

The Personal Is the Organizational in the Ethics of Hospital Social Workers

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Understanding the social context of clinical ethics is vital for making ethical discourse central in professional practice and for preventing harm. In this paper we present findings about clinical ethics from in-depth interviews and consultation with 7 members of a hospital social work department. Workers gave different accounts of ethical dilemmas and resources for ethical decision making than did their managers, whereas workers and managers agreed on core-guiding ethical principles and on ideal situations for ethical discourse. We discuss the research team's initial interpretations, the relevance of the extant ethics literature to organizational structures and dynamics, and alternative perspectives on clinical ethics.

Key words: clinical ethics, organizational structures and dynamics, social work ethics

Before ethics discussions can become central to ordinary clinical service, a systematic account of professionals' lived experiences with ethical dilemmas is necessary. But what do we mean by *ordinary clinical service*? Many members of the helping professions work in institutions and agencies, such as hospitals, mental health and child guidance clinics, and family counseling centers. These settings are typically

organized hierarchically with men generally serving as administrators and predominantly women providing direct service and, increasingly, middle management. Accordingly, there are different perspectives depending on the person's location within an organization's hierarchy, although there is some overlap between workers' and managers' realities.

We also use the term *lived experience* to underscore the importance of understanding workers' experiences with ethical issues embedded in the concrete situations of their jobs. This investigative approach stands in contrast to examining professionals' abstract thinking about ethical discourse on the basis of moral philosophy or their use of cognitive, utilitarian decision making on the basis of codes of professional ethics.

When we began our inquiries into clinical ethics, our belief, based on our own service experience in clinical settings, was that organizational structures, procedures, and the correlative interpersonal dynamics play a major role in the ethical decision making of helping professionals. But we encountered a lack of literature on the social ecology of applied ethics. Accordingly, our research became an attempt to understand the social context of clinical ethics in actual practice as an ecological basis for making ethical discourse central and for preventing harm. However, we could not anticipate at the outset the rich, concrete evidence and insights that our inquiries would yield, as described in the previous and present case study. In this article, we report the findings from the interviews in relation to the thorny ethical issues that we ourselves experienced in the conduct of our investigation. Then we show the relation of our findings to the literature and offer critical interpretations on the theme of "the personal is the organizational."

CASE STUDY

Method

Our inquiry entailed consultations and in-depth interviews with members of the social work department in a medium-size general hospital in Canada. The 14 members, all women, were registered with the provincial college of certified social workers as a condition of employment. The college relies on a formalized Code of Ethics to guide the conduct of its registrants. The department had its own ethics committee and there was also a hospital ethics committee.

In May 1993, at the invitation of the director, the first and second authors gave a presentation on clinical ethics at a departmental meeting. Subsequently, the first author met with members of the department ethics committee to plan the shape and content of a research project on ethics. The initial agreement was to focus on the role of clinical ethics in the workplace for the purpose of informing professional education in ethics. In Fall 1994 five women who primarily provided direct service either in medical social work or in the hospital's mental health clinic volunteered

to participate. The two social work managers (the director and the supervisor of social work in the mental health clinic) also volunteered.

The first author, a male academic psychologist, conducted interviews with six participants. Because the direct service workers were very anxious about the safety of their research participation in terms of anonymity and confidentiality, the second author, a female academic social worker, later interviewed the director. Consequently, to respect the participants' concerns and to attempt to prevent harm to any participant from a feedback report, we circulated an earlier draft to the five workers for their review in which we described our findings as anonymously as possible. The controversy generated by this report is a subject we will address later.

The interviews concentrated on five areas: (a) how the participants understood ethical dilemmas, (b) the guiding principles they employed to deal with ethical dilemmas, (c) resources available for ethical decision making, (d) ideal situations for dealing with ethics, and (e) organizational influences on ethics.

Findings

Ethical dilemmas. The mental health social workers identified ethical dilemmas that were primarily organizational in nature rather than directly related to clients. They reported that frequently, when discussing given ethical dilemmas, their different supervisors' directions were in conflict, leading to worker confusion about how to proceed. For example, these workers strove to support the principle of client self-determination, but they were influenced by the need to comply with powerful clinic professionals' decisions *for* clients.

