

**THE MEANING OF ETHICS AND ETHICAL DILEMMAS IN
SOCIAL WORK PRACTICE:
A QUALITATIVE STUDY OF GREEK SOCIAL WORKERS**

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By

Dimitra Giannou

***School of Health Sciences and Social Care
Brunel University***

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Abstract

Social work struggles between the dichotomy of “*individual*” and “*society*” as it is characterized as enhancing both individual well-being and social justice. As these are not always easily balanced and social work has limited autonomy, social workers must develop their capacity for making moral judgments and defend these within their various roles and responsibilities. Studies which explore the role of ethics in social work practice enhance the potential for maintaining a common identity. This exploration permits a deeper understanding of social work ethics and reinforces a common framework inclusive of purpose and standards for the profession. These studies also capture the contextual factors impacting on the moral agency of social workers, and thus substantiate the role for social work in a world with structured oppression.

The purpose of this study was to obtain an in-depth understanding of social work ethics in the practice context of public hospitals in Greece. Using a case study design, data was gathered to explore and understand the role of social work ethics in daily practice and the formation of what is perceived as “*good*” practice. The analysis followed Yin’s (1993) descriptive strategy. Data collection included fifteen in-depth interviews with hospital social workers, a group interview with social work academics, and a thematic analysis of the social work journal of the Hellenic Association of Social Workers (HASW). The meaning of ethical dilemmas and problems appeared to be constructed by personally held values, a lack of attention in social work education and the HASW on social work ethics, a professional emphasis on individualism rather than collectivism, and insufficient social protection in Greece. Importantly, these factors led to a fairly consistent response to ethical problems. “*Having a clear conscience*”, character traits such as bravery and imaginativeness, as well as the use of psychotherapy emerged as characteristics of “*good*” social work practice. These findings are of value to those who try to restore the values and ethics as central in social work. Values and ethics as key elements of social work expertise can lead social workers to a more competent and effective practice in terms of their ethical engagements.

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Table of Contents

Abstract	2
Acknowledgments	3
Chapter 1	
Introduction	
1.0 An introduction to social work ethics	10
1.1 Research aims	14
Chapter 2	
Literature Review	
Introduction	17
2.1 Philosophical approaches to ethics and their influence in social work	18
2.1.1 The Greek philosophy of ethics-The genesis of virtue ethics	18
2.1.2 Christianity and ethics	21
2.1.3 The philosophical approach of Immanuel Kant	22
2.1.4 Consequentialism, the Utilitarian approach on ethics	23
2.1.5 Feminist ethic of care	24
2.1.6 Postmodernism, ethics and social work	26
2.1.7 Summary	27
2.2 Ethics and social work	29
2.2.1 Values and ethics and the social work identity	30
2.2.2 Social work education and ethics	35
2.2.3 Value-based evaluation of social work practice	37
2.2.4 Fundamental ethical issues and dilemmas in social work	38
2.2.5 Ethical decision-making in social work	43
2.2.6 Ethical decision-making in health care settings	48
2.2.7 Summary	51
2.3 Exploring the context of social work ethics in Greece	54
2.3.1 The history of social work in Greece	55
2.3.2 Social work and the welfare state	58
2.3.3 The social work profession within a globalized environment	61

2.3.4 The National Health System in Greece	63
2.3.4.1 Social work in Greek public hospitals.	67
2.3.5 Summary	68
Conclusion	69

Chapter 3

Theoretical foundations: social work ethics and critical social work practice

Introduction	72
3.1 Politics and ethics	73
3.1.1 Social policy and social work	76
3.1.2 Politics and social work ethics	79
3.2 Critical practice and social work	81
3.2.1 Critical practice and its values	82
Conclusion	85

