This new text illuminates the essential information about health and social work critical to understanding today’s complex health care systems and policies. Chapters highlight current practice, policy, and research in different settings and with special populations. Readers learn how to advocate for the individuals, families, and communities they serve to help improve health and well-being for all. All those interested in micro, mezzo, and macro practices in a health care setting will appreciate this rich resource.

Highlights include:
- Each chapter speaks to the interconnections between practice, policy, and research and how they are integrated to inform social work and health.
- Unique chapters dedicated to special populations such as children and families, older adults, immigrants, persons with HIV/AIDS, LGBTQ individuals, veterans, and people with disabilities provide a deeper understanding of the health care issues specific to these groups.
- Thorough coverage of the role of social workers in a variety of settings such as substance abuse, correctional systems, public health, and integrated behavioral health care.
- An in-depth discussion of the values and ethical issues in a health care environment.
- An intersectionality lens used throughout promotes a greater understanding of a client’s multiple status of race, ethnicity, nationality, socioeconomic status, education level, religion, sexual orientation, and gender identification.
- Detailed case examples developed by professionals in the field in Parts II and III accompanied by discussion questions further enhance an understanding of the issues.
- Online instructor’s resources including PowerPoints, discussion questions, case studies, and a sample syllabus.

Intended as a core text for MSW and advanced BSW courses on health and social work, social work practice in health care, health and wellness, or integrative behavioral health taught in social work, public health, or gerontology programs, this book is also of value in social work practice courses that focus on health care and special populations. Social workers practicing in the health care field will also appreciate this book.
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Health and Social Work:
Practice, Policy, and Research

Janna C. Heyman, PhD, LMSW
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Editors
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To our students and all social workers, who inspire us every day with their commitment and interest in health and health care. Their recognition of health issues and health disparities and the need to integrate practice, policy, and research motivated us to write this book.

To our husbands, Neil J. Heyman and the late Robert T. Snyder, and our families, who always encouraged and supported us in our academic endeavors and pursuit of promoting good health and well-being and providing equal access to health and health care for all.
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Foreword

Social work has a long-standing commitment to health care and the recognition of the inextricable link to quality of life and well-being across the life span. Our professional values and ethical principles provide important context related to the challenges of the affordability and accessibility of quality health care for all. While there have been remarkable gains in medical science that include cures and advances in disease treatment, sadly too many Americans continue to experience poor health outcomes. From the early days of our profession, attention was given to the need to improve care for vulnerable and at-risk populations. During the progressive era, settlement houses were known for establishing clinics to address the prominent health challenges of the era. This emphasis on meeting the health care needs of poor and marginalized populations has continued and has been supported by practice, policy, and research aimed at improving outcomes, especially for those who have experienced lifelong and generational disparities associated with racism, homophobia, and other stigmatizing conditions that negatively impact access and affordability as well as the health care experience.

Today’s social workers must continue to close the pernicious gaps in health care that prematurely claim the lives of individuals and the associated impact on their families and communities. My father, a World War II veteran, succumbed to the complications of diabetes at the age of 57 years over 35 years ago. He is an exemplar of disparities that travel across the life span and create cumulative disadvantages. Although the gap is closing, the Centers for Disease Control and Prevention reports that there is an overall 4 year lower life expectancy for Blacks versus Whites. This gap widens based on gender and geographical locations. David Katz, President of the American College of Lifestyle Medicine, states, “Social justice is among the more important determinants of health outcomes, and disparities are very revealing about social justice and equity in public health.”

It is my hope that within my lifetime, I will see the gap removed and the improvement in health care for all groups. This generation of social workers has the opportunity, despite the potential disruptions to the Patient Protection and Affordable Care Act (ACA), to realize continued health gains that will address the needs of most vulnerable populations. This will be done by our engagement in culturally competent practice that reaches out to marginalized groups and determines best approaches to engaging them in prevention and compliance. For example, social workers will be instrumental in helping the one in seven persons who are unaware that they have HIV to get tested and treated. By understanding their resistance to testing, social workers can help to develop outreach programs that break through the barriers that prevent testing. Additionally, social workers can organize support groups that educate individuals and family members to better respond to HIV in the family. Practice initiatives like this can make a difference. Coupling practice innovations with evidenced-based assessments provides social workers with valued leadership positions on interdisciplinary teams.

Additionally, policy initiatives that give primacy to enhanced prevention and treatment can also contribute to closing the equity gap. The ACA is an example of such legislation. For example, adding coverage for prevention services and coverage of preexisting conditions offer needed support, especially for historically oppressed and marginalized groups. It is important for social workers in health care to advocate for legislation that seeks to address
pernicious inequities. Finally, eradicating social injustice in health care requires research that documents disparate outcomes. Understanding where gaps have closed and where they continue to exist allows us as social workers to use our keen sense of culture and environment. For example, there are critical questions that relate to modifying behaviors to prolong quality of life. Understanding the social determinants of health and the sometimes hidden barriers to better care is critically important. The government-sanctioned disparities such as the Tuskegee syphilis experiment, involuntary sterilization, and more still remain in the hearts and minds of many African Americans and continue to breed distrust in the health care system. Findings such as those in the 2002 Institute of Medicine “Unequal Treatment” report documented disparities in the treatment of cardiac patients and the premature amputation of lower extremities for African Americans suffering from diabetes. My father possibly fell victim to this undesirable life-changing event. I am convinced that my father fell victim to medical care that was “race-based” rather than person-centered. While it is wonderful to see the changes that have come about from this groundbreaking study, there is the nagging question of “what if” someone had stepped in earlier and addressed the disparities that compromised generations. Today, as social workers, we are empowered to stand up in the variety of health care practice settings that we serve and insist on equity. We can make a difference for our veterans, members of racial and sexual minorities, as well as other valued and marginalized members of our diverse society. The payoff is improved quality of life for many.

