.*

Some of the participants recognized the need for more courses that have seniors, and exposure to seniors, as their focus. Participant 6 pointed out, "Because anybody who ends up in acute care medicine, predominantly we're working with the older population over 65." Such courses would have as an additional aim reducing ageism. Here were a few of the suggestions put forth by the participants:

*Participant 1: The first thing I'd do...is talk to students...to share with them my love of work with seniors. Um, I think the key issue in all the things I've expressed*



*is an understanding of seniors as real-life human beings.... And if you can really allow students to have an experience with seniors... then you have a batch of social workers who even if seniors aren't their first choice of population to work with, have some sense of them of that, not at sixty-five you become a senior and that makes you a different...race, you know.*

*Participant 4: ...I think exposure to the population would go a long way, somehow. Some...reality checking, some real understanding of real-life cases, you know, that that would get people thinking a little bit more, and reduce the amount of ageism.... Ya, a course in ageism, somehow.*

#### Adding Appropriate Resources

Participants clearly indicated that there needs to be some humanity in the system. And social workers are inclined and willing to provide that humanity. But due to resource restrictions, the social worker must swim against the current to provide some humanity. One social worker talked about the lack of an intangible resource—time—facing all those working within the acute health care system. Social workers would use this time to engage with clients and build trust, which would make the more concrete tasks involved in their jobs less trying for both workers and clients, and more humane. These participants address the issue of a lack of time:

*Participant 3: ... just sitting with someone and just talking to them and listening to them, isn't always seen as a priority, because it's not, like these concrete tasks like doing the paperwork to get this person to somewhere else. Or, you know. It's an undefinable task, and yet I feel that that's very important.*

*Participant 4: ...ideally I would be following along, I would be talking frequently, I would know what the outcome was, um, but that's not the reality. You know the reality is that you can't you can't follow every case that you see....*

*Participant 6: I mean, we really do get single-session therapy. You often see these people once. You write up an assessment report, and they're gone.... We see people as inpatients and then they go. We don't have time to carry an outpatient caseload.*

Participant 5 spoke of the direct relationship between resource shortages and client choice:

*Participant 5: We don't have enough long-term care beds, we don't have enough acute care beds. So, you can't stay here any longer, you have to go somewhere else.... To me, that is a very difficult situation, and I would have a hard time working consistently within that because my concept (laughs), philosophy of end-of-life care is um a palliative care unit is where people come to end your life, so why would you have to be discharged from that if it doesn't seem appropriate?*

Participants had some suggestions for change at the level of the system, and the community:

*Participant 1: I would love at some point, a way of helping on a regional health authority at a Calgary level, even a provincial level, but how do you look at seniors' wants, and how do we incorporate those in our fifteen-year plan.... And I'd want the public to be more attuned.*

*Participant 5: So you know those rules wouldn't be there that we'd have to follow.... You know if you're talking about Ethan, if you're talking about Mr. Chan, Elizabeth, um, you know, all of those cases would be much simpler if you were able to access the kind of resources people need, if you were able to um, you know, provide the kind of support they needed, and if you had people who understood holistically what the situation entails, and you didn't have people who were very quick to judge situations.*

## SUMMARY

When asked what sets social workers apart from the other disciplines on the multidisciplinary team within the acute care environment, Participant 1 replied: "I think when I compare us to the other ...disciplines that I work so closely with, I think it's the ethics. I do." Perhaps this is why, if there is an ethical dilemma to be experienced, challenged, or resolved, it is the social worker on the multidisciplinary team who most often leads the charge.

Though the social workers participating in this study had enough experience to be “sullied,” or hardened against maintaining their original ethical obligations, this was not the case. All participants identified numerous ethical dilemmas inherent in the fictional case studies and in their work. They were quite congruent in their recognition of and responses to these dilemmas, and often creative in their strategies for relieving ethical discomfort.

When the researcher faced the task of summarizing the ethical dilemmas encountered by the study participants in terms of their sources, it became evident that all dilemmas fit neatly into one of two categories: those arising from systemic constraints, and those arising from the belief in the right to self-determination.

Strategies for relieving ethical discomfort were far from passive, and involved self-awareness (soul-searching), advocating, educating, and brokering. Resources used in support of the discharge planning role included both the instrumental and the intangible, with the most valued being consultation with colleagues. Participants identified changes needed in the system to make ethical decisions more palatable and to reduce ageism.

Despite the restrictions imposed upon the application of social work ethics and values to practice in the acute health care environment, it remained very important to each of the participants to uphold these values. Five of the participants spoke with pride about remaining steadfast to these values, often against the odds. The sixth participant spoke with disappointment at not being able at times to uphold a standard of practice of which a social worker could be as proud as desired.

Nevertheless, the message behind each participant's words was the same: despite systemic restrictions, none had forsaken the values and ethics of the profession of social work. In fact, they showed a tenacious commitment to the field and its values, against the odds.

## **CHAPTER FIVE:**

### **DISCUSSION AND RECOMMENDATIONS**

#### **INTRODUCTION**

By the time of the writing of this section of the research report, the researcher had partaken of the creative process that characterizes grounded theory methodology. Theoretical sensitivity was heightened and original contributions to the knowledge base arising from this research study stood out.

The first section of this chapter is devoted to a discussion of those general aspects of this study's process and findings that struck the researcher as significant or intriguing. Excerpts from the literature and from participant interviews are minimal and are presented solely for the purposes of supporting or illuminating the findings.

The reader is reminded that grounded theory methodology distinguishes itself from other qualitative research methods in its emphasis on theory development. The theory that evolved from this study will be presented in the second section of this chapter. Recommendations for action, arising from existing and new knowledge, are presented in the third section of the chapter. A discussion of the strengths and limitations of this research study, as well as suggestions for future research, form the final two sections of the chapter.

#### **DISCUSSION**

The outstanding aspects of this study, in the perspective of the researcher armed with theoretical sensitivity, are presented under the subheadings in this section.

### *A Long-standing, Broad-based Issue*

The reader likely noted the literature references dated as far back as twenty-five years. In most reports, such dated references would indicate a topic no longer worthy of investigation. In the case of this study, the researcher considered relevant the fact that, after a quarter century, social workers within the acute health care system are still being forced to grapple with the ethical conflicts that plagued their predecessors, without innovations in mechanisms that support their discharge planning role.

Identical issues spanned not only across time, but also across space. The researcher noted that whether references evolved from Canada, the United States, or the United Kingdom, or from the discipline of social work or nursing, the revelations were interchangeable. In short, ethical dilemmas in discharge planning work with senior clients have been of long-standing concern to client-centred professionals across North America.

