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Ethical Problems in End-of-Life Care Decision Making Faced by Oncology Social Workers and the Need for Practice Guidelines

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ABSTRACT. Difficult ethical problems are often faced by patients, families, and social workers who assist in decision-making around issues regarding end-of-life care. In qualitative interviews with 12 hospital social workers in one large urban cancer center, common ethical issues identified through thematic analysis were preservation of patients' autonomy/self-determination, beneficence of health care providers, and medical futility of end-of-life treatments. Continued communication with all parties involved was key in resolving ethical problems. Discussion, along with referrals of more complex cases to ethics committees and ethics consultation teams, also occurred. Participants further indicated the potential helpfulness of developing practice guidelines for social workers dealing with decision making about end-of-life care. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2004 by The Haworth Press, Inc. All rights reserved.]*

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Issues regarding end-of-life care are emerging as an important area for social work practice and research. In particular, ethical problems in end-of-life care may be among the most difficult situations faced by social workers who practice in the health care arena. Often these situations involve decision making concerning treatment issues or the use of advanced technology in what may be a futile effort to preserve life. Not only do patients and families struggle with these issues, but social workers, whose goal is to assist patients with decisions about appropriate end-of-life care, may struggle as well.

One study of health care social workers identified common end-of-life decision-making situations that posed potential ethical problems (Csikai & Bass, 2000). These situations included issues concerning the use of advance directives, patients' competency, and lack of discussion regarding patients' wishes with family members or physicians. The exceptionally difficult issues of euthanasia and assisted suicide also have received some attention in the social work literature with regard to social workers' attitudes and how social workers would respond to requests for discussion of those practices (Csikai, 2000a, 2000b; Manetta & Wells, 2002). The particular issues for Oregon social workers regarding physician-assisted suicide have been examined as well (Miller, 2001).

What may make ethical problems in end-of-life care so difficult for social workers may, in part, be the lack of education or training in this practice arena. Christ and Sormanti (1999) specifically investigated the preparation of social workers for working in end-of-life care and found that most practitioners in the study did not feel prepared for such challenges. Educators reported that many students wished to take courses on death and dying, but the courses were oversubscribed and many faculty were not prepared to teach this content. In addition, few hospital and hospice social workers reported being exposed to content in bioethical principles, ethical theories, models of ethical decision making, emerging issues in health care, and quality-of-life issues in their social work programs or in continuing education (Csikai, 1999a; Csikai, 2004; Csikai & Bass, 2000).

When situations present ethical problems, a variety of resources may exist in the health care setting, such as bioethics committees, ethics consultation teams, or other team approaches, to help health care professionals deal with these complicated issues. Social workers also may

seek assistance from supervisors and other colleagues in attempting to resolve difficult ethical problems. In addition to relying on educational background, continuing education, or institutional support, social workers may look to their professional organization for guidance. The policy statement of the National Association of Social Workers (NASW, 2000), "Client Self-Determination and End-of-Life Decisions," provides general guidelines for practice in end-of-life decision making; however, social workers who spent more than 50% of their time in practice with end-of-life care issues were not aware of the policy's existence (Csikai & Bass, 2000).

Most studies of end-of-life care issues in general and of ethical problems occurring in end-of-life-care decision making conducted to date have been quantitative and have involved small convenience samples. To further explore the complexities of ethical problems that occur in end-of-life decision making, we undertook a qualitative study. The results of 12 semistructured qualitative interviews with hospital social workers in a large urban cancer center are presented in this article. Three research questions were addressed:

- In general, what end-of-life care and decision-making situations do hospital social workers encounter? What ethical problems arise in such situations?
- How are ethical problems in end-of-life care situations resolved in practice?
- Should end-of-life care practice guidelines be developed for social workers?

METHOD

Twelve master's level hospital social workers employed by a large urban cancer center in the Southwest participated in the qualitative semistructured interviews. All the participants were women who ranged in age from 29 to 58 years. Eight participants were Caucasian, one was African American, one was East Indian, one was Hispanic, and one was Vietnamese. There was considerable variability in the length of time the participants had been involved in medical social work (range, 3 months to 30 years). All of them worked with diverse cancer populations within the cancer center. None of them were current members of the facility's ethics committee, and 9 of the 12 participants were members of NASW.