If we are to achieve health care equity, we must unlock the formula to translate knowing better to doing better. This is the next frontier of social work practice. This book offers valuable content that will provide new social work insights into practice, policy, and research, and their integration aimed at the elimination of disparities and achievement of health equity. I am grateful on both professional and personal levels to the contributors—I firmly believe that their insights will open eyes, hearts, and minds and lead to the highest standards of health care that honor the social work values of social justice and the dignity and worth of all persons. Our constituents deserve no less.

Sandra Edmonds Crewe, PhD, ACSW
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Preface

The pursuit of health and well-being is important to all people in the United States and globally. Historically, the settlement house movement was committed to promoting better health for recently arrived immigrants. The social work profession has continued to focus on this goal by working with diverse populations in many different health and behavioral health settings—inpatient, outpatient, and community-based. This is accomplished by collaborating with other health care professionals in partnership with individuals, families, groups, and communities served.

As we go to press, the United States is spending 17.8% of its gross domestic product on health care (Centers for Medicare & Medicaid Services, 2016) and only 9% on social services (Bradley & Taylor, 2013). The enhancement of social services is needed to help improve health and positive health outcomes. In collaboration with other health care professionals, social workers need to address issues of access, quality of care, prevention, and social justice to further advance the health care field. As health care is expanding, the U.S. Department of Labor Bureau of Labor Statistics (2016) has predicted there will be increased employment opportunities for social workers in health-related fields. Education and training to ensure social workers are prepared to meet this need are critical.

We were inspired to write this book, *Health and Social Work: Practice, Policy, and Research*, by the interest expressed by our students regarding health and social work. We quickly became aware of how challenging it was to consider each theme separately, so each chapter also speaks to the interconnections between practice, policy, and research and the way in which they are integrated to inform the health care field. Case examples are provided throughout the book to further enhance an understanding of these issues. Questions at the end of each chapter are used to generate further reflection and critical thought on chapter content.

Part I of the book includes chapters that address general topics of social work ethics and social determinants of health. In Part II, specific areas such as health promotion and public health, integrated behavioral health care, palliative and end-of-life care, substance misuse and abuse, and correctional health and psychosocial care are discussed. Part III focuses on specific populations, including children and family health, older adults and their families, immigrants and refugee health, LGBT health, health for people with disabilities, veterans, and health for persons with HIV/AIDS. An intersectionality lens is used throughout to promote a greater understanding of clients’ multiple statuses of gender, race, ethnicity, socioeconomic status, education level, sexual orientation, and gender identification. A discussion of the greater power and privilege of social workers and other professionals in the health care field affects the health and well-being and the lives of clients.

Although we are the primary creators of this book, we have shared this journey with the many contributors who have provided information about health care and social work. First, we would like to thank all our contributors from across the United States who, with their extensive academic and practice experience in the health field, made outstanding contributions to this book.

We would like to acknowledge the social workers who have worked tirelessly in the field to help individuals, families, and communities in addressing health care. Without their significant efforts, the profession would not be where it is today.

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We also want to acknowledge our dean at Fordham University Graduate School of Social Service, Dr. Debra McPhee, who is very committed to advancing the role of social workers in health care and provided continual support and encouragement. Several colleagues, Martha Bial, Shirley Gatieno Gabel, Ralph Gregory, Peggy Kelly, and Linda White-Ryan, served as consulting editors to help us prepare the book for publication. Special thanks to Karen Dybing who worked extensively with the formatting and the final editing for this book. We also would like to thank Fordham University doctoral student Sara Matsuzaka, who is the co-author of the chapter on intersectionality (Chapter 4), and MSW student Lindsay Poulos, as well as Kelsey Blumenstock and Gary Reback who provided additional material and support for the book.

We would like to acknowledge our Springer editor, Debra Riegert, who provided important guidance to us from the initial birth of the idea through submission of our manuscript. We also want to extend special thanks to Mindy Chen, assistant editor at Springer, who was always available for any question that we had and was able to speedily advise us how to proceed. We would also like to recognize the extensive support of Rose Mary Piscitelli, Senior Editor, and Vinolia Benedict Fernando, and their production team who provided valuable support to us.

As our book heads toward publication, there are still many unsettled and remaining questions about health and health care. There are continuing challenges about changing federal and state health care policies and how this will affect health care, especially for those from low socioeconomic status and/or vulnerable populations. The good news is that there are breakthroughs in terms of new treatments that will cure or minimize the negative symptoms of many illnesses and chronic conditions. In spite of all the advances, while life expectancy is increasing in the United States, there are still many health disparities that need to be addressed. While there has been progress in the field, there still are challenges confronting social workers and the individuals, families, groups, and communities they serve.

As always, social workers will continue to engage as a profession, as well as join with other health care professionals, in advocacy efforts to work toward our common goal of promoting good health and well-being for all.

Elaine Congress
Janna Heyman

REFERENCES


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Health and Social Work:
Practice, Policy, and Research
Ethics and Values in the Health Field

Elaine P. Congress

Social work values and ethics continually guide policy, practice, and research in the health care field. Using the lens of social work values, this chapter begins with examining social work policies and government policies on health care. Identifying ethical challenges and dilemmas and applying a model of ethical decision making for practitioners is also addressed. The chapter closes with the need for continued research on ethics to enhance social workers’ understanding of this important area.