### *Ethical Dilemma or Practice Challenge?*

The researcher experienced a moment of near panic well into the study at the realization that the phenomena under study may in fact not have been ethical dilemmas at all. Based on purely instinctive criteria, the issues encountered in the short exposure to discharge planning in the hospice environment were framed as ethical dilemmas. After all, it was the researcher's understanding of her ethical commitments as a social worker, placed in opposition to the practice reality, that caused discomfort and uncertainty as to what was the "right" course of action. In addition, only one of the study's six participants framed the "planted" ethical dilemmas otherwise (as practice challenges).

It was upon the discovery of definitions from the nursing literature for the terms *ethical dilemma* and *ethical distress* that the researcher postulated that perhaps the problem lies with social work's definition of the term ethical dilemma. Social work definitions all seem to imply that an ethical dilemma occurs necessarily when a professional is forced to choose between two—presumably equal—ethical commitments. These dilemmas are presented as win-lose situations in which, when one ethical principle is chosen, the other is forsaken. Is not any situation that causes the worker ethical distress potentially an ethical dilemma? It seems to this researcher that, when the overall welfare of clients is potentially at risk based in part on the ethical judgment of the social worker, we should be as inclusive as possible, in order to provide the utmost safeguard, in our characterization of what constitutes an ethical—rather than a practice—issue.

### *The Calibre of Social Workers in Discharge Planning*

Despite the serious challenges under which they operated, this researcher recognized the high calibre of social workers performing discharge planning in the Calgary region's acute care sites. These social workers clearly had not compromised on the basic values and roles of the profession. The values of compassion, empathy, egalitarianism, and the roles of teacher, broker, and advocate were evidenced as alive and well.

Participant 5 nicely summed up the social worker's orientation, persisting over several years of practice, within a system that often presents significant challenges to the expression of this social work orientation:

*Participant 5: ...the real meat of what social work is all about was in that one case—empowerment, ah, right to self-determination, ah, respect for client's rights, um, advocacy, looking at compassion... respect the client's opinion... be as non-judgmental as possible....It comes by understanding. It comes by empathy....And the basis and foundation of social work practice is engagement and being warm and empathetic toward your client, and non-judgmental and respecting their rights, and advocating for their needs....and if you don't have the basic understanding and empathy and warmth for people, I don't think you should be in social work. You know, you need to come from a place where they're at.*

### *In Defence of the System*

There is likely a tendency in any social worker who has been exposed to discharge planning work within the acute care system, or perhaps simply exposed to the findings of this study, to experience frustration and even anger toward a system that makes granting clients their most basic rights a difficult challenge, a sometimes futile endeavour. Yet a more objective stance allows us to recognize the possibility of an inherent conflict between the values and ethics of the social worker and the goals and objectives of the system.

In keeping with the representation by the participants in this study of the system as a living “being” of sorts, it may not be the “intent” of the system to deny client choice and dignity. Dash et al. (1996) point out that the system is simply behaving true to standard form, under current economic and political conditions. These authors recognize the obligation of the acute care institution to balance the rights of *all* clients. They say: “The foundation for institutional decision making is the utilitarian model, ensuring equal care, concern, and resources for all patients. Thus the interest of one patient may be compromised to serve the interests of all” (Dash et al., 1996, p. 161). Jecker (1991) echoes the dilemma inherent in the structure of the system: “We like to think of



individuals as unbounded, free agents, yet, on reflection, the larger society has moral authority to choose how to use and distribute its common stock” (p. 210).

## EMERGENT THEORY

The researcher equates the term *theory* with the generation of knowledge of aspects of the lived experience of the study’s participants. The discussion of theory is broken into three subsections that correspond generally to the two objectives of this research study. These three subsections present theory around: (1) how ethical dilemmas are experienced by social work discharge planners, (2) how these professionals resolve the discomfort arising from ethical issues, and (3) how their efforts to deal with ethical dilemmas on the job could be supplemented by initiatives beyond their own.

### *Sources of Ethical Dilemmas in Acute Care Geriatric Discharge*

The development of theory began with the identification of the major themes emerging from the study’s findings. As noted in Chapter Three (Analysing the Data, Coding), all data could be organized into one of three strong themes: competency, client choice, and systemic constraints.

Upon further contemplation on the data and reference back to the literature, the researcher realized that these three themes could be re-categorized as two major sources of ethical dilemmas: (1) those arising from constraints imposed by the health care system (both acute and community-based); and (2) those arising from the uncompromising commitment to the social work value of client self-determination.

### Constraints Imposed by the Health Care System

By far, the major source of ethical dilemmas in discharge planning with geriatric clients is one that to date has received relatively little attention in the literature—the constraints imposed by the health care system. One of these constraints is the recognized dearth and inaccessibility of community resources for providing continuity of care once an elderly hospital client returns to her community.

Yet the greater constraint seems to be in the form of another scarce resource. That resource is the time available to social work discharge planners to: first, develop a trusting relationship with the client and the client's family; second, develop a comprehensive discharge plan that provides quality, continuous care; and third, to follow the client into the community and evaluate the outcome of their interventions.

This study revealed that the participants performed the second function extremely well given their restrictions, but that they (and presumably the clients and families) often suffered negative consequences for being unable to perform the first and third at all, or with a degree of thoroughness.

### The Uncompromising Commitment to Self-determination

The social work discharge planners who participated in this study, like all social workers throughout the history of the profession, fall victim to the lack of guidance provided by our profession with respect to the application in practice of the ideal of client self-determination.

The Social Work Code of Ethics (CASW, 1994) provides no middle ground on this principle. As social workers, we recognize intuitively that, given the predominance

of self-determination in the Code, paternalism is not an option. Yet, this does not relieve one of the discomfort of watching vulnerable clients make decisions that put them at risk.

All in all, the participants in this study dealt with this dilemma with a minimum of lost sleep, relative to the first source of dilemmas. Yet the continuance of the autonomy–paternalism debate over the history of the profession indicates the need for a more satisfactory means of resolving ethical dilemmas on this point.

### *Adaptive Strategies for Dealing with Ethical Discomfort*

It is quite logical, not to mention resourceful, given the lack of guidance from our profession on the application of ethical judgment to real practice situations, of the participants to have developed their own strategies for coping with the ethical discomfort and other demands of the job of discharge planner. Thoughtful examination of the research findings revealed that participants developed strategies for coping with each of the major sources of ethical dilemmas. Following are those strategies, grouped according to the source of the discomfort.