Chapter 4

Study Design

Introduction	87
4.1 Qualitative research methods and the case study approach	88
4.1.1 Data collection methods and a case study approach	93
4.2 Ethical considerations	94
4.3 The sample	95
4.3.1 Research sites	96
4.3.1.1 Athens	96
4.3.1.2 Patra	97
4.3.2 The participants	97
4.4 Data Collection	103
4.4.1 Securing the sample	103
4.4.2 Pilot work	105
4.4.3 The interviews and reflections on them	105
4.5 Data analysis and management	107
4.5.1 Empirical description and thematic analysis	108
4.5.2 Analyzing interview data	110

4.5.3 Analyzing the social work journal	111
Conclusion	112

Chapter 5

Social Work Practice in Greek Public Hospitals: The meaning of ethics and ethical dilemmas

Introduction	114
5.1 Values and the social work identity	115
5.1.1 Caring and protecting	116
5.1.2 Respect	119
5.1.3 Self determination	124
5.1.4 Summary	125
5.2 The social work role in Greek public hospitals	126
5.2.1. Psychotherapeutic practice	127
5.2.2 Psychosocial support and discharge planning	129
5.2.3 Advocacy	132
5.2.4 Social control	135
5.2.5 Financial assistance	138
5.2.6 Summary	139
5.3 The meaning of ethical principles in practice	139
5.4 Understanding ethical problems and their impact on practice	146
5.4.1 The absence of welfare support	147
5.4.2 Structured social exclusion	152
5.4.3 Bureaucracy and public hospitals	154
5.4.4 The under-funding of public health	156
5.4.5 Health professionals and unethical practice	158
5.4.6 Social workers and the violation of law and organizational rules	164
5.4.7 Summary	167
5.5 Understanding ethical dilemmas	167
5.5.1 Truth telling	167
5.5.2 Autonomy versus safety	172
5.5.3 Patient best interests versus hospital rules	175
5.5.4 Protecting oneself	178

5.5.5 Obstacles in the resolution of ethically difficult situations	179
5.5.6 Summary	182
5.6 Evaluating hospital social work practice	183
5.6.1 Characteristics of the “good” social worker	186
5.6.2 Personal values as the moral base for “good” social work	186
5.6.3 Psychotherapy and the “good” social worker	188
5.6.4 Summary	190
Conclusion	191

Chapter 6

Ethics and Ethical Dilemmas and the Broader Social Work Context: Social work education and the Hellenic Association of Social Workers

Introduction	194
6.1 Ethics and ethical dilemmas in social work education	195
6.1.1 Social theory versus social work practice	196
6.1.2 Social work students and practice learning	197
6.1.3 Whistle blowing	202
6.1.4 Accountability and social work academics	205
6.1.5 Summary	206
6.2 Hellenic Association of Social Workers and the promotion of social work ethics	207
6.2.1 Roles and responsibilities for ethical social work	209
6.2.2 New knowledge and knowledge transfer for ethical social work practice	210
6.2.3 Summary	213
Conclusion	214

Chapter 7

Discussion and Conclusion

Introduction	217
7.1 The meaning of ethics and ethical dilemmas in hospital social work practice in Greece	218
7.1.1 Social work in Greek public hospitals	219
7.1.2 The meaning of ethics in hospital social work practice	220
7.1.3 Ethical dilemmas and ethical decision-making	225

7.1.4 Ethics and the evaluation of “good” social work practice	230
7.2 Implications for social work policy and practice in Greece	231
7.3 Study limitations	234
7.4 Recommendations for further research	235
Conclusions	237
Appendices	
1. Letter to hospitals	240
2. Participant information sheet	241
3. Consent form	243
4. Interview schedule for hospital social workers	244
5. Interview schedule for the representative of Hellenic Association of Social Workers	245
6. Interview schedule for social work academics	246
7. Ethics approval letter, Brunel University	247
8. Interview transcript	248
References	260

List of Tables

Table 1: Participating organisations and number of interviews	97
Table 2: Characteristics of hospital social workers	99
Table 3: Social Work publications and professional social work ethics	211