The first author recruited and interviewed the participants. Recruitment initially involved direct telephone contact from the first author to the director of the center's social work department to gain permission to pursue the research with social work staff. The director agreed and then distributed a memo to the social workers describing the project (description provided by the first author) and soliciting interest. The first author then contacted potential participants by E-mail to explain the project in more detail and the interview process and scheduling. The first author conducted all 12 interviews over a three-day period.

The interview schedule consisted of open-ended questions that explored numerous domains related to hospital social workers' experiences in end-of-life care. In the analysis presented in this article, questions that focused on participants' experiences with the various types of ethical problems in end-of-life care (typical and complex), methods of resolving such problems, educational preparation for end-of-life care, and perceptions of the need for practice guidelines were examined. Interviews lasted between one and two hours and were audiotaped with the participants' written consent. Tapes were later transcribed for data analysis.

The data from the 12 interviews were analyzed using template analysis (Crabtree & Miller, 1992). This method of qualitative data analysis involves the creation of a set of a priori coding categories (i.e., first-level coding categories) based on the content areas addressed by the main research questions. Those codes are then used to group the data into meaningful categories for data management (Crabtree & Miller, 1992; Miles & Huberman, 1994). In the present study, we analyzed the transcripts of the interviews using the first-level coding categories to organize the qualitative data. To enhance the trustworthiness of the first-level coding, all three researchers independently coded one randomly selected interview. When the results were compared, the researchers determined that the first-level coding scheme needed to be simplified to increase reliability. Simplification involved collapsing redundant and overlapping categories. The revised first-level coding scheme was then used to code the remaining 11 interviews. Each researcher independently coded three or four of those interviews.

First-level codes, relevant to the research questions examined in this article, were selected for second-level interpretive analysis to derive themes. Each researcher was assigned to perform second-level interpretive analysis independently on a given set of codes. Peer debriefing via a series of conference calls among the three researchers was used to vali-

date the trustworthiness of the thematic interpretations provided by each researcher.

Given the small sample size of 12, the results should be interpreted with caution. Because of the study's exploratory nature and the in-depth views gained from these social workers, the results do suggest that a larger study is needed that examines the difficulties faced by social workers in end-of-life care in specialty settings as well as in more general medical settings. Only from wider input can generalizations also be made about whether practice guidelines in this area are needed.

RESULTS AND DISCUSSION

Ethical Problems Concerning End-of-Life Care

Initially, participants were asked to describe general end-of-life issues encountered in their practices and, more specifically, the situations in which ethical problems arose when dealing with decision making about end-of-life-care. Most of the social workers responded by giving specific case examples. The themes identified among the ethical problems they presented corresponded well to the bioethical concepts often considered in problematic end-of-life care situations.

Bioethical concepts can serve as an organizing feature in categorizing ethical problems faced in health care. Because medicine uses such a taxonomy, it also is useful for social workers in health settings to conceptualize issues or problems encountered in practice in this manner. These concepts include (but are not limited to) patient autonomy/self-determination, truth-telling, beneficence, nonmaleficence, and distributive justice.

Patient autonomy. Patient autonomy is essentially synonymous with the social work value of self-determination. This concept means that competent individuals' rights to make informed choices about their medical care and well-being should be respected. Also implied is that individuals must be informed of all available options and participate in discussions about the potential risks and benefits of proposed treatments. This value is closely tied to the concept of truth-telling—for medical decision making and the informed consent process to occur, patients must be given truthful information about their medical conditions as well.

To illustrate a conflict related to the principle of autonomy, most participants were able to recount cases in which family members either ig-

nored patients' wishes regarding treatment or demanded treatment that differed from the wishes patients had previously expressed. One participant discussed the following situation:

In the earlier part of that [treatment], the patient had indicated that he would want the treatment stopped when there was no hope for any quality of life, but his wife totally denied that. So, what happened I think [was] he started having some severe problem at home, and she called the ambulance and she brought him into the ER and he was intubated. [After calling a family meeting] . . . and after the doctor explaining to them how painful it was for him to be intubated, . . . the doctor's recommendation was that we let him go and extubate him and peacefully let him go. The whole family agreed to that, including his children, but his wife did not.

Truth-telling. Also, participants often discussed situations where the patients were not fully informed or told the truth about the possibility of recovery or cure with a particular treatment. One participant described such a case as follows:

I have seen situations where doctors themselves are not able to look at the family and the patient in this situation . . . [and say] "Hey, the kind thing to do for this patient is to take them off this life support system. The patient is not going to get better." Instead they say just the opposite until they get their research sometimes completed regarding that engraftment of that bone marrow and then they may talk about, "Well, we have had this patient on life support for a month now and, you know, a little bit of this has changed and a little bit of that has changed, but you know we need to look at taking the patient off the life support system."