#### *Discomfort Arising from Systemic Constraints*

With the exception of the strategy discussed in the sub-section entitled Discomfort Arising from the Commitment to Self-determination, all of the adaptive strategies identified as used by the study's participants were targeted at reducing the discomfort arising from systemic constraints.

These adaptive strategies comprised: establishing client interests (and sometimes those of the family) as the priority; defining their alignment with the system; providing an

ethical conscience on the multidisciplinary team; and maintaining as much compassion within the acute health care system as is within their control.

An interesting concept arising from this study was that advocacy is not only vital to maintaining the rights and dignity of clients within the acute care system. It became evident that a willingness to advocate for client rights and change at the level of the system is vital to the identity of the health care system social worker. The social workers in this study aligned themselves in relation to the system in various ways. As depicted in Figure 4.1, they aligned themselves as working for, with, around, or against the system. Working *for* the system signified a type of sacrifice of principles, a resignation to the forces opposing social work ideals, a sense of futility in being able to act as an agent of change for the benefit of the client. The associated sentiment was disappointment with oneself as a professional.

Working *against* the system meant taking a stand on behalf of the client, at risk to one's own professional stature, based on a strong commitment to the obligation to advocate for the well-being of the client. The sentiment associated with this end of the continuum was pride in oneself as a professional. It would seem, then, that one's willingness to persist in the fulfillment of the obligation to advocate for the client is a crucial element of a social worker's identity.

Again, this researcher would like to de-emphasize the critical nature of this analysis. After all, the onus on the social worker as multidisciplinary team member to fulfill the role of client advocate is onerous. Says Donnelly (1992),

Keeping this balance between clinical practice and organizational priorities can be a formidable task when trying to communicate to an audience of administrators who are increasingly beleaguered by financial and regulatory constraints. This balance is also difficult to accomplish in a way that enhances the professional image and self esteem of line workers who are continuously bombarded with inappropriate expectations from professional and non professional staff alike (p. 108).

Consider the burden of fulfilling the competing obligations presented in the Social Work Code of Ethics (CASW, 1994). Point 1 of the Social Worker Declaration of the Canadian Association of Social Workers Code of Ethics (CASW, 1994) states, "I will regard the well-being of the persons I serve as my primary professional obligation." This includes applying the values of acceptance and self-determination, and battling discrimination in any form.

But according to this same code, a social worker also has a responsibility to the workplace. Specifically, subpoint 8.1 states, "The social worker is accountable and responsible to the employer for the efficient performance of duties." In 8.2, it warns us that "At times the responsibilities to the employer and the client may be in conflict...." In such cases, the subpoint stresses that it is the social worker's obligation to "safeguard client rights and promote changes in the procedures of the agency which will be consistent with the values and obligations of this Code. It may be required of the social worker to subordinate the employer's interest to the interest of the client" (CASW, 1994).

When one's livelihood is at stake by virtue of her position on the social-worker-system alignment continuum, the choice to work *for* the system is a sensible one. Considered in this light, a social worker might well encounter a no-win situation in

standing firm on the advocacy issue. The Social Work Code of Ethics (CASW, 1994), within the confines of a system that functions on a criterion other than client welfare, may actually present a kind of built-in guilt trip, with the potential of causing the most competent, client-centred social worker to experience feelings of failure. To choose a “compromise” position on the continuum, then, might well be considered a reasonable survival mechanism for social workers within the acute care system.

#### *Discomfort Arising from the Commitment to Self-determination*

The researcher frames the simple equation discussed in Chapter Four—mental competence equals the right to self-determination—as an ingenuity on the part of health care practitioners (all the credit for this one cannot go to social work). When time is at a premium, it is efficacious to be able to “sort” one’s caseload, and the potential ethical dilemmas associated with it, into categories with predetermined methods of intervention.

This study would suggest that social work discharge planners subscribe to this equation and apply the predetermined interventions to competent (education regarding the risks associated with and alternatives to living at risk) and incompetent (protect the client from harm) clients alike. The commitment to self-determination is indicative of their recognition that client well-being goes beyond the physical realm. These social workers are to be given credit, though, for going the step further. When it does not conflict with the client’s right to self-determination, they also willingly apply with whatever attempts at protecting the physical safety of the client they are able to achieve.

The ideology of self-determination seems to have persisted despite organizational constraints. In an environment where the stream of social work referrals for discharge is

constant, according to Rein, in Spicker (1990), "...it could be argued that self-determination has had a functional or adaptive role. Social workers have had little option but to accept the 'self-determination' of their clients; one cannot accept responsibility for behaviour over which one has no control. The arguments for 'self-determination' can be seen as making a virtue out of necessity" (p. 233).

A caveat for both of the variations of the competency–self-determination equation is necessary here. This study discussed the evolution of the debate around the resolution of dilemmas caused by the obligation to respect self-determination and concern for the client's safety. The most recent commentary indicates a softening toward paternalism as a positive and appropriate response to clients with a degree of dependence, and a recognition of interdependence as the ideal human state. Moody (1998) cautions, "in relationships and in caregiving in particular, non-interference can serve as a mask for indifference or the detachment of a stranger" (p. 121). We must remain careful to distinguish those clients who are truly in need of our protection.

On the other end, Participant 3 describes a situation where client incompetency can be used too loosely, used almost as rationale for an intervention that is performed for the efficiency of the system. This dangerous precedent rightly causes concern for the social worker:

*Participant 3: I think too there's a perception sometimes, um, from from other staff that once a person is assessed as not being competent, we can suddenly just go ahead and make these plans for them. But, but, you know they're aware of what's going on and it's, you mean you can't force somebody to go. So I that's a real struggle for me.*

With the luxury of significant time to establish a trusting rapport with clients and families and to think through and consult with colleagues and the literature on such issues, any of the social work participants in this study might have taken further steps to reach the *ideal* balance between client self-determination and client safety. Yet they may also have found themselves limited by the lack of community and personal resources for approaching such ethical challenges.

#### *Supplementation from the Profession*

The third category of emergent theory regards those changes that could be made to the system and to social work education to supplement the efforts of social worker discharge planners to minimize their ethical discomfort in discharge planning work with elderly clients. This theory is presented in the Recommendations section below. It should be noted that this researcher equates the ethical comfort of the social worker with client welfare, as the client's welfare is the ethical social worker's primary concern.

### RECOMMENDATIONS

At the risk of sounding pessimistic, it is unrealistic for this researcher to expect to provide any substantial recommendations for changing an acute health care system that has for at least twenty-five years presented its social work professionals with the identical sources of ethical distress. And perhaps it is not the role of an ethical code to provide more than a philosophical base for practice. It is far more productive, then, to focus on recommendations for change in social work education that could better prepare the members of the profession to cope in an environment that presents such ethical challenges. Therefore, after a brief address to the obligation for advocacy at the level of



the health care system and society, recommendations for changes in social work education form the thrust of this section.