The medical social workers noted that their complex jobs incurred conflict in the application of the principle of preserving clients' confidentiality. For example, they reported that some medical professionals showed lack of respect for clients' privacy, and that many medical doctors would freely consult each other regarding a patient without written consent. These workers wondered how to advocate for patients when what they perceive as disrespectful, neglectful, or biased medical care occurs. They regarded the reporting of questionable medical practices as problematic, due to what they experience as an unsupportive climate in the hospital concerning ethics.

Central to the managers' understanding were the needs of clients and the importance of collaborating with them concerning treatment decisions. Ethical dilemmas for social workers arise, according to the managers, because social workers struggle to protect clients' right to make informed decisions in an institutional context in which, historically, client self-determination and confidentiality have been practiced infrequently. The multidisciplinary nature of a general hospital poses challenges to social work values in that medical staff do not necessarily share these values; physicians drive the hospital, and social workers have to take a back seat. A key issue for the managers was encouraging social workers to deal with the

ethically questionable behavior of colleagues from other disciplines. The managers observed that workers tended to maintain silence about such problems out of fear of creating conflict in the organization.

Guiding principles. The workers freely spoke of the core social work values of client self-determination, respect, and confidentiality as intrinsic to their daily work. For example, several linked a notion of client democratic participation to self-determination, concretized in direct consultation and joint planning of treatment with the client. One participant emphasized that the principle of *Do no harm* needs to be tempered by the fact that, as she sees it, treatment harm is more likely to be subtle, indirect, and implicit. Another cautioned that all social work ethical guidelines need to be contextualized and rendered flexible according to the unique circumstances of each clinical situation.

The managers made specific and ample reference to the College Code as their framework for understanding ethical principles in concert with meeting the needs of all parties: clients, workers, peers, and students on placement. In this sense, the managers view ethics as the ability to identify a dilemma and to reflect on the application of the Code to the particular case, obtaining consultation if necessary. They had a high regard for the usefulness of the Code as a framework for ethical decision making and as a necessity for professional practice.

When considering workplace ethics, the managers had comparatively less to say than the workers, who dwelt heavily on what they regarded as dubious organizational practices. The supervisor discussed guiding principles for resource allocation, multidisciplinary ethics, and collegial ethics. The director characterized management ethics as “much more fuzzily stated” in the Code than in worker–client ethics. She readily noted guiding principles in this domain: “maintenance of positive, constructive workplace conditions” and “working in constructive ways to advocate for policy changes.”

Resources for ethical decision making. The workers were unanimous in identifying their immediate peers as their chief but informal resource for assisting them in dealing with ethical dilemmas. In all cases but one, the workers meant that their peers were other social workers within their respective mental health or medical units. Several reported that they found their team leader or team members from other disciplines or even colleagues external to the hospital as valuable resource persons.

Two workers mentioned that they experienced social work supervision as helpful at times regarding ethics. However, the workers unanimously reported that they did not feel safe disclosing ethical dilemmas with their social work supervisors, because they believed that after sharing uncertainties, expressing feelings, and showing vulnerability about ethics, they experienced negative performance evaluations in the form of judgments of inadequate competency. Consequently, they are fearful of nonconstructive criticism if they raise ethical issues. One participant

prepares her position in advance to keep control of supervision, as a strategy for not being criticized rather than for safe discussion of ethical dilemmas.

Moreover, none of the workers nominated the hospital ethics committee as a resource, which one worker perceived as compromised by conflicts of interests among the members. Because the workers also perceived lack of safety in the *department* ethics committees, they used these resources minimally.