POLICIES/CODES OF HEALTH CARE PROFESSIONALS

What values and ethics influence policy in the health care field? The Hippocratic oath that guides medical practice stresses the importance of doing no harm and non-maleficence continues to be the mantra of those in the medical and health-related professions. Social workers often use this principle in guiding their practice in the health field. This also relates to respect for the worth and dignity of each person, as social workers believe that this approach is the best way to minimize doing harm. Social work as well as other professions in the health field (nursing, physical therapy, rehabilitation counseling) have different codes of ethics to guide professional practice (Kangasniemi, Pakkanen, & Korhonen, 2015). Other codes also address the importance of respect for the dignity and worth of each patient (Kangasniemi et al., 2015).

But how is this policy translated into practice during the modern age with so many complicated choices? How can one navigate a health environment with many possibilities each with different consequences?

SOCIAL WORK CODE OF ETHICS

Since social work is a value-based profession, it is essential for social workers to look at what standards the profession has developed to guide policy, practice, and research in the health field. The National Association of Social Workers (NASW) Code of Ethics provides the primary framework for ethical practice for social workers (NASW, 2017). While the NASW Code does not specifically mention the word “health,” its values and principles can be applied to health care practice (Table 2.1).
All of these values and ethical principles are incorporated into social work practice in the health field. Social workers continually promote a social justice mission, are committed to service for all people who need health care regardless of their ability to pay, and often become involved in internal and external advocacy initiatives to expand health care benefits to all. All patients/clients in a health care setting, regardless of national origin, ethnicity, age, disability, or social/economic class, are treated with dignity and respect. Finally, all social workers in the health care field continually try to develop their competency by taking advantage of in-service or external continuing education opportunities to increase their knowledge and skills.

**SOCIAL WORK ETHICAL STANDARDS IN HEALTH CARE**

Perlman (1975) said that a value has small worth unless it can be actualized in practice. What type of guidance does the NASW Code of Ethics with its general values and principles provide for social work practitioners in the health care field? While the Code addresses major issues, it does not provide direct guidance about the particular challenges that practitioners in the health field face. The NASW, however, has developed standards for social work practice in health settings that do outline ethical principles for social workers in the health field (NASW, 2016).

The first standard in this 13-standard document explicitly describes how social work values and ethics affect practice in the health field:

**Standard 1. Ethics and Values**

*Social workers practicing in health care settings shall adhere to and promote the ethics and values of the social work profession, using the NASW Code of Ethics as a guide to ethical decision making.* (NASW, 2016, p. 16)
The following interpretation is provided:

The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs, with special attention to the needs of people and communities who are vulnerable, oppressed, or living in poverty. Social workers have an ethical obligation to address the health care needs of these groups and advocate for change to ensure access to quality care. The profession’s mission is rooted in core values that have been embraced by social workers throughout the profession’s history and highlight social work’s distinct purpose and perspective. These values—service, social justice, dignity and worth of the person, importance of human relationships, compassion, integrity and competence—constitute the foundation of social work and underlie the practice of social work in health care settings. The NASW Code of Ethics establishes the ethical responsibilities of all social workers with respect to their own practice, clients, colleagues, employees and employing organizations, the social work profession, and society. Acceptance of these responsibilities—which include upholding a client’s right to privacy and confidentiality and promoting client self-determination—fosters competent social work practice in health care settings. In a health care system characterized by technological advancement and rapid change in care delivery and financing of health care services, ethical dilemmas among and between clients, families, health care professionals, and organizations are potentially numerous and complex. The NASW Code of Ethics and prevailing clinical bioethics provide a foundation for social workers to manage such dilemmas. Health care social workers have the responsibility to know and comply with local, state, federal, and tribal legislation, regulations, and policies, addressing topics such as guardianship; parental rights; advance directives; and reporting requirements for abuse, neglect, exploitation, suicide, and threat of harm to others. When an ethical dilemma or conflict occurs, the health care social worker is expected to employ available mechanisms, including social work supervision, peer review, institutional ethics committees, and external consultation, to resolve the dilemma. (NASW, 2016, pp. 16–17)

Ethical standards in health care similar to the Code of Ethics, however, set forth general principles but do not provide much specific guidance about navigating ethical dilemmas and decision making in health care practice.

**DISTRIBUTIVE JUSTICE PRINCIPLES**

What principles can be used to guide ethical practice for social workers in health care? The principles of distributive justice (Congress, 1999; Reamer, 2001) can be helpful in understanding the dilemmas that arise in health care. Four principles—equality, need, compensation, and contribution—are often used to develop health care policies and programs.

Social workers believe that all have an equal right to health care, but know that socioeconomic differences frequently create inequities in access and treatment. When there are limited options, how can a resource be divided equally? For example, a social worker in a hospital had only one available opening in a skilled nursing facility, but four clients who were waiting for immediate discharge to an outpatient facility.

Need is also an important criterion that is often used to determine how to distribute a scarce resource. Ethical dilemmas arise on the macro, mezzo, and micro levels about who has the greatest need. For example, what macro government decisions are made about funding? Are decisions made in terms of age as, for example, an assessment is made...
that adolescents may have greater need for a new program than seniors? On a mezzo level, especially in a time of cutbacks, agencies frequently make decisions about which programs to keep and which to eliminate. Unfortunately, current management decisions are often made in terms of financial viability with minimal consideration of need (Reisch, 2014). On a micro level, health care practitioners continually struggle with how to serve first, especially when there are many clients all needing immediate help. For example, in a very busy large metropolitan hospital, a social worker recently debated about whom to see first, a family with a 5-year-old child who was just diagnosed with leukemia, or a 55-year-old single person with no support system who, following hospitalization for a heart attack, now needs to be discharged immediately.