### *Changing the System and Community Attitudes*

The social worker on a multidisciplinary hospital team is obliged to uphold and advocate for the rights of discharged clients to return in safety to the homes and communities where they derive their sense of well-being. Within the health care institution, we must resist all pressure to practice coercion in discharge planning.

At the macro level, administrative attitude changes are undeniably desirable. Feather (1993) argues that hospital administrators need to support the discharge planning function not only with resources, but also by “fostering an atmosphere in which careful discharge planning is seen as a hospital priority” (p. 12). Both Jackson (1997) and the National Advisory Council on Aging (1995) recognize that it is not hospital stays but discontinuity of care that may actually end up being the most expensive problem in health care. Given their track record to date, it is unlikely that a movement by hospital administration to address these shortcomings is in the offing. Perhaps the best social workers can do at the macro level is to take all steps available to develop and support public policies that foster viable community-based alternatives to institutional care.

Recognizing this obligation to advocate and practising it in the face of strong counter-forces toward expeditious discharge are two different matters. Exercising one’s obligation to advocacy can be risky, as one participant in this study discovered. As Figure 4.1 showed, the failure to advocate as strongly as they might have for individual clients was a source of professional disappointment for the participants in this study. While the

Social Work Code of Ethics (CASW, 1994) instructs us to “subordinate the employer’s interest to the interest of the client,” it displays no recognition of the difficulty or the dire consequences for the social worker of enacting this principle. This study’s participants deserve credit and should have high, not low self-esteem, for being smart enough, astute enough, and strategic enough to do the best they can for their clients under difficult circumstances.

Perhaps social workers need to take a more forgiving stance on their abilities to solve ethical dilemmas, as Reamer (1990) promotes:

The professional journey of every social worker includes encounters with complex and troubling ethical dilemmas which cannot be skirted.... Even after considerable thought and reflection a clear resolution, one with which we can live comfortably, may not be apparent.... Our abiding obligation as social workers is to use our abilities to respond sensitively and compassionately to the needs of those who suffer, and to use our capacity to reason to make sound judgments about what is right and wrong. Our attempts to think carefully about ethics will not always make a difference (pp. 243-245).

### *Practical Education*

Various writers have recognized that social work practitioners need clearer guidelines from the profession about when, how, and why competing obligations should be handled in the real world of practice (Abramson, 1991; Ejaz, 1991; Whittington, 1975). Decades ago, Gilbert and Specht (1967) indicated a need for the specification of boundaries for professional behaviour in areas where elusive ethical principles, like client self-determination, resisted operational definitions.

In full recognition of the difficulties arising from totalistic interpretation of ethical principles, Rothman (1989) called for the clarification of a *range* of conditions—“more

subtle and calibrated” (pp. 608-609)—under which, say, paternalism might be advisable. Whittington (1975) even extended the argument to a proposal that an ethical ideal like self-determination, “given its long and entrenched history of convoluted usage,... would be best set aside as a dominant precept in social work” (p. 81). Abramson (1991) suggests that “New conceptual paradigms are needed to help practitioners make these hard decisions with as much ethical comfort as is possible” (p. 135).

The question remains, of course, as to *how* social workers would be equipped with the knowledge and skills necessary for them to serve as ethical decision referees. It was recognized by the participants of this study, and has likely been recognized by any social worker with practice experience, that social work education, at least as it is delivered to students in this Region, does not teach us *what* to do when encountering an ethical dilemma, only how to feel and think about it. Nor does our curriculum recognize the unique dilemmas that can arise in specific contexts, like acute health care geriatric discharge. It is apparent from the literature that this is neither a new nor a localized problem. Butcher (1992) says, “curricula have made little, if any, provision for students wishing to enter practice in a health care or hospital setting” (n.p.).

This researcher joins those authors who are calling for changes in social work education, such as: courses in applied ethics (Clemens et al., 1994); “structured opportunities and resources for dealing with ethical dilemmas, overcoming isolation, and nurturing informed and mature ethical judgment” (Holland & Kilpatrick, 1991, p. 143); and dialogue about ethical dimensions of practice (Healy, 1996).

This researcher would advise, based on the findings of this study, courses and opportunities for practice in the areas of both ethics (including models for decision-making) and advocacy (micro and macro). As well, social workers will be ill-equipped to facilitate decisions on ethical issues specifically related to the growing number of seniors, or to advocate for the rights and wishes of seniors, without a knowledge of the ethical issues associated with aging.

*Exploring an Alternative Model of Service Delivery*

The researcher would be amiss to leave this chapter without addressing the likely upcoming change in the role of the social worker in the acute health care system in the Calgary Region. Around the time of completion of this research study, a CRHA committee was investigating an alternative model of service delivery that would remove the responsibility of acute care discharge planning from the social worker and increase the social work presence in the community.

This researcher would argue that such a model could actually increase the ability of the system to achieve the major goal to which discharge planning hypothetically contributes—continuity of care. At the same time, it would contribute more directly to the goal of senior clients (and thus increase the ethical comfort of the social workers who serve them) to remain independent in their own homes and communities.

Social workers with discharge planning experience or exposure, placed in the communities where seniors live, could be of vital importance to maintaining seniors' independence. As client advocates, social workers often prove indispensable to elders entering the health care system by helping them to remain in their own living

arrangements or to select another arrangement that is consistent with their values and financial resources. They would be well placed to request assessments of a senior's living arrangements. They could be instrumental in promoting the well-being of seniors by encouraging whatever autonomous decision-making the elderly individual is capable of exercising, and by supporting family members to do the same.

Given the changing context of health care, social work practice could be modified and placed where it is most effective. From the point of view of the social worker, discharge planning should help clients and their families cope with their illness and its effects and move through the hospital system back to the community with all the necessary supports (Rossen, 1997). The social worker is trained in all aspects of the discharge planning continuum, from screening, to psychosocial assessment, to provision of counseling and education, to co-ordination of an interdisciplinary team of providers, to accessing community resources, and finally to follow-up and evaluation.

Social workers are qualified to provide program planning and community development. These functions entail the identification of unmet needs among elderly persons receiving services, advocacy for the development of relevant services, and evaluation of the impact of policies on service delivery. Social workers can meet this responsibility through participation in professional, agency, and community planning committees. Social workers are adept at building formal and informal linkages with other service providers and community groups, and at working on joint projects to improve existing services and responding to unmet needs in the community (Ontario Association of Social Workers, 1998).