In other cases, "The doctor is treating, and you are not sure if he should be more open and let the patient decide more for himself if this treatment is appropriate more so than the doctor or clinical team deciding." This implies that treatments are performed with secrecy about their effectiveness in curing the cancer and is an indication of unethical behavior.

Beneficence and nonmaleficence. In medicine, beneficence is defined as the act of providing benefit. This term is often considered in tandem with nonmaleficence, which holds that professionals should act in ways that do not intentionally cause harm or injury to others. Often,

deciding what is the best for the patient and what may be seen as doing more harm than good becomes an ethical issue for the medical team that is confounded by personal feelings and concerns. The following are examples of participants' comments:

A lot of times, and I would say a couple of times a month, you would come up with either the doctor still wants to treat . . . and it is an ethical dilemma: At what point is it causing more harm to treat? Does the doctor have appropriate boundaries? Does the medical team in general have appropriate boundaries? Have they become too close to the patient and they are hoping that . . . [something] will work . . . even though the statistics may be low? And finally, if you are open with the patient as far as saying, "I am still pushing treatment, but there is only a 10% chance this might work," we have that end of it.

I would say some patients, and sometimes it is the family, cannot give up treatment even though they know it is not appropriate or [they] have been told by the physician that is not appropriate to continue treatment. And [they] insist on having continued treatment even though it is only doing more to tear down the patient at this point physically. It is doing more harm than it is good at that point . . . so the main issues would be around when to treat, how long to treat, when to stop treatment.

Distributive justice. Some denial of reality by patients and families concerning the chances of successful cure may have to do with the particular medical environment. The specialty cancer hospital often is considered to be the place of "last hope" for a miracle cure, or minimally, for maintenance of an acceptable quality of life. By the time they seek help here, many continue in denial and have reached a point of desperation. This situation may raise a question of distributive justice in weighing the appropriate use of limited resources. According to this concept, which is similar to social work's value of social justice, benefits and burdens (or risks) of health care should be distributed to members of society in a fair manner (Beauchamp & Childress, 1994). Judicious use of resources in this hospital, such as experimental treatments, can be a source of ethical problems. To illustrate the principle of justice, one participant described a particularly poignant and difficult case involving a

clinical trial with limited enrollment for eligible patients. The patient in this situation wanted to continue with any available treatment possible:

[The patient] has further found out that her husband is in ill health, and it sounds as if she is just trying to stay alive long enough for him to die first and to care for him and his terrible medical situation. . . . Right now we are pretty much down to the last thing available in clinical trial, knowing that there is a 99% chance it is not going to help and you may be taking the spot from someone else that it might help, but if the patient is requesting the treatment and they have been given the information that there is only the small percent chance that it will work and they still want it, can you deny the patient that to give the opportunity to another patient?

In addition to the themes associated with the bioethical framework, two additional themes were found among the end-of-life situations with the potential for causing ethical problems: acceptance, both among patients and physicians, and surrogate involvement. The situations involving the lack of acceptance of the diagnosis and the fact that treatment had failed were reported to be among the most challenging for the social workers. The difficulty that some patients have accepting a cancer diagnosis is demonstrated by this telling observation: "There are a lot of patients that come here and say this is not cancer, that is a very big challenge . . . even though they are coming to a cancer center." In addition, the social workers reported many cases in which physicians cannot accept their inability to cure a dying patient. In a profession where death is seen as a failure, this is not surprising, but acknowledging it does not make it any easier for anyone on the care team. According to one participant:

One of the most challenging things becomes when typically the family members see the handwriting on the wall, the nursing staff, all the allied health professionals you see, a lot of times, if that is the situation that . . . [the patient] is in, if the doctor does not deliver the [bad] news. So the . . . preparation for the death cannot begin . . . not being able to discuss things that everybody is ready for except for the doctor.

This problem is often seen when the patient, the family, or the physician insists on continuing treatment. However, particularly difficult for the patient or family and the social worker is when the physician does

not want to discontinue treatment. One social worker described situations in which she had rehearsed with patients and families what to say to one physician in particular “who is never going to quit. It is his patients who often time feel guilty about quitting the treatment.”