In health care practice, does a triage system develop? The concept of triage began during World War II when decisions were continually made about whom to save among seriously injured solders. Sometimes not the most seriously injured patient received the greatest medical attention, but rather the one who would survive. Do social workers in the health field also prioritize need in this way by giving more immediate attention to the patient who can be helped, not the one who is terminally ill (Congress, 1999)?

A third principle is that of compensation based on the belief that certain populations who have often received severe deprivation in the past should now receive special compensation. Affirmative Action programs provide an example of this principle in action. Applying this principle to the health field, should certain populations who have been previously disadvantaged receive special attention for their health care, especially if it can be established that their current need is great?

A fourth principle of distribution and possibly the most controversial is that of contribution. Should someone receive access to health care and treatment based on what they have contributed to society? The 2010 Patient Protection and Affordable Care Act (ACA) requires organizations with more than 50 employees to provide health care to their employees. Those who have the skills and are documented have the option to work in a larger organization and thus have greater access to health care. The underlying but unspoken belief is that their contribution is more. Another example of how contribution is used to distribute limited health care resources is that those who have contributed the most to society (or sometimes to fund-raising efforts) can afford luxurious accommodations in hospitals and 24-hour health care attendants as outpatients.

Where there is limited availability, distribution of transplanted organs is also an area of concern. While social workers believe that distribution of limited resources should have equal access, this seems to be related to status and socioeconomic factors. For example, about 20 years ago, many in health care were appalled to learn that a famous baseball star, Mickey Mantle, received a liver transplant despite having compromised health (Congress, 1999). Also, decisions about giving heart transplants are made in terms of availability to take medicines on a regular basis and thus unfortunately many homeless people are excluded (personal communication).

**COMPETING ETHICAL PRINCIPLES**

In an attempt to navigate among so many competing principles, Loewenberg and Dolgoff (2000) developed the following hierarchy:

1. Autonomy and freedom (self-determination)
2. Equality and inequality
3. Least harm
4. Privacy and confidentiality
5. Protection of life
6. Quality of life
7. Truthfulness and full disclosure

A later study by Dolgoff, Loewenberg, and Harrington (2009) found that there was little consistency about how social workers rank these often competing principles. Context is viewed as very important in deciding which principle should prevail. For example, promoting the right to self-determination and preserving life are two major principles that may be in conflict. Understanding the context, however, can help the social worker understand how protection of life may be more important when working with a healthy 18-year old with suicidal intent, while promoting self-determination and quality of life might be paramount in social work practice with a 80-year-old man suffering from terminal lung cancer.

**PRACTICE**

What are current practice challenges in the health field? Administrators in health care identified the following issues, ranging from macro financial to clinical micro dilemmas (Larson, 2013):

1. Balancing care quality and efficiency
2. Improving access to care
3. Building a sustaining health care workforce of the future
4. Addressing end-of-life issues
5. Allocating limited medications and donor organs

Health care providers have the desire to provide quality services, but often struggle with the need to reduce costs. At times, the best treatment option is not always the least expensive as sometimes a health care provider wants to readmit but knows that there will be a penalty as the patient has one of the six diseases designated for outpatient care. At other times, a social worker may believe that an undocumented person is in need of health care, but the individual may lack funds to pay.

Current practice in health care supports a patient’s right to self-determination. This may be compromised, however, because of the complexity of medical care and the limited time doctors and other health professionals have to spend with patients. Another challenge is the increasing number of those seeking health care who may not speak and understand English well. Using children as interpreters is not a good option because they often are kept from school to accompany parents to medical appointments or they may be asked to participate in health care discussions that are not appropriate. Since there are problems when a child or relative is used to translate, there have been efforts to support and develop skilled translation services in the health field (Drugan & Tipton, 2017).

**Health Care Challenges—Beginning of Life**

On the borders of life and age there are dilemmas. There are macro issues based on policy and legal decisions, but also practice issues that confront clinicians in the health care field.

When does life begin? The right for women to plan their families—even when it involves termination of pregnancy—was established in the United States by the 1973 *Roe v. Wade* Supreme Court landmark decision. Over the years, there have been modifications based on length of gestation, mother’s health, age, and financial status, and the laws governing abortion differ from state to state. Some who argue that life begins at conception have...
introduced funding reductions to agencies like Planned Parenthood that provide educational and service programs around family planning for women and their families. While NASW has supported a woman’s right to choose (Bailey, 2004), individual social workers may have differing views about this issue that may make it challenging for them to work in a multiservice health facility.

What is the age at which neonatal infants can survive? One hundred years ago, children who were born prematurely would not have survived at all, and 50 years ago they may have survived but often with severe visual and other handicaps. Now infants even under one pound or with severe physical problems can be saved. The costs of neonatal and sometimes lifelong intensive care for the premature pose challenging ethical questions (Murakas & Parsi, 2008).

Health Care Challenges—End of Life

The population in the United States, as well as around the world, is increasing (Population Reference Bureau, 2008). Older people as well as younger people, even those with life-threatening illnesses, live much longer than previously. People are asked to make health decisions for themselves before their health is so compromised that they lose the capacity to make their own decisions. All states recognize some form of living will, advance directives, or proxy (American Bar Association, 2017).

How does this policy decision affect those in direct practice? Self-determination is seen as an important ethical principle in the health care field. Patients are now asked to consider using Advanced Health Care Directives for themselves about what medical measures should be used and also to name health care proxies to make health decisions for them if they are unable to do so. This illustrates an important way by which patients are given the right to exercise self-determination and participate in making their own health care decisions.

Informed Consent

Another ethical concern and challenge for the health care social worker is enhancing informed consent for all clients. There are numerous examples in medical history of disadvantaged and vulnerable populations not being afforded informed consent. The often-cited Tuskegee Syphilis Experiment from 1932 to 1972 is a classic example of a minority group that was not given the option to exercise informed consent because information about effective treatment was withheld.