Perhaps even more important to the well-being of the client, the social worker's continued involvement in the discharge plan can ensure that the discharge planning process and implementation reflects social work values. Specifically, the discharge planning process should: support client and family self-determination; assume the inherent strengths of the individual to grow and change; grant the right to informed choices; enhance dignity and self-sufficiency by facilitating the individual's right to make decisions for their own lives; promote client involvement in service planning and evaluation; maximize quality of life as defined by the client; develop and strengthen family and community support; respect religious and cultural beliefs, practices, and traditions, sexual orientation and lifestyle preferences and, where possible, integrate these into the biopsychosocial service delivery plan; broker between the client and the service delivery system; and advocate for clients and for the creation of services on the basis of need (Ontario Association of Social Workers, 1998).

Donnelly (1997) promotes the role of social work in home care and says, "In this effort medical social work will realize its greatest potential for promoting continuity of care, improving outcomes, and engaging consumers in managing their own care....In helping [patients] develop choices, medical social workers empower patients, while improving patient health and reducing health care costs" (p. 31). A system of proactive case finding through referral from hospital staff to a community social worker, prior to discharge, can allow social workers to engage families and coordinate the community resources vital to their seamless transition to and continuing independence in the

community. In so doing, they would also be reducing costs by way of preventive measures that keep seniors from returning to hospital.

It is reasonable to assume that, without the constraints imposed by working within the hospital system, the social worker would more often be able to work to a standard that elicits pride. But the system still has a responsibility to contribute to the achievement of a standard for continuity of care that is comfortable for clients and their families.

#### STRENGTHS AND LIMITATIONS OF THE STUDY

The major strengths and limitations of this study are presented here.

##### *Strengths*

A strength of this study, as noted by four of the six participants, was the realism of the fictional case studies. The cases themselves, and specific aspects of the cases were cited as “familiar,” “common,” “not at all unusual,” and “very real.” This aspect of the case studies, then, served the intended purpose of acting as a springboard for the participants to recall actual practice situations in which they encountered ethical dilemmas, and the means by which they dealt with these dilemmas. The one aspect of the fictional case studies that was noted as unfamiliar was the pact for euthanasia described in Case Study 3. Participants were able to extrapolate from this situation to the general concept of family pacts and cite a number of examples of such pacts encountered in their work, and the ways in which they chose to deal with them.

A definite benefit of the study, as noted by most of the participants, was the opportunity for these social workers to reflect on and voice their practice values and to experience pride for remaining true to the primary obligation of their profession. There

was evidence that the interview elicited self-doubt in three of the participants. In other words, thinking about their responses to the questions caused them to question whether they were practicing as “ethically” as they might have been. Though it was not the researcher’s intention to cause discomfort or embarrassment for any of the participants, they indicated an intention to become more self-aware in terms of ethics as applied to their practice. This is what one participant said:

*Participant 4: ...This has been a good learning opportunity for me.*

*Interviewer: That's great.*

*Participant 4: To to have to think some of these things out and struggle with some of these things....Tough questions. I'll pay more attention from now on.*

The researcher considers the greatest strength of this study its success in generating original theory around a little-investigated phenomenon. The grounded theory methodology was structured enough and at the same time flexible enough to allow the practice reality of the participants to shine through. It also met the requirement of providing direction for action in relation to the phenomenon under study.

It is difficult to know if generalizability of findings could be considered a strength of this study. Given the distribution of participants across three acute care sites, there is reason to believe that the findings of this study would be generalizable to and representative of the majority of social work discharge planners in the Calgary Region. The litmus test for this grounded theory study would be to investigate whether its conclusions were congruent with others practising discharge planning in the field.



### *Limitations*

The size of the sample limits the generalizability of the findings. Nevertheless, a sample of six proved adequate for the generation of theory, which is the aim of grounded theory research.

Probably the greatest limitation of the study was a lack of external validity. In that only the researcher was analysing the data, the potential existed for the biases to which that researcher was prone to occur more strongly as themes.

### DIRECTIONS FOR FUTURE RESEARCH

There is a dearth of empirical research in the area of ethical dilemmas in social work practice in anything but a theoretical sense. It would be hard to imagine a study that could add to that body of knowledge. It is time to concentrate our efforts on research that uncovers the nature and experience of ethical dilemmas in practice, and that develops recommendations to address the ethical challenges encountered daily by social workers, in all different practice contexts. This researcher encountered no references that provided concrete guidelines on the application of social work ethics to practice, regardless of context. Questions that arose from this study that could form the basis of further exploratory research include:

- How do other disciplines on the multidisciplinary team experience and deal with ethical dilemmas in their work with senior clients?
- How do other professions support their members in their encounters with ethical dilemmas?

- How do social workers in (other contexts) experience and deal with ethical dilemmas in their work?
- What are the attitudes toward and experiences of social workers with paternalistic interventions?
- How does a course on ethical decision-making affect the ethical discomfort of social workers planning the discharge of elderly clients at risk?

These are only a few of the many questions that could be investigated.

## SUMMARY

Whether we frame them as ethical dilemmas or practice problems, decisions around actions that maximize client welfare will continue to challenge social workers attempting to contribute to a high quality of continuous health care for seniors. This study indicated that, in the specific context of acute care discharge planning with geriatric clients within the Calgary Region, ethical dilemmas arose from two factors: constraints imposed by the health care system, and the uncompromising commitment to the ethical value of client self-determination.

In response to the ethical discomfort arising from these dilemmas, the social workers in this study developed various strategies for dealing with ethical discomfort. These strategies included: determining mental competence, establishing the client as priority, defining one's alignment with the health care system, providing an ethical conscience for the multidisciplinary team, and maintaining compassion in a seemingly heartless system.

The social workers who participated in this study should be applauded for their initiative in integrating a high degree of professional judgment with a sound understanding of the values that underlie the profession. They should also be recognized for their courage in standing up to a contrary health care system on behalf of client welfare. To a large extent, the very system that prepared them for fulfilling this onerous obligation has abandoned them when it comes to applying ethics to practice.

It is well beyond the time when we should be restricting ethical discussions to a theoretical level and expecting social workers to devise their own strategies for dealing with ethical conflicts. The education system that trains social work professionals is obliged to provide these individuals with exposure to, discussion around, and concrete actions to take in the face of ethical challenges that they encounter daily.

Research in the area of applied ethics in the various contexts in which social workers practise has just begun. The scope of potential future investigations in this area is wide.