Both managers painted quite a different picture concerning resources for ethical decision making. They relied on consultations with the College for interpretations of the Code regarding dilemmas, while in the hospital, the supervisor consulted with her administration team, and the director with a hospital vice-president. The managers regarded the hospital ethics committee favorably, although the supervisor reported that this committee was doctor-driven and was underutilized, perhaps due to staff's lack of awareness and ownership concerning its mandate. The director described the recommended pathway for dealing with ethical dilemmas as workers discussing them with their supervisor, perhaps preceded by peer consultation; then, if necessary, moving up the hierarchy to the director and the vice-president; consulting the College is the ultimate step. The director also identified the department ethics committee as "a sounding board" for social workers, similar in concept to the hospital committee.

Ideal situations. All the workers expressed the desire for a safe, supportive climate in their work setting in which to discuss ethical dilemmas. The workers placed the highest importance on legitimized peer consultation time, because it ideally would be a situation of trust, safety, and equality, that is, structured nonhierarchically. Under these conditions, in which people feel confident in taking risks by admitting their ignorance, a free speech situation for accessible ethical discourse could occur.

The supervisor likewise spoke of the need for a safe climate as essential for genuine discussions about ethics. For her, ideal ethics involves people with multiple perspectives developing relationships with a spirit of cooperation, community, and mutual respect; the goals of her envisioned process would be to increase awareness in an accessible forum that would be grassroots in nature with staff investment.

The managers also identified macrolevel directions for ideal ethics. They would like to see a departmental plan for professional education on ethics created, and they hoped the department's participation in the present research would serve to stimulate and challenge other hospital disciplines to become proactive regarding ethics. The ideal ethical setting would incorporate attention to the levels of responsibility and power in the hospital with which social workers routinely interface.

Organizational issues. Throughout the interviews, the participants were keenly aware of social work's marginal status in the institution. Whether in the mental health clinic or on the medical floors, the workers encounter organizational circumstances that produce conflicts for them between their profession's ethical

values and their required clinic behavior. But the workers did not feel safe to discuss the conflicts and were anxious about how to deal with the clinicians in power, and many tended to operate in silence with this tension. For example, the structure of the hospital works against patients knowing how their information is shared among other professionals. Some workers chose not to directly name such ethical issues, because many medical professionals become defensive, even with the term *ethics*. Another worker learned to use indirect and masked forms of nonthreatening communication to raise the concerns and have them heard. Although physicians' power in the hierarchy often overrode social workers' struggles to think carefully about and to discuss ethics, some participants found ingenious ways of raising ethical issues, such as writing on patients' charts what patients stated they wanted. Other workers did identify ethical issues directly with physicians, and some reported that they were persuasive in convincing physicians to listen to patients' expressed needs.

From the managers' perspectives, social work was a vulnerable, secondary service in a setting in which physicians hold the greatest power, and there are many tiers of responsibility, all impacting on social workers' coping with ethical dilemmas. For example, in addressing conflicts around utilization of beds, social workers had to balance serving clients' needs with not alienating the physicians and other professional staff who might have ownership of the particular unit. Furthermore, social workers end up educating others, such as physicians, about ethical principles, because, as the director noted, "[doctors] may not have the same recognition as social workers for . . . clients' rights to self-determination and much more. They're used to operating very autonomously . . ."

Initial Impressions

Upon analysis of the interviews, we developed the following global impressions:

1. The participants' ethical decision making was influenced to a great extent by the compounded organizational tensions that they encountered. The tensions arose from the participants' struggles with the demands of hospital policies and procedures, physicians' authority, other hospital professionals, and social work supervision. The direct service workers coped with their consequent stress by relying on informal peer support, whereas the managers had multiple resources within the hospital.

2. All the participants desired a safe space for considering ethical issues and for identifying and supporting appropriate ethical action. But there were rather significant gaps between *ideal* conceptions of ethics and perceived *realities* of the hospital, and no open dialogue about these gaps. The managers understood supervision and the departmental and hospital ethics committees to be neutral. The workers, however, experienced these resources as situations of judgment, and they felt

profoundly unsafe in disclosing ethical dilemmas. Consequently, the workers tended to use avoidance, to practice "covering your ass" in supervision, and to maintain subgroups for support.