The NASW Code of Ethics addresses informed consent by advising social workers to “use clear and understandable language to inform clients of the purpose of the service, risks related to the services, limits to services because of the requirements of third-party payer, relevant costs, reasonable alternatives, clients’ right to refuse or withdraw consent, and the time frame covered by the consent” (NASW, 2017, p. 8).

Informed consent requires three main elements: presumption of competence, voluntary action, and disclosure before consent. Presumption of competence implies that a client can gather diverse information, exercise judgment, and make a decision that may differ from that of the practitioner (Palmer & Kaufman, 2003). Minors and individuals ruled incompetent by the courts are presumed unable to provide informed consent. This is not an inflexible policy, though, because minors, people with mental illnesses, individuals with disabilities, and individuals affected by dementia are increasingly given the option of exercising informed consent to the extent of their ability. Ensuring that all people are deemed competent to make their own decisions is vitally important. There may be an
erroneous perception that people who do not understand English and/or have limited education may not be competent to make their own decisions. The use of professional interpreters and explanations of medical conditions and procedures in simple vocabulary may help those with limited education or English to make competent health care decisions. In order for patients to be ruled incompetent to make decisions, there must be a court decision that is not based on diagnosis or language difference.

Another important aspect of informed consent involves voluntary action without duress or coercion. Voluntary action may be hampered when there are institutional pressures to prevent clients from making independent decisions. Some patients/clients may be overly influenced by the authority of the health care provider and thus are not able to exercise independent judgment. This may be especially true for populations of individuals who have been stigmatized, oppressed, and prevented previously from making their own decisions. Also, all too often, clients are prescribed medications with serious side effects without being informed of the full extent of the medications’ possible side effects. Care must be taken that clients are able to refuse taking medications without undue threats that doing so will be detrimental to their health.

A final condition for informed consent is that consent must be preceded by the disclosure of adequate information. All possible risks and side effects must be reviewed and understood before clients can be expected to provide informed consent, even though such disclosure may lead clients to refuse treatment. In working with clients, social workers must ensure that they have complete understanding of possible consequences and risks of different types of treatment. For example, the American Psychiatric Association reported that nearly 50% of individuals with severe and persistent mental illnesses may develop permanent neurological symptoms, such as tardive dyskinesia, as a result of the medications they take (Swenson, 1997). While it was hoped that the new type of antipsychotic medication would not lead to such a large incident of tardive dyskinesia, this has not been the case (Vox, 2010). Yet many psychiatric patients and their families from poor minority populations may be pressured to take very strong psychotropic medications without having had the possible risks made clear to them.

**Ethical Challenge—Cultural Difference in Health Beliefs**

Another challenge for the health care practitioner occurs when clients have differing health beliefs. The NASW Code of Ethics stresses the importance of cultural competency. Social workers should “be able to demonstrate competence in the provisions of services that are sensitive to clients’ cultures and to differences among people and cultural groups” (NASW, 2017, pp. 9–10). Culturally competent practice involves more than speaking the client’s language or having knowledge about a client’s specific culture. It involves understanding and accepting how culture has shaped the client’s health beliefs. With all clients, but perhaps especially with clients from different cultures, social workers should work toward maximizing clients’ self-determination. With clients from diverse backgrounds, the social worker needs to be continually aware of the power dynamics that enter into any social work relationship, especially when working with individuals from backgrounds that have been traditionally oppressed.

**Cultural Humility**

A new perspective in culturally competent work is adopting a stance of cultural humility in working with clients from different cultural backgrounds (Ashford, 2008). Cultural humility has been defined as an approach that begins with greater self-reflection on the part of the practitioner in terms of the power differences. Learning from clients about
their cultures is paramount rather than the traditional cultural competency approach whereby practitioners had preconceived ideas about the cultures of their clients and sought to increase their skills in this area. Beginning first in the medical field where doctors first learned in multicultural trainings about the importance of listening to clients from different fields and not imposing practitioner beliefs on clients (Tervalon & Murray-Garcia, 1998), this approach is very relevant for social workers in the health care field when clients from different cultures are encouraged to share their own beliefs about health, well-being, disease, and health care.

**Intersectionality**

Incorporating a cultural humility approach with an understanding of power dynamics that impact the practitioner/client relationship, social work education and practice has now focused on intersectionality (Council on Social Work Education [CSWE], 2015). The social work practitioner in the health care field has to be cognizant of the multiple identities that should be recognized in working with clients with diverse identities of gender identification, race, ethnicity, age, social/economic class, religion, educational level, sexual orientation identities many of which may be devalued and stigmatized in society (see Chapter 4, Intersectionality, Social Work, and Health).

**Westernized Health Care Approach—Prevention, Diagnosis, and Treatment**

Those who work in health care quickly learn that people from different cultures may approach health prevention, diagnosis, and treatment in different ways. Most social workers in the United States are very aware of the importance of prevention, how diet, exercise, not smoking, and regular health screenings can contribute to improved health. Yet many, especially those who come from countries in the developing world, may not have this concept of prevention. For some, health care might have been minimal and only sought when there are health emergencies.

Most social workers in the United States believe in a Westernized system of medical care that includes regular physical examinations, x-rays, MRIs, CAT scans, blood tests, and surgery when necessary. For physical complaints, people seek consultation with physicians; for mental/behavioral health problems, they consult psychiatrists, psychologists, and social workers. Many immigrants, especially those from developing countries, may see the physical and mental as very connected. Mental health symptoms may be defined in physical terms, as for example “dolor de cabeza” (pain in the head) referring not to a physical headache, but rather to anxiety related to a stressful living situation.