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**APPENDIX A:**  
**ETHICAL DUTIES, OBLIGATIONS, AND RESPONSIBILITIES OF CANADIAN  
SOCIAL WORKERS (CASW, 1994)**

1. Maintaining the best interest of the client as the primary professional obligation.
2. Carrying out professional duties and obligations with integrity and objectivity.
3. Maintaining competence in the provision of service to a client.
4. Refraining from exploiting the client–worker relationship.
5. Protecting the confidentiality of all client information.
6. Guarding against conflicts of interest.
7. Conducting private practice in a trustworthy manner.
8. Advocating for workplace conditions and policies that are consistent with the  
Code.
9. Promoting excellence in the social work profession.
10. Advocating change in the best interest of the client and for the overall benefit of  
society.

## **APPENDIX B:**

### **INTRODUCTORY MEMO**

Date

#### **WHO ARE YOU?**

My name is Kathy Austin. I am a registered social worker and a graduate student in the Faculty of Social Work at the University of Calgary. Your department supervisor may have mentioned that I might be making contact with you.

#### **WHY HAVE YOU CONTACTED ME?**

I am currently working on a Master's thesis entitled **ETHICAL DILEMMAS IN ACUTE HEALTH CARE GERIATRIC DISCHARGE**. I am in the process of recruiting six to eight social workers as participants. Discussions with your supervisor (and/or my thesis supervisor, Dr. Carol Austin) about the background of each of the social workers in the CRHA indicate that you would be an ideal participant.

I am looking for people who have:

- at least two years experience in discharge planning within the acute care system in Calgary
- a large proportion of this experience being with geriatric clients
- a desire to participate in research on this particular topic—in other words, you have something to say on this issue and are willing to discuss the topic openly

#### **WHAT IS THIS RESEARCH ABOUT?**

Planning the discharge of clients from acute care institutions is fraught with practical, political, and ethical issues. Social work discharge planners are often placed in the position of having to choose between two competing social work values. The resulting ethical conflicts often face the worker with the responsibility of planning the discharge of elderly clients recovering from illness or injury from the highly structured and supervised environment of acute care to prior or new living arrangements in the community.

Philosophical debate on the conflict between certain social work values is well documented. Yet there is a dearth of empirical research addressing the specific nature, occurrence, and outcomes of ethical dilemmas and the process of applying ethical principles to practice. Research is needed to determine the extent to which social work ethical principles are realistically practicable with various types of clients and to specify the boundaries for professional behaviour in these areas.

Through my thesis research I am attempting to answer the question: *How do social workers in acute care geriatric discharge experience and deal with ethical dilemmas in their work?*

### **WHAT WOULD I BE EXPECTED TO DO?**

Basically, I would like to involve you in a 1- to 1.5-hour, face-to-face interview about your experiences with ethical dilemmas in acute care geriatric discharge. Prior to the interview, I would provide you with three fictional case studies representing typical scenarios encountered in geriatric discharge. You would be given time (I'm proposing 1-2 weeks) to jot down your ideas about how you would respond to each case.

The subsequent interview would involve a half-dozen very open-ended questions inviting you to describe your responses to the fictional case studies, as well as to real ethical dilemmas you have encountered in your work.

The interview would be audiotaped for transcription. Resulting qualitative data from all the interviews would be analysed using the ATLAS computer program. The study is aimed at inducing new theory pertaining to the question of how social workers deal with ethical dilemmas encountered in their work.

### **HOW ARE MY RIGHTS PROTECTED SHOULD I DECIDE TO PARTICIPATE?**

Should you decide you are willing to participate in this research study, the first thing I would have you do is sign a consent form which explains, among other things:

- your right to withdraw from the research at any point
- your right to review the transcript of the interview to ensure accurate representation of your views
- your right to anonymity, ensured through the coding of your identity, the physical securing of the data, and the compilation of all results
- your right to contact my thesis supervisor to discuss any concerns about the study

Please also be assured of your right to view correspondence confirming ethical approval of my thesis proposal by the CRHA and the Conjoint Health Research Ethics Board.

### **OKAY, SO WHAT'S NEXT?**

I would like to phone you the week of November 13 to discuss your willingness to be involved in my thesis research. You are under no obligation to participate, but your willingness to do so would provide a very valuable contribution to my findings.

Thank you for your time.

Kathy Austin, B.S.W., R.S.W., M.S.W. student  
(Contact information)

**APPENDIX C:**  
**INTERVIEW QUESTIONS**

1. How did you go about planning for the discharge of the client in each case study?
2. What ethical dilemmas did you encounter in planning these discharges?
3. Please describe the most challenging ethical conflict you have encountered in a real discharge planning practice situation with a geriatric client.
4. In your discharge planning work, what ethical challenges have you encountered in devising a discharge plan that satisfies all parties?
5. Do you find certain resources helpful in situations where you encounter ethical dilemmas in discharge planning? Please elaborate.
6. How have you processed your discomfort with the ethical dilemmas you have encountered in discharge planning?
7. What contributions or changes, if any, would you make to social work education, ethical codes, or practice guidelines to increase the ethical comfort in planning the discharge of elderly clients at risk?

**APPENDIX D:**  
**COVER MEMO**

(Interviewer contact information provided on letterhead)

DATE: January 3, 2001

FAX TO: Participant Name, Social Work  
Rockyview General Hospital

FAX NUMBER: 123-4567

# PAGES INCLUDING COVER SHEET: 2

Attached are the questions that will guide our discussion. I reveal them so that you can prepare yourself for the general thrust of the interview. Again, though, what is important is not that you provide structured answers to specific questions. The questions are intended to be open-ended enough to allow you to say what *you* feel is most relevant about ethical dilemmas in your discharge work with seniors. My role will be to listen and to facilitate the expression of your thoughts and feelings on this topic.

See you Tuesday January 30 at 2 p.m.

Ka

CONFIDENTIAL	This material is intended only for the individual to whom it is addressed and should not be distributed, copied, or disclosed to anyone else. Material may contain confidential and personal information which may be subject to the Freedom of Information and Protection of Privacy (FOIPP) Act. If you have received this communication in error, please notify the sender immediately. Thank you.
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**APPENDIX E:**  
**CONSENT FORM**

**Research Project Title:** "Ethical Dilemmas in Acute Health Care Geriatric Discharge"

**Investigator:** Kathy Austin, B.Sc.(Psych.), B.S.W., M.S.W. Candidate, R.S.W. (Alberta)

**Funding Agency:** Self and Graduate Research Scholarship

This consent form, a copy of which has been given to you, 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 detail about something mentioned here, or information not included here, please ask. Please take time to read this form carefully and to understand any accompanying information.