Finally, facilitating surrogate decision makers’ involvement, particularly the determination of next of kin, was another difficult situation for many participants. This may be not only an ethical concern, it may have legal implications as well:

Just figuring out who the heck the next of kin is. You know you don’t want to fill out these medical powers of attorney, but do you realize that someone that you don’t want making your decisions for you is going to be making them [if the documents are not filled out]? If you want to make your decisions, then you need to do it on paper to make it legal. Because if you are married . . . [or] you are living with your boyfriend and your boyfriend is the one you want to make the decisions, it is not going to happen. I said, “Your husband is going to make your decisions regardless of what you want if you don’t do the documents.”

As the preceding discussion indicates, the participating social workers were faced with myriad ethical issues in the context of their practice. Not only did they shed light on the various complex issues they must contend with, they also discussed strategies they used to address such issues.

Methods Used to Resolve Ethical Problems

After describing the ethical problems they encountered, the participants were asked to discuss how they resolved these ethical problems in their daily practice. The participants indicated that they typically continued communication among all parties involved in the situation until resolution occurred. As one social worker said: “It has to be a process. We sit and discuss and talk it and sit and discuss and talk it.” In this particular cancer center, collaboration among members of the health care team also was seen as an integral part of daily activities.

In particularly difficult cases in which informal communication could not resolve the ethical problem, the center’s ethics committee was contacted for a full committee meeting or for an ethics consultation. “If there is any question, if one person does not agree within the medical team, then it will go to ethics [committee or consultation].” Ethics com-

mittees make recommendations based on the input from the health care team involved in the case and from deliberations of the standing multidisciplinary members of the committee. Most participants reported infrequent use of the ethics committee—from less than once per year to two or three times per year. In the interest of time, an ethics consultation team, usually consisting of two or three members of the full ethics committee, was involved more often in difficult cases. These teams investigate facts of the case and make recommendations instead of convening the full ethics committee. In the center, the chair of the ethics committee (at the time of the study) was someone who is well recognized in the field of bioethics and is open to receiving informal calls from representatives of the care team to discuss potential ethical problems in a case. In addition, the social work participants used supervision, proper identification of the next of kin, and time for resolution of the situation on its own as other means of resolving difficult situations. However, sometimes it is only the patient's death that may resolve intractable situations. In other words:

Some problems go to the ethics committee [and] some problems are resolved just by good communication among the staff. Some problems are resolved by repeated, and I do mean repeated, counseling sessions with the family, and some problems are resolved by a sudden change of the situation, meaning that sometimes the patient will have a turn for the worse overnight and pass away even prior to the planned discharge time. . . . Of course, the longer that the patient remains in the hospital, the more likelihood is that is going to happen.

Arguably, the best way to deal with ethical problems in health care practice is to address them before they become problematic if at all possible. One social worker reflected on this very idea as follows:

We have a patient who came in [who] has been disease free for nine years and then has had a bad recurrence to her hip, and so she has been here for a course of radiation. I kind of foresee that ethical things could come up about this particular patient because her husband is a cancer patient here. But I think her condition is worse than his is right now, and so a lot of times you kind of anticipate things that may come up.

What makes the end-of-life decision-making situations encountered by these social workers even more challenging is that several ethical

problems and concepts may be involved in any given case. Thus, anticipating all the eventualities requires acute awareness of the range of problems that could occur. In the analysis of the participants' remarks, this awareness was noted repeatedly.

Need for Sound Practice Guidelines

One possible strategy for recognizing and preventing potentially problematic end-of-life practice issues, or for addressing such issues as they arise, is the reliance on sound practice guidelines for social work practice in this arena. To address the participants' perceived need for such guidelines, we gathered data in the following areas: participants' familiarity with NASW's policy (2000), "Client Self-Determination and End-of-Life Decisions"; perceived helpfulness of guidelines for practice; suggested content of guidelines; potential barriers to implementation of guidelines; and determination of who should sanction such guidelines.

Familiarity with NASW's policy. When asked specifically whether they were familiar with the NASW policy, most participants said they were not. This result was consistent with a recent survey of 63 health care social workers regarding knowledge of NASW's policy (Csikai & Bass, 2000). In fact, many of them seemed to be apathetic regarding such information received by professional organizations, stating reasons such as the following: "I am non-practicing, I get my newsletters and I get my journals, but I don't really participate much." This participant also said, "I read what I find relevant to me. I follow the hospital policies, those are very relevant to me." More important, the social workers who vaguely recognized the policy had never used it and could not recall exactly what it said. As one social worker remarked: "I have the forms, I have the documents. I think I have looked at it, but I have read too many things. I have stopped following." The NASW policy statement was provided to the participants upon completion of their interview.