3. The medical hierarchy, which clearly signals that the physician's position is strongest, rendered multiple points of view and their differences less audible. The hierarchy tended to discourage social workers' expression of their ethical principles in the form of appropriate ethical action. Thus, the departmental culture reflected the larger organizational culture of unquestioned authority and unheard alternative voices.

4. Internalized standards of professionalism, including the social work code of ethics, gave the department some status, protection, and a unique identity in the hospital. But there is a risk in relying on the prescribed ethical principles. Although ethical procedures and values can be beneficial, their unquestioned implementation can create the feeling that there are standards of certainty which demand compliance. This pressure can thwart the type of communication vital for ethical dialogue, namely, free uncertainty, honest doubt, and affective openness. Codes and standards can be helpful if they are applied contextually and sensitively, but they can be counterproductive if they inhibit the expression of moral doubt and preclude consideration of the personal issues that workers bring to ethical dilemmas.

5. In sum, the power of medical professionals had a disempowering impact on social workers and adversely affected their practicing their ethical principles. But the participants did not seem to be aware of the impact that these organizational structures and dynamics had on their behavior. Or, if they were aware, they did not appear to have consciously planned an agenda of solidarity within the department to counteract systemic influences on social work ethics.

DISCUSSION

Ethics Literature

At this point we turned to our ethicist and to the ethics literature for consultation. As we suspected, the standard literature on ethics does not help us reflect more deeply on the meaning of this case study. First, evidently there is little Canadian research on social workers' understanding of clinical ethics (Cossom, 1992). Second, social work articles and books on ethics are primarily prescriptive, even though focused on agency practice, or they concentrate on the individual practitioner of individual or family therapy and ignore organizational influences (e.g., Dean & Rhodes, 1992; Woody, 1990). Third, the small research literature on social work ethics only gives impressions about the social context of clinical ethics. Several authors allude to the impact of authority relations, policies, and procedures on workers' ethics (e.g., Cossom, 1992; Holland & Kilpatrick, 1991), while another suggests that female social workers are more inclined than male social workers to an ethic of care (Dobrin, 1989).

Our findings connect with just two social work studies. First, Vicentia and Conrad (1989) conducted a correlational inquiry of social workers' influence on ethical decision making in multidisciplinary health care settings. The authors observed that those social workers who were satisfied with their roles and who perceived clear role responsibilities tended to be more influential with physicians and other staff, and to be more involved in collaborative decision making than those social workers who were less satisfied and less clear on their roles. We also found that professional role was influential, as the managers reported more personal efficacy in multidisciplinary ethical decision making than the workers did. Second, Holland and Kilpatrick (1991) noted that none of the service providers in their interview-study nominated the professional code of ethics as a resource. Most of their participants felt troubled and alone in struggling with their ethical dilemmas, unsure of how to proceed, and alienated from helpful resources. These findings dovetail with our own.

The psychology literature on ethics is likewise marginally helpful. There are extensive studies on private practice ethical issues (e.g., Pope & Vetter, 1992), and conceptual pieces and manuals for psychologists rooted in cognitive-utilitarian ethical decision making (e.g., Pope & Vasquez, 1991; Tymchuk, 1986), virtue ethics (Pettifor, 1996), and the relevance of family systems theory to ethical decision making (O'Neill & Hern, 1991). But, as near as we can tell, there is no psychological study addressing the interplay of individuals' clinical ethics with organizational structures and dynamics.

In their book on mental health professionals' ethics, the psychiatrists Reiser, Bursztajn, Appelbaum, and Gutheil (1987) only address organizational influences conceptually. They argue that therapists experience divided loyalties, pulled between the needs of their institutions and professional affiliations and the needs of patients. Consequently, therapists are in tension between professional autonomy extending to abandonment of patients and paternalism extending to coercion, between professional rights and patients' rights.