**Challenges With Clients From Different Backgrounds**

While social workers work to maximize choice for their clients, they may face special challenges when clients’ health beliefs differ radically from those of the employing agency. Although social workers strive to maximize their clients’ rights to self-determination, the NASW Code of Ethics also states that social workers have an ethical responsibility to their employer (NASW, 2017). Social workers may face a dilemma in advocating for their patient’s right to choose alternative health care when there is a marked difference in the health policies and practices of their employing institutions.

What if the immigrant’s behavior seems contrary to accepted medical practice? What should the social worker do if the relative of a hospitalized patient continues to bring
in food that is antithetical to a prescribed diet? What if the hospital policy proscribes a clear discussion about end-of-life decisions and a client refuses this discussion stating that it will bring bad luck? Research suggests that many minorities are particularly wary of making end-of-life decisions (Gutheil & Heyman, 2005).

While social workers are respectful of clients’ rights to pursue their own choices, what if the choices are potentially quite harmful? What about a patient with a serious health problem that insists that the only cure for her illness is taking a special tonic that she received in a local botanica?

For example, consider the case of a 50-year-old female patient recently diagnosed with leukemia who told her social worker that she had decided not to pursue medical treatment. Instead, she believed that taking a special preparation her grandmother made would cure her. Using professional judgment, the social worker could argue that self-determination should be compromised because there is risk of “serious, foreseeable and imminent harm to a client or other identifiable person” (NASW, 2017, p. 7). How direct should the social worker be in encouraging the client to follow prescribed medical treatment? Although most adults might have the right to make individual decisions about their health care, court proceedings can be initiated to declare clients incompetent to make their own health decisions. A court proceeding to declare a person incompetent is used most frequently for older people and people with mental and developmental disabilities where their judgment is severely compromised and much less frequently with adults who do not choose a specific type of medical intervention.

Goldberg (2000) sees a dilemma for social workers who strive to respect the beliefs of all cultures but also support the basic human right to health and well-being. Although social workers are respectful of differing health beliefs, a conflict can arise if the practice is potentially life-threatening. This is especially challenging if the patient is a child. For example, what about a parent who refuses to let her child be immunized because she fears he will develop autism? What is the appropriate ethical stance for a social worker if a parent chooses to consult a faith healer rather than a surgeon for a child with a brain tumor? Should the parents be referred to Child Protective Services because they did not pursue recommended medical treatment for their child?

**Challenges—Interdisciplinary Work and Interdisciplinary Committees**

Although social workers in the health field have always worked with professionals in other disciplines, interdisciplinary work can be very challenging (Sherman, 2013; Wynia, Kishore, & Belar, 2014). This may be a new area for many beginning social workers since most social work schools, as well as other professional schools like medicine and nursing, spend most of the time focusing on their unique professional identities, rather than learning about how to successfully work with those from other disciplines.

A formal way in which social workers work with other health care professionals is through interdisciplinary ethics committees. Reamer (2006) outlines some issues that arise in these committees, but notes that social workers who participate in such groups usually become well respected team members (Cole, 2012; Reamer, 2006). Since health care has moved from the hospitals to the community, there may be additional challenges in assembling a team of health care professionals.

**Ethics Audit**

Since there are so many ethical challenges that may arise in health care and growing out of a concern for risk management, Reamer has proposed an Ethics Audit to help social
workers assess ethical practice within their health care organization. The Social Work Ethics Audit promotes ethical practice in health settings and minimizes ethics-related risks (Kirkpatrick, Reamer, & Sykulski, 2016).

**Ethical Dilemmas and Decision Making**

Faced with ethical dilemmas in health care, how do social workers make difficult decisions? Over the years, social workers have proposed many models for ethical decision making (Congress, 1999, 2000; Lowenberg & Dolgoff, 2000; Reamer, 1990). Reamer (1990) provides six guidelines and Loewenberg and Dolgoff (2000) suggest an “Ethical Principle Screen” that places seven ethical principles in a hierarchy.

The ETHIC model developed by this author (Congress, 1999, 2000) took into consideration that social workers in the health field are often overworked with little time to address ethical dilemmas in practice (Figure 2.1). How much do social workers engage in a process of ethical decision making? It has been suggested that social workers rarely, if ever, engage in a process of ethical decision making (McAuliffe, 2005).

Recognizing that social workers have limited time to engage in a decision-making process, a short, easy guide to ethical decision making was created (Congress, 2000). The ETHIC model consists of these five steps:

**EXAMINE**

What personal, social, agency, client, social, professional, and cultural values affect this ethical dilemma?

**THINK**

What ethical standards from the NASW Code of Ethics and the NASW Standards for Practice in the Health Care field apply to this issue? What government laws and policies, as well as agency practices and regulations, are relevant?

**HYPOTHESIZE**

What would be the consequences of pursuing different courses of action? Scenarios that focus on the risks as well as the advantages of alternative decisions can be developed to help in the decision-making process.

**IDENTIFY**

Who will be the most harmed and helped if different decisions are made? As social workers, it is often best to consider these choices in terms of social work’s commitment to the most vulnerable.

**CONSULT**

The first person to consult for social workers is often their direct supervisor, but in the health field there are many others with whom one can consult. Sometimes these consultations take place in a structured way through regularly scheduled case consultations or interprofessional ethics committees.

**POLICY**

**International Social Work Ethics and Health**

Social workers in the health field in the United States are often impacted by health issues of those around the world, such as the increasing number of immigrants and refugees that access health care and the concern that deadly new viruses such as Ebola and swine flu are only a plane ride away. Thus, social workers need to have a global perspective...
in addressing health concerns. The International Federation of Social Workers (IFSW) in cooperation with the International Association of Social Workers has adopted a statement of ethical standards for social workers (IFSW, 2012).