Perceived helpfulness of practice guidelines. Participants were then asked if they believed practice guidelines would be helpful for social workers facing end-of-life care situations with patients and families. The majority of them said such guidelines would be helpful. One participant said, "I don't know how many people would actually refer to or would use them, but I think it would be helpful if they were there." Another participant said, "Absolutely, I think that all the social workers who work in these kinds of situations develop their own styles and their

own resources, [but] . . . it would be wonderful to have guidelines somewhere when you are getting into the field.” A third participant agreed, saying, “I think that guidelines are always helpful for someone who is experiencing “it” for the first time or who does not have to do it often.” Another participant said, “I do think that there should be a process because I think that it may be good to look at and to keep some guidelines in mind.”

Most of the participants gave the impression that because of their particular role, they were familiar with end-of-life issues, but other social workers might benefit from guidelines. For example: “I can certainly see that social workers in other settings would very clearly need them.” It appeared that support for guidelines existed, but such guidelines were thought to be more for social workers than for others who work with end-of-life issues on a daily basis. Despite our small sample size, the participants’ responses may have exploratory value. A larger study regarding helpfulness and suggestions for guidelines would be needed.

Suggestions regarding the content of guidelines. Participants then discussed the types of guidelines and content that might be helpful. Possibly the guidelines could be formatted to be similar to the biopsychosocial assessment process “and relate it to end-of-life stages and family systems.” Suggestions for content included techniques to allow social workers to “maintain trust and respect for family and patients . . . encourage realistic expectations by the family . . . if there is a way to help facilitate it or help families . . . and just respect for the whole situation.” Also “providing patients with the basic right to information” should be stressed along with “working with the family and supporting them as well as the patient.” According to one participant, discussion of advance directives should be done routinely with every patient:

The words “living will” create a tremendous amount of anxiety in many people and they push you away. . . . I tell them that it is one of the things that I will be discussing with you because it is part of this system. . . . So if you put the living will as part of their own control of . . . making decisions, it is much more acceptable.

Hopefulness and cultural issues also were voiced as important to consider as content to address in proposed guidelines. Several participants expressed a need for standards in these areas:

I wish that the first time I walked in to a patient's room, I knew what to say.

I think that we should look at all aspects; the person should be approached holistically in their care, including religious and cultural preferences.

Communication should be clear and concise, and patients should know everything about their condition . . . [recognizing] there will be exceptions: people from other countries, people from rural areas, people from other belief systems that may not want such clear, concise communication.

Interestingly, some participants said that general guidelines could help not only social workers but other members of the health care team as well. One participant said:

I think that even for non-NASW members it would be helpful to have some kind of booklet, or maybe if they had a class for . . . [continuing education], . . . something that would discuss those kinds of things, because the ethics views don't always deal with end of life decisions.

According to another participant, the NASW code of ethics and general end-of-life care guidelines could help all hospital social workers, "whether it is cancer, renal disease, or heart disease, or whatever. . . . A lot of similar themes will come up whatever situation you are in. To have step-by-step practice guidelines would be very helpful." Lastly, a participant said that such guidelines should include the following:

What should a social worker's approach be? Stepping back and saying, "Okay, what do you know about the disease? What have you been told so far?" [and] . . . to suggest different things as appropriate measures at different points. When you are under active treatment and chemotherapy or starting to do this, we suggest this, this, and this. When patients are no longer able to take any more treatments because it would be more detrimental than beneficial,

then we suggest this option . . . which could be home health care, hospice, or something where the patient is able to enjoy a better quality of life.

Potential barriers to implementation. We also discussed potential barriers to implementing guidelines with the participants. Themes related to identified barriers included differences in practice situations, costs of implementation, communication and content of information about developed guidelines, issues faced by interdisciplinary care teams, cultural diversity issues, and policy dilemmas between social work and hospitals.

The participants referred to differences in practice situations on several occasions as well as to the issue of one policy not being broad enough to deal with every event: "I think a general . . . [policy] might be useful, but every situation is so different because, even within this hospital, it is different, let alone [in] other hospitals." Personal resistance and fear were cited as situational factors that also could contribute to guideline failure. Although the participants said they felt comfortable discussing end-of-life issues, they speculated that social workers who did not face these issues routinely might experience considerable discomfort and would resist or fear implementing such guidelines.