In the edited book by Kolenda (1988) on ethics and organizations, the contributors deal abstractly with variants on the theme of ethical individualism relevant for organizational life. Waterman (1988), for example, describes the ethically responsible person, like the fully functioning psychological individual, as exercising free choice and judgment, while respecting the dignity of others and supporting justice as equity. The contributors recommend changes in management practice to encourage ethically responsible individuals to flourish in organizations. For instance, Scott and Mitchell (1988) propose an ethical model of processual wisdom, in which caring and compassion play key roles. However, the basic conception of ethical individualism, to which the contributors append interdependence, cooperation, benevolence, and caring to varying degrees, seems inadequate to the task of identifying both inhibitory and facilitative systemic structures, policies, procedures, and interpersonal dynamics in organizations. Hence, this conception seems ill-suited to the task of enabling a dialogical ethics embedded in a consensual process to flourish.

Operating from a psychology framework, Trevino (1987) described a *person-situation interactionist model* to understand managers' ethical decision making in organizations. She viewed an ethical dilemma as leading to individual ethical or unethical behavior in relation to three principal dimensions: the particular stage of moral development of the person; individual *moderating variables*, namely, ego strength, field independence, and locus of control; and situational moderating variables, namely, the immediate job context, organizational culture, and work characteristics. Trevino then discussed many specific hypothesized relationships, such as organizations that promote a democratic culture of active participation in decision making, in resolving conflicts, and in taking multiple perspectives that enhance ethical decision making. She did not explicitly deal with human service organizations, but implied that her conceptual model applied to them.

More so than psychology and social work, nursing seems to have incorporated an appreciation of organizational influences and even a psychology of oppression in relation to understanding clinical ethics. For example, Yarling and McElmury (1986) asserted that, inasmuch as paternalistic hospital hierarchies place nurses in a kind of Babylonian captivity, nurses are not free to be moral agents. Specifically, the oppressive factors of sexism and paternalism are the historically constituted dominant-subordinate roles and positions of physicians and nurses and of nursing leadership within the bureaucracy. Placed in question, then, is the nurse-patient relationship, which is the heart of nursing ethics. Due to their power over job security, hospital administrators, and those nurse-managers who "identify with their oppressors," as described by Roberts (1983), can coerce nurses to comply with policies and procedures that contradict the ethical primacy that nursing gives to the nurse-patient relationship. Accountability for specific practices has rested within the structures and dynamics of loyalty to the medical hierarchy, despite the ideological shift in nursing over recent decades to nursing autonomy and accountability to patients, not physicians. Actual hospital practice, Yarling and McElmury (1986) contended, contradicts the espoused ethical imperative of commitment to patients. Nursing education reflects the new ideology, but nursing practice reflects the oppressive realities. Although this argument steeped in the psychology of oppression might have been overstated and be somewhat outdated, we see a link to the status of hospital social workers' ethics. In our study, the managers and the workers alike, all women, identified the compromised nature of their professional functions, including ethical decision making, within a historically paternalistic institution.

Critical Perspectives on Ethics

The nursing approach to ethics, which incorporates an explicit recognition of organizational realities, intersects with social constructionism in social work (Franklin, 1995; Leonard, 1994) and critical theory of the helping professions (e.g., Waitzkin, 1989). The latter critical perspectives are indebted to Foucault's

(1980) analysis of professional social power and control mediated by scientific knowledge, and to Habermas's (1985) critique of scientific ideology in professional relationships. The core argument is that scientific legitimation of the professions produces relations of domination, which make undistorted communication impossible. These critical perspectives enable us to better understand the operation of the structures and dynamics of professional knowledge and power in any given health care or mental health setting. Thus, professionals unintentionally reproduce relations of subjugation of clients and patients, in part because of the insulated nature of the dyad, the focus on helping the client cope, and the absence of a power analysis in professional training (Waitzkin, 1989). Social work education, for instance, reproduces the features of modernity, namely, omniscient vision, rationality, certainty, and truth, while students prepare to become experts in the regulation and containment of marginalized groups in society, the Other (Leonard, 1994). Models of ethics rooted in objectivity and technical knowledge provide a plausible rationale for established standards of practice, and they serve the profession's institutions of control, namely, training, supervision, theory, and research. Social work's technology of surveillance of society's Other is the basis for principles of professional ethics and for social workers carrying out their well-intentioned actions.