While this document is similar to the NASW Code of Ethics and the Practice Standards in Health Care, it does not specifically address ethical decision making for practitioners. However, it does stress a rights approach for addressing policy and practice issues in the health field. The right to good health and what is needed to achieve it is considered a basic human right (Olsen & Chatterjee, 2014).

When adopting a global perspective on ethics and health, the United Nations (UN) Sustainable Development Goals (SDG) provide guidance in this area. A specific goal (Goal 3) in this document focuses on good health and well-being for all (UN, n.d.). A main part of this goal has been maternal health, child health, and decreasing HIV, malaria, tuberculosis, infectious and chronic diseases around the world. Other SDGs focus on related health goals such as no poverty (Goal 1), zero hunger (Goal 2), and clean water and sanitation (Goal 6).

Health care policy in the United States limits access to health care based on the ability to pay. There is concern that it does not seem to incorporate a rights-based approach and the newest proposed federal health care policy may move even further from a rights-based approach to health. However, there are some positive indications that social work values have been adopted into U.S. health care policies.

Confidentiality is an important ethical standard for social workers and the NASW Code of Ethics has 18 standards related to this theme, more than any other area (Rock & Congress, 1999). The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the ACA stress the importance of maintaining confidentiality for patients/clients receiving health care. The use of technology for medical records adds new confidentiality challenges (American College of Health care Executives, 2016) and these concerns have been addressed in the social work literature (NASW, 2017; Reamer, 2013).

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Figure 2.1 ETHIC model of decision making.
Another major area in which social work ethical standards seem to have been incorporated into American health care policy is in terms of informed consent. Over the last 50 years, the need to secure informed consent of patients has become an accepted part of medical practice. All patients have the right to have medical procedures and possible consequences spelled out to them. This corresponds positively with social work’s ethical standard on honesty and integrity in relating to clients (NASW, 2017).

Healthy People 2020 Policy

Involving patients in identifying what are their health problems played a major role in United States Department of Health and Human Services’s Healthy People 2020 (USDHHS, 2010). This document is an interesting illustration about how the social work ethical principle of respect and inclusion of all was incorporated into conducting this large U.S. government survey, as it involved implementing an extensive stakeholder feedback process that was unparalleled in government (USDHHS, 2010). This federal government agency received more than 8,000 comments from professional public health experts, health organizations, as well as the general public regarding the selection of Healthy People 2020 objectives.

On the basis of these comments, a number of new topic areas were added, such as:

1. Adolescent Health
2. Blood Disorders and Blood Safety
3. Dementias, Including Alzheimer’s Disease
4. Early and Middle Childhood
5. Genomics
6. Global Health
7. Health-Related Quality of Life and Well-Being
8. Health Care–Associated Infections
9. Lesbian, Gay, Bisexual, and Transgender Health
10. Older Adults
11. Preparedness
12. Sleep Health
13. Social Determinants of Health

An ongoing focus of Healthy People 2020 has been the elimination of health disparities and inequities. Health disparities refers to the differences in illnesses, chronic health conditions, and mortality that occur across racial, ethnic, and economically oppressed groups, of which people of color often are the most at risk (Pollard & Scommegna, 2013). Because of social workers’ ongoing commitment to promoting social justice, this topic is of particular concern to those in the health field (Keefe & Jurkowski, 2013).

Since unequal access to health care based on race and ethnicity has been a contributing factor to health disparities (Smedley, Stith, & Nelson, 2003), working to overcome disparate health care access and to improve health outcomes for all people is an important area for social workers in the health field (Keefe & Jurkowski, 2013).

Healthy People 2020 (USDHHS, 2010) recognizes that the goal of reducing health inequalities and disparities cannot be limited only to health in the United States, but must include other countries as well. As a result, global health has become a new topic area and is listed as one of the Healthy People 2020 core topics.

Addressing Health Disparities

Addressing health disparities is an important ethical concern for social workers who are keenly aware of how life expectancy is related to race, ethnicity, and social/economic
class. Although the gap is reducing, African Americans consistently show poorer life expectancies than Caucasians; for example, a non-Hispanic White woman or man in the United States may live to 79 years of age while African Americans have a life expectancy of only 75.6 years (Tavernise, 2016). Income, social/economic class, and access to health care are also contributing factors to differences in health and those of higher social/economic class have life expectancies of about 5 years higher than poor Americans (Waldron, 2007).

How much do current U.S. health policies address health care disparities? The ACA did extend health care coverage to more than 20 million people who were previously denied (Sifferin, 2014). Yet many people face continuing challenges in accessing health care and this negatively affects health outcomes. In contrast to most other developed countries with a single payee system, the United States has financial and employment issues that detrimentally affect people’s access to health care. As mentioned, under the current ACA, those who work in organizations with under 50 employees or above Medicaid standards for their state may not have any health insurance coverage, and marginalized populations such as undocumented immigrants still lack any health care coverage. There is also evidence that all immigrants, even those who are citizens, may still lack coverage as 21% of foreign-born Latinos who are now U.S. citizens still lack health care, while only 14% of all native born citizens do (Krogstad & Lopez, 2014).

Policy—Access to Health Care

As this book goes to press, there is concern that the number of people covered for health care will be decreased. According to the Congressional Budget Office (CBO), the passage of this bill might result in 13 million people losing health care insurance. Those who would not be covered are predominately the poor who cannot afford the higher health care premiums or now that Medicaid standards have increased in many states may not have their health needs covered through Medicaid.