The costs of implementation were another potential barrier. As one participant said:

Some hospitals and treatment settings are just administratively ineffective about seeing that those kind of things are put into place. . . . I think the bottom-line economics and dollars make more of an impact on some facilities than the best care . . . and if it is not cost-effective, . . . [the guidelines are] going to be difficult to implement.

Training and evaluating the effectiveness of using guidelines may be one potential cost incurred in implementation. For a facility to endorse the use of interdisciplinary guidelines on end-of-life care and potentially of social work services in general, outcomes would need to be measured in relation to cost savings to the facility. As one social worker commented however:

The hospital does not really care about what NASW thinks, and so that would probably be a difficulty. . . . Are you aware that other hospitals here are getting rid of their social work departments [because of cost considerations]?

Communication was identified as crucial in the development of guidelines. More important, clear communication between social workers and patients, families, and other members of the care-team is essential. The issue of communication was often linked to care team issues. One participant believed that physicians should be involved in developing guidelines “because the physicians, especially in the medical setting, their ideas, opinions and decisions are important to us. . . . If their governing body was approving it, then they would be more accepting of it also.” Despite all the identified barriers to the implementation of practice guidelines, most of the participants still supported the creation of guidelines.

Suggestions regarding who should sanction the guidelines. Finally, sanctioning of practice guidelines for end-of-life care was addressed, if such guidelines were indeed developed. The participants were split on this topic between the guidelines being sanctioned by NASW or by both NASW and the medical facilities. Those who believed NASW should sanction guidelines made statements, such as, “I think it would be good if NASW did. . . . I mean every facility usually has its own policy,” alluding to the idea that centralizing the policy would create some common ground. One participant said:

I think it is good to have an offering from an organization such as NASW, and then you can modify that when you need to. I think that is a good beginning point because it would be developed with the broadest application in mind.

Participants who believed in a joint venture gave reasons, such as the following:

Like all guidelines, it has to start from somewhere. . . . I think that the institution should have some type of training provision. An organization like NASW should be involved, you know, everyone should be working together.

I do not know if I would say NASW, maybe NASW or a combination. Somewhere where social workers are involved. I . . . think I

would like to keep it within our profession, to be able to come up with these guidelines. I think it should be ours.

Other suggestions were to combine sanctioning by NASW with sanctioning by other the sanctions of other professional organizations, such as the Association of Oncology Social Work (AOSW) and physicians' groups. All the participants seemed to view NASW as a desirable organization to be involved in the sanctioning of guidelines, and many also believed it should be a joint effort with the institutions.

Some organizations have begun to interpret issues concerning end-of-life care for their members and currently can serve as resources for social workers: for example, AOSW, with its position paper titled "Active Euthanasia and Assisted Suicide" and its scope of practice and practice standards documents, and the National Hospice Care and Palliative Care Organization, which is beginning to revise its practice standards for social workers in hospice and palliative care. In addition, as a result of the "Social Work Summit on End-of-Life and Palliative Care" (2002), social workers from multiple constituencies participated in developing priorities for social work in end-of-life care, grief work, and bereavement. The topics covered included development of a consensus statement encompassing both the scope and standards of practice as the first priority. Gwyther et al. (2003) are currently developing such a statement with wide participation by professional social work organizations.

CONCLUSION

The present research demonstrated that hospital social workers in end-of-life care must grapple with many difficult ethical issues in the context of their daily practice. These resourceful social workers have developed numerous strategies to deal with these issues, and all of them indicated that the development of practice guidelines would, for the most part, be helpful. They viewed those guidelines as needed particularly for inexperienced social workers and for social workers who do not work with end-of-life issues on a daily basis. Although they viewed the development of such guidelines as desirable, many indicated there would be numerous barriers to their implementation.

As some participants implied, social work practice guidelines for end-of-life care need to be developed considering the context of the sys-

tems in which such guidelines would be implemented. Given that much end-of-life care is delivered by interdisciplinary teams, development of the proposed guidelines would require consideration of the values and professional roles associated not only with social work but also with members of other disciplines with whom social workers interact. Social workers do not practice in a vacuum, and their day-to-day work is influenced directly by the systems that surround them. More research needs to be conducted to address what type of specific content would be valuable in the proposed guidelines and how the barriers to their implementation can be overcome. Consideration of other disciplines and larger systems would enhance the probability of successful implementation. Social workers helping patients and families at the end-of-life in all types of practice settings need solid guidance and support to provide high-quality psychosocial services.

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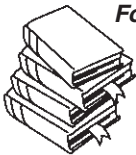
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