If the essence of this case study is that ethics and morality in human service organizations are socially constructed, the thrust of this discussion is toward the moral imperative of reconstructing ethical discourse. In their study of social workers' ethics, Holland and Kilpatrick (1991) concluded

The improvement of professional practice requires structured opportunities and resources for dealing with ethical dilemmas, overcoming isolation, and nurturing informed and mature judgment. The ethical problems social workers confront involve complex issues and evoke strong feelings that often have no clear forum for expression, analysis, and resolution. (p. 143)

This position, in fact, is what our participants in both case studies conveyed to us. Moreover, in his book on professional ethics, Kultgen (1988) advocated peer review of ethics: "The only persons both *equipped* and *in a position* to evaluate the professional's ordinary performance are colleagues in the immediate community and worked with on a daily basis" (p. 91).

The democratic alternative for ethical discourse is consensus (Jennings, 1991). The creation of a civic, intentional process, consensual ethics is an open, communal activity of discovery in which all persons ideally are free to be moral agents. If we embed morality in discourse, then we render ethical discussion open, dynamic, and energizing rather than closed, static, and sterile, as occurs in rule-bound or abstract conceptions of ethics. Jennings argued that the postmodern crisis in the alleged authority of moral principles and the bureaucratization of ethical decision making in institutions, concretized in ethics committees, prescriptions, and forms, call into question what kind of consensual process is possible. Professional power and

control will prevail under the guise of superficial consensus, he warned, if role relationships become personalized, the consensual process is subjected to ascending authorities' approval, and responsibility becomes diffuse.

Correspondingly, in her feminist take on Habermas's theory of discourse ethics, Chambers (1995) suggested that the interpersonal process of consensus requires five attributes from every participant: responsibility, self-discipline, respect, cooperation, and struggle. This "inefficient" approach to ethical decision making entails constructive conflict, while it is grounded in an ethic of care. Interestingly, the participants in our two case studies also identified comparable characteristics for a safe space to effect discourse ethics.

Reflections on This Case Study

These critical perspectives on ethics help to illuminate the interrelationship of the personal and the organizational, which we see as expressed in two interpersonal dynamics: boundaries and misrecognition. Clinicians in agencies and institutions do not contemplate ethical issues in cognitive, disembodied, decontextualized isolation. Rather, ethics questions about conflicting obligations are socially positioned in various levels of power relations. Problems of boundaries and misrecognition occur when the structures of the hierarchy are taken up as functions of individuals' personalities and there is insufficient view of how these structures and role requirements shape perceived personality characteristics. We propose understanding that clinical ethics are embedded in relationships produced by organizational structures.

Hierarchy creates identity positions for all parties through which others recognize them, and a paternalistic environment, like a traditional hospital, militates against staff recognizing the power and control in the system itself. One consequence is mutual misrecognition. From our vantage point on this case, workers and managers were entangled in a highly complex, structured organizational web that was difficult to recognize and that precipitated interpersonal stress for all. Consequently, managers and workers understood ethics subjectively, that is, affected by personality conflicts. For example, the workers tended to conflate the managers' personalities with the designated role of the latter in the hospital system. That is, the workers had difficulty distinguishing between the structures and power of administration on the one hand and the persons who mediated the structures and power on the other hand. Thus, the managers' attempts to protect the social work department were sometimes read as forms of social control. Yet, for the managers, ethical accountability meant not just social workers "doing the right thing," but also protecting social work's status in the hospital. Managers might attempt to counter the professional vulnerability of social work in a medical setting by adhering to rules that feel like surveillance to workers. On the other hand, workers need to know what the limits are concerning disclosures to their supervisors about ethical issues, lest the workers' expressed feelings be used against them in performance appraisals.