Policy decisions continually affect practice as this Case Example 2.1 illustrates.

Case Example 2.1

Robert, a 50-year-old married father of two children, lost his job when the factory where he worked closed. At that time he also lost his health insurance, so he has not been able to go to the doctor for over a year. He has a persistent cough, but treats it with over-the-counter medications. When he went with his children to a community health fair, Joanne, a social worker in the health field, encouraged Robert to go to the outpatient clinic for evaluation of his cough. Unfortunately, however, he lacked health care insurance and was not eligible for Medicaid. The clinic’s policy was not to accept clients who did not have Medicaid or were not self-paying. This created an ethical dilemma for Joanne as she wanted to adhere to agency policy, but felt that her main responsibility was to provide service to a client who needed it.

Policy—Health Care Move to the Community

Another recent policy decision that has affected practice is the move from the hospital to the community. Many surgical procedures are now provided on an ambulatory basis and hospital stays have been greatly reduced. This move has been compared to deinstitutionalization in the mental health field in the 1950s and 1960s that spearheaded the move from psychiatric hospitals to community treatment. With new Medicaid guidelines,
hospitals are penalized by additional fees if patients they have treated are rehospitalized within 1 month of discharge (Rau, 2016).

Expanded treatment options in the community are viewed as a positive way to treat patients as it provides greater opportunity for involvement with families in the care and support of medically fragile patients. There are many advantages to this move from hospital to community care. While in the hospital doctors and nurses ruled, in the community clients had much more say in their health care decisions. Another positive is increased demand for social workers to provide guidance, education, and community support for clients with poor health and their families. While health care provided primarily in the community increases opportunities for social workers, as well as is more supportive of clients’ rights to make their own decisions, there are new dilemmas.

Are people, especially frail older adults who may live alone in the community, able to secure needed medical and support services? How is confidentiality maintained in the community clinic? There may be additional challenges in maintaining confidential records in a community setting. Also there may be ongoing difficulties in communication between the hospital and those involved in community care.

RESEARCH

There are many ethical questions that need further research. While there are many ongoing research studies of new medications and treatments for different medical diseases, there is much less focus of research of ethical issues and dilemmas in health care settings and how they are addressed. Much of the literature has focused on identifying problems (Allen, 2011; McCormick et al., 2014; McIntosh & Hoek, 2006).

Social workers may struggle with ethical dilemmas in the health care workplace, but the conflictual issues and the methods they use to address them are rarely the focus of research studies. Crigger, Fox, Rosell, and Rojanasrirat (2017), however, did look at health care professionals’ experiences with ethics consultations and used their findings to develop a theory to guide professionals in making ethical decisions.

Another exception is Lillemoen and Peterson’s (2012) study on identifying ethical dilemmas that arise in the workplace. Lack of knowledge and skills was seen as contributing to workers’ difficulty in identifying and addressing ethical challenges in the workplace. Case studies have been proposed as an important way to help the social work health professional learn more about and navigate difficult dilemmas (McCormick et al., 2014).

CONCLUSION

There is good and bad news in the study of ethics and health. A general most discouraging fact is that among developing countries, the United States does not have a good record in terms of infant mortality, heart and lung disease, sexually transmitted infections, adolescent pregnancies, injuries, homicides, and rates of disability. Longevity rates are also not encouraging as a recent study of 17 high-income countries found that the average U.S. citizen can be expected to live almost 4 years less than those who lived in other high-income countries (Woolf & Aron, 2013). The good news, however, from a social work ethical perspective is that although many in the United States have limited access to health care and there are major health disparities, especially for minority populations, health care policies often reflect social work principles of self-determination, inclusion, and confidentiality. In addition, the move of health care from the hospital to the community
Case Example 2.2

Jessica, a licensed social worker, has worked for a major hospital for the last 5 years, two of which have been in a community-based outpatient facility. Her newest client is Carmen, a 40-year-old Latina woman who was recently diagnosed with type 2 diabetes. Carmen and her five children, ranging in age from 2 to 18, moved into a shelter for the homeless last year when Carmen’s husband became abusive. Several ethical dilemmas surrounding Jessica’s work with Carmen arose.

The first involved agency policy and the client’s need for ongoing treatment, while the other dilemma involved client self-determination. Jessica first began with an examination of what were relevant values. She looked at her own beliefs in that she could not understand how a person could have had five children and continue to live with a man who was abusive and not supporting his family. Jessica also recognized that she felt that a person should take more responsibility for her own health care and became concerned when Carmen reported eating a large piece of cake at a family party.

Jessica was also aware of agency policy and how this impacted her work with Carmen. The hospital had very strict guidelines for only providing medical care if clients were covered by Medicaid or self-paying. Carmen had a part-time job in a neighborhood pizzeria, so her income was slightly above Medicaid standards, and she could not afford medications to treat her diabetes. In the shelter, a conflict developed when Carmen continued to see her estranged spouse and the shelter had very strict rules about visits from male guests. In terms of values, Carmen really questioned taking pills for her diabetes. Her aunt had given her a special medication from the botanica and she thought it would work just as well if not better.

(continued)
Case Example 2.2 (continued)

Questions for Discussion

1. Values
   How do Carmen’s and Jessica’s values differ? What health care agency and shelter values affect this case?

2. Policies
   What laws and agency regulations are relevant in this case?

3. Scenarios
   What would be the consequence of Jessica telling Carmen that she must abide by agency rules about male visitors or insisting that Carmen follow the health procedures of her employing agency? What are other alternative courses of action?

4. Vulnerability
   Who is the most vulnerable in this case example and how much should this affect Jessica’s ethical decision making?

5. Consultation
   Who should Jessica speak with about this case?

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