1. **Purpose and Usefulness:** As social workers, we recognize the primacy given to the principles in our Code of Ethics. Yet there is a dearth of empirical research addressing the specific nature, occurrence, and outcomes of ethical dilemmas and the process of applying these ethical principles to practice. Research is necessary to determine the practice reality of applying these principles in geriatric discharge planning and to specify the boundaries for professional behaviour in these areas. The study will aim to develop theory grounded in observation regarding how social workers deal with ethical dilemmas they encounter in their discharge planning work with geriatric clients. The results of the study are intended to contribute to the development of clearer, more realistic guidelines for practice behaviour in this area that allow social workers a higher level of ethical comfort in their practice decisions.
2. **Participants, Procedures, and Your Participation:** I am asking for your participation in this study, which comprises my thesis submitted to the Faculty of Graduate Studies in partial fulfillment of the requirements for the degree of Master of Social Work. You have been selected to participate because of your willingness to discuss openly the ethical dilemmas and for your ability to articulate the challenges inherent in your work. You will be asked, based on your experience as a social worker in geriatric discharge, to review three fictional case studies and to formulate a discharge plan for each. These case studies will present typical scenarios encountered in geriatric discharge and contain potential ethical dilemmas. You will be provided with time to prepare your responses to the case studies as if they were actual cases. Following the development of the discharge plans, I will arrange to meet with you.

The second phase, the interview, will be semi-structured; that is, I will have some specific, open-ended questions prepared in advance to ask you. In this interview, we will review each of your discharge plans and explore your decision-making process in formulating the plans. You will also be invited to describe your response to real ethical dilemmas that you have encountered in your work. In addition, you will have the opportunity to share any other information that you believe to be relevant to your decision-making process in discharge planning. I will provide a copy of the interview questions prior to the interview, so that you have time to prepare your verbal responses.

The interview will be audiotaped and is anticipated to be sixty to ninety minutes in duration. A confidential secretary who will not know your identity may transcribe the audiotapes from the interview. You will be provided with a copy of the interview transcript and asked to review it to ensure that your thoughts, feelings, and ideas have been accurately presented.

3. **Research Design:** I will be combining your responses with those of from five to seven other participants, all of whom, like yourself, are social workers with experience in planning the discharge of geriatric clientele from acute care environments. The combined results will be coded and categorized to identify themes across the entire data set. Resulting qualitative data will be analysed using the ATLAS computer program.

The study will aim to induce new theory grounded both in previous literature and the actual experiences of practitioners. Rather than relying exclusively on deductions from existing literature to address basic questions, I will directly tap the rich reservoir of experience among seasoned professionals by exploring with you and others how you actually understand and deal with ethical issues.

4. **Risks/Costs/Benefits:** This research poses no risks to anyone who will be participating in it. The only costs to you are the time that it will take in order to review the case studies, devise a discharge plan for each, participate in a one-on-one interview to discuss your discharge plans, and review the interview transcript—approximately three hours in total. The process of participating will allow you to express the challenges you face in your position and provide you with the opportunity to learn (through reviewing the cumulative results) how others in your position address ethical issues they encounter in geriatric discharge planning.
5. **Your Choice:** Participation in this study is entirely voluntary and you are free to withdraw at any time during the research process. If you decide to take part at this time, and find later that you do not wish to continue, you may leave the study then. If you are agreeable, however, in writing the final report I will use the information from the interviews that have already taken place.



**6. Confidentiality:** The audiotapes of the interview and its transcript will be assigned a number so that no name will be used in the research process. As the researcher, only I will have the list of participant names and their identifying numbers. Only my thesis supervisor, a research consultant, the transcribing secretary, and I will have access to the numbered transcripts. The data will not be provided in any form that will allow others to know who you are. The audiotapes of the interview and its transcript will be used solely for research and will be kept by the researcher, locked in a secure location for seven years, according to University policy. If this information is used for a different study in the future, a committee will have to give approval for this. After that period, the audiotapes will be erased and the transcripts will be destroyed.

**7. Further Information:** In appreciation for your generous participation in this research study, I will be pleased to share the results of this study with you at its completion. I will provide an abstract and research findings to each participant.

Your participation in this research is greatly appreciated. If you are interested in learning more about my research, you are invited to read my research proposal. Please feel free to call me should you have any questions concerning the study.

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 investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time. 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. If you have further questions concerning matters related to this research, please contact:

Kathy Austin, (403) 765-4321 (private cellular line)

If you have any questions concerning your participation in this project, you may also contact my supervisor, Dr. Carol D. Austin, at the Faculty of Social Work, University of Calgary, (403) 123-5678.

\_\_\_\_\_  
Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Investigator/Witness (optional)

\_\_\_\_\_  
Date

- A copy of this form has been given to you for your records and reference.
- If you would like to have a copy of the findings of this research, please provide your mailing address.

## APPENDIX F:

### FICTIONAL CASE STUDIES

#### Case Study 1

Ethan is a seventy-eight-year-old man who is admitted to hospital one afternoon by ambulance. One day a neighbour in Ethan's apartment building complained to the landlady of Ethan's "wild" behaviour and a foul smell emitting from his apartment. When Ethan answered neither phone nor doorbell, Ethan's landlady let herself into the suite. She found Ethan unconscious on his couch. The suite smelled strongly of urine and both Ethan and his couch were soaked in urine. The landlady called 9-1-1, and Ethan ended up being admitted to your unit.

In hospital, Ethan's condition improves somewhat. With proper nutrition he proves completely mentally competent. Despite physiotherapy, it is clear Ethan is extremely frail and at high risk for falls. He remains incontinent, and requires a one-person assist with toileting and bathing. Ethan is angry and makes it clear to all the caregiving staff that he hates the hospital environment and that he really belongs at home. Staff have complained to you that he is "demanding," "negative," and "downright rude."

Early in his hospital stay, you visit Ethan to perform an assessment. Due to your common heritage, you manage to establish a friendly rapport with your new client. You learn that Ethan had been living alone in his apartment for twenty years, and is very proud of his independent lifestyle. He is an educated, intelligent man. Ethan confides in you that he had been receiving Meals on Wheels for the past three months, but that he usually gives the meals to a neighbour, as they are never to his liking. About a month ago, Ethan also cancelled his daily visits from Home Care, as he commented that he did not like the inconsistency that accompanied having "a different, often non-English-speaking caregiver every day."