This latter type of control of clinical ethics constitutes surveillance, in keeping with the social and historical function of health and mental health professionals. Nevertheless, the reality was that the managers *were* accountable to their administrators for social workers' ethics. Therefore, the managers were expected to ensure that workers did not "make mistakes." The ideal safe space, an ethics of dialogue, would provide mutual recognition, which is the prelude for moral integrity. Mutual recognition is possible, however, only when there is consciousness of how different social locations in the hierarchy affect ethical discourse. Not recognizing power and control means that there is little opportunity for accessing social workers' capacities for building mutual recognition, respect, and solidarity with each other. But we would argue that social workers' strategies for solidarity are crucial to fostering the profession's development of meaningful, effective ethical consensus.

We suspect that medical settings do not encourage understanding and acting upon ethical issues as social and organizational in nature; rather, they see ethics as the purview of individual moral agents. Therefore, it is highly questionable whether the consensual ideal is possible in undemocratic settings, where helping professionals typically work, especially during this era of neoconservative economic policies, reengineering of program services, and downsizing of staff positions. What happens to ethical discourse under these conditions and what happens to the quality of care for patients and clients?

Incorporated in our research was feedback to the participants on our findings and interpretations. We sent a lengthy report initially to the participants, and distributed a summary of it to all staff. At a subsequent meeting of the department ethics committee, we learned from some of the members their feelings about the report. These individuals perceived three problems: (a) The worker sample was comprised of complainers who triangulated with us against the managers, (b) the interview content failed to address departmental strengths and successes in dealing with ethical situations in the hospital, and (c) the managers felt disrespected by not having the same right of previewing the draft report as the workers did. Moreover, the tone of the meeting made us aware of the pain that the report had caused in some members.

The complexity of this response is an aspect of the research that we have reflected on considerably, and our own responses have varied from feeling aggrieved by the reception to the report to criticizing ourselves for inattention to the research process. Our current perspective is that the data, although from a limited number of participants, were clear that organizational tensions regarding the safety of open dialogue inhibited a safe space for workers to process ethical dilemmas. But further, a kind of prohibition on discussion about those tensions seemed to be the norm in the department. Our research broke with that norm by calling attention to worker dissatisfaction with the organizational climate that impinged on ethical decision making. However, we also came to appreciate the viewpoint of some members who felt that our assessment of the organizational climate had the effect of totalizing the department as dysfunctional. This feeling was particularly the case regarding

our failure to sufficiently capture the strengths of the department, which were considerable.

In retrospect, we believe that we learned a great deal about how hierarchical systems reproduce authority at the expense of dialogue and that gender plays a significant role in that process. Nevertheless, our learning was costly to a beleaguered department that by necessity had developed its own survival codes in relation to the hospital. Our report might have undermined the department's capacities to function with dignity in a system that continually challenges staff's integrity.

The situation of battered women might be an apt analogy. Such women have considerable resources that permit them to cope in impossible situations. They draw from significant strengths in their attempts to maintain family relationships and to survive within a climate of constant threat. Our report might have forced staff's recognition of the threat without acknowledging either the skills needed to continue working effectively in the hospital or the courage, even if tinged with denial, that their positions required. An image that remains powerful for us is one worker who described her confrontation with a male doctor regarding an ethical issue. She reported that she shakes physically to this day when seeing him in the hospital corridors. Our report noted the threat that is carried in such power relations, but it did not acknowledge the courage that this woman summoned to engage with the doctor. Accordingly, we have had to think deeply about the possibility that we reproduced power relations between researcher and researched, and that our participation in organizations that involve such complex power relations was not free from the very structures and dynamics on which we commented.

We believe the department needed our theoretical understanding to name the problems we found. But what balance can we attain between hearing these professionals' diverse views on ethics, and communicating our own perspective on the relationship between the personal and the organizational in ethical discourse? The language of ethics needs to be made accessible to everyone—clients, workers, managers, as well as us academics—so that consensual ethical discourse can occur. As academics, we have considerable power and privilege vis-à-vis staff in human service organizations, who might be easily intimidated by our presumed authoritative knowledge. Our challenge has been to learn how to acknowledge different interpretations of experiences, while effectively promoting with compassion and justice a participatory framework for clinical ethics that leads to both a liberatory analysis and solidarity with our participants.

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