Ethan's describes his social support system as consisting of one brother and his landlady and landlord. He sees his brother very seldom, stating that they do not get along and that he manages just fine without him. For the past year or so, for groceries, prescriptions, and other small errands Ethan has called on the landlady and landlord, whom he comments are his "dearest friends" and who, he says, are "always happy to help out."

One day the doctor delivers the news to Ethan that he has advanced bladder cancer, with likely metastases to the liver. He estimates Ethan's prognosis as about six months. Ethan is informed that the social worker will come by to discuss a transition from hospital to a setting providing a more appropriate level of care for his needs.

You and Ethan discuss the realities of each option for terminal care. You provide Ethan with the knowledge to make an informed decision and express the team's recommendation that he consider placement in a palliative care unit of a long-term care facility. Ethan will not entertain even a tour of other facilities and states that he would rather kill himself than end up in "one of those places." He insists that he was "managing just fine" on his own and that he is going home.

You assess Ethan's support system. A phonecall to the landlady extended over an hour, with the landlady expressing the extreme frustration of herself and her husband at being called upon daily to perform tasks for this "arrogant little man." She says that it is only because of their Christian faith and her lack of legal grounds to evict Ethan that they have supported Ethan for this long. She says that if Ethan is coming back to his apartment, "we can't stop him, but we can't be at his beck and call anymore." She forbids the social worker from sharing any of this conversation with Ethan and declines a straightforward discussion with Ethan herself.

The next day, you receive an angry telephone call from Ethan's brother. He argues that the hospital "cannot allow" Ethan to return to the "filthy state" in which he had been living. "If he goes home, I wash my hands of him," he said. In speaking with the home care co-ordinator, you discover that it was difficult to find people who would tolerate a visit to Ethan, adding that they are "short-staffed enough as it is."

At a case conference, the physical and occupational therapists are adamant that Ethan will not be safe at home. The doctor agrees, stating "If we let him go home, he'll be back here in a matter of weeks." Clearly, the team's expectation is that you will arrange Ethan's discharge to a long-term care facility.

## Case Study 2

Mr. Chan is a good-natured eighty-six-year-old man who is restricted by severe COPD to a wheelchair and an oxygen tank. One evening, he is “dropped off” by his niece at the emergency department of the hospital where you work. He is in acute respiratory distress and is very anxious. He is admitted to your unit for failure to thrive. A physical examination reveals bruising around his shoulders and back, which Mr. Chan reports to the doctor, through a Cantonese-speaking staff member, is due to movement between wheelchair and bed. The doctor makes note of the bruising and requests a social work assessment.

In your preliminary assessment, you determine that Mr. Chan is quite affluent, having inherited his parents’ substantial fortune. He has been living independently in his Mount Royal home with full-time support from the same private caregivers who cared for his wife until her death about six months prior. Upon questioning, you determine that Mr. Chan is unclear as to why he ended up in Emergency, but that he has complete faith in the judgment of his niece, who delivered him there. Since the death of his wife, the niece has become Mr. Chan’s sole living relative in Canada. Mr. Chan allows the niece to make most of the decisions for his care. She also makes all the decisions regarding his finances, having been granted power of attorney by Mr. Chan directly after the death of his spouse. He reports that his niece gave up her job and apartment two months ago and moved into his home to be “a good niece” to her uncle. You discover in casual conversation that the niece is in the process of redecorating the house and has bought herself a new luxury car using his money.

Mr. Chan is seriously considering his niece’s strong suggestions that he would be better off in a nursing home, though the thought of leaving the only home and community in which he and his wife spent their married life deeply saddens him. “It would break my heart. I wouldn’t last long in a place like that, I suppose.” You arrange to meet with the niece and find that her assessment of her uncle’s functioning differs markedly from that of the unit team. She states that her uncle is “increasingly confused; sometimes downright demented.” Some of her questions lead you to suspect that she is fishing for information on how one goes about having someone “committed.”

You gently broach your suspicions of economic abuse with Mr. Chan. Mr. Chan is concerned about his niece’s expenditures of his funds, but feels powerless to do anything about it. He becomes nervous when you inquire as to whether the niece has been physically abusive toward him. “She is my only family!” he cries.

At rounds, you are told that Mr. Chan is medically “more than ready to return home” and instructed to arrange for his discharge as soon as possible.

### Case Study 3

Elizabeth is a pleasant seventy-five-year-old woman who has been brought into Emergency by a citizen who found her wandering a downtown street, dressed only in a bathrobe. She was unable to remember her name or address, so the person brought her to the nearest hospital.

An emergency nurse traced Elizabeth's family through the National Wandering Person Registry. Her panicked husband, Jack, was at the hospital within fifteen minutes. Elizabeth had a large bump on her head, and Jack readily accepted the suggestion that the hospital admit his wife overnight to be on the safe side. You are called in to support the husband, and to initiate Elizabeth's discharge the next morning.

Jack is crying as you greet him and lead him to a quiet room for a discussion. You note he is pale and gaunt and there are dark circles under his eyes. Through your conversation, you determine that Elizabeth was a vibrant woman, wife and mother of two who, up until two years ago, was active in her work, sports, and community. Two years ago, she was diagnosed with Alzheimer disease. The disease has progressed to the point that she needs assistance attending to her activities of daily living.

You determine that Elizabeth's family is unconditionally devoted to her. Together they have accessed all the community resources available through The Alzheimer Society of Calgary, including support groups for themselves and the day program for Elizabeth. They have also enlisted the assistance of family friends. Despite the family's resourcefulness, the demands of Elizabeth's condition have taken a tremendous toll on their physical, emotional, and financial resources. The couple's two adult children, both single university students in graduate school, have moved home to be of assistance to their father in caring for their mother and in running the household. Jack is deeply concerned about this, as he and Elizabeth highly value and support their children's higher education, and want nothing to jeopardize their studies. Jack himself has given up a thriving consulting business in order to be at Elizabeth's disposal. In the past year, he has been diagnosed with diabetes and a heart condition.

At your query as to whether an alternative living arrangement would be more appropriate for Elizabeth, Jack becomes furious. They are determined to keep Elizabeth at home. He informs you that this is his wife's wish as well. The family, at Elizabeth's request, have gone so far as to make a pact that, at the point at which her care at home becomes unmanageable, they will make arrangements, "legal or not," for euthanasia.

**APPENDIX G:**  
**DEMOGRAPHIC DATA QUESTIONS**

1. How long have you been a social worker?
2. How long have you worked in an acute care environment?
3. What is your present general area of practice within the acute care system?
4. How much of your time has been spent in discharge planning?
5. What proportion of your discharge planning work would be with the elderly?