Chapter 1

Introduction

1.0 An introduction to social work ethics

Historically, social work is identified with the “*helping*” or “*caring*” professions as it is dedicated to help people meet their needs and advance their potential in a continuously changing society. Social work indeed began as a philanthropic helping activity, but it was developed as a special scientific field. Therefore, the identity of social work needed to be more specific and formed with specific characteristics which would enable a unique description of its practice among the other “*helping*” professions and the social sciences. By defining or characterizing it as both a science and a profession, we acknowledge elements in social work such as the existence of specific theories, ideologies, methods, techniques, and values and ethics. Furthermore, we recognise social work as having a social function which is provided by the state vis à vis the department of social welfare. We also acknowledge that this role is in a constant state of development, like everything else in society, by what we briefly call social dynamics.

Current ethical codes define social work as a profession which has its main purpose defined in relation to social change. Specifically, the International Federation of Social Workers (2005) and the U.S. National Association of Social Workers (1999) see social work as a profession that not only helps individuals to meet their needs, but also promotes social justice and social change. Importantly, the notion of social change can only describe an explicit change to the structure of a given society, a transformation of important aspects of human societies, changes in beliefs, values, culture, attitude, social relationships, civilization, stratification and anything else that affects human lives (Goode, 1988). What remains for social workers then, is to depict the changes that need to be done in order to ensure the personal and social well-being of all individuals. Therefore, social workers should be engaged not only for the purpose of social change, but for a common vision of what can replace an old status. Social workers should, therefore, define specific aims for social change in order to ensure their professional accountability and scientific identity.

Social work by its engagement with specific values and ethics determines the kind of social change that the profession wants to bring. Thus, by the use and interpretation of the profession’s

values, the purpose of the profession is not abstract and could be identified in exploring practice. Through our common values and ethics we gain a common vision and a common identity that no one can take from us or criticize us for being unspecific. Through the profession's common values and ethics a vision for change and its identity emerges. Thus criticisms aimed at suggesting social work lacks specificity or remains undefined are unfounded.

Although social work is not the only profession that is dedicated to the promotion of important values, its relationship with social policy, its holistic approach to human needs and its engagement with mutually opposed values create complicated ethical dilemmas. There is an apparent agreement in the literature that social work tries to practise among conflicting interests, and therefore complicated ethical dilemmas are common in every day social work practice (IFSW, 2005; Rossiter, 2001; Briskman, 2001; Clark, 2000). For example, by approaching an individual's needs holistically, social workers have to deal with various needs and rights that should be addressed simultaneously. However, this is practically impossible. In light of these conflicts, social workers can only proceed by making value judgements (Clark, 2000).

As stated above, the concern of social work is not only to help individuals, but also to affect change in society to enable it to adequately correspond in its response to individual needs. Tragically, as Rossiter (2001) argues, this is something that social workers forget or ignore:

...I realized how exhausted and beleaguered I am by a lifetime of being positioned as a "professional helper" by a state that organizes the people's problems as individual pathologies that are best administered by professionals who are trained not to notice the state (pp.2).

If social workers are only familiar with seeing injustice as having only to do with individual relationships, then structural or social policy issues are removed from decision-making, including the value judgements they make. In this instance, they are unable to identify all of the stakeholders that are implicated within a problem(s); the identification of which is a very important part of the ethical decision-making process (Boland-Prom and Anderson, 2005). Consequently, an important condition for what is perceived as a "good" social work practitioner is introduced. In particular, and as Speicher (1998) indicates, ethical awareness is a prerequisite of ethically informed decision-making, and ethical decision-making is a significant aspect of social work practice as social workers continually mediate among conflicting interests or competing values (Clark, 2000).

Furthermore, social work's ethics and values are not a matter for finding "goodness" or, as Briskman (2001) says, a place of "innocence" in social work practice. Rather, by focusing on ethical social work issues we acknowledge and identify a special characteristic of our professional identity, and we confirm the criteria by which effective or "good" social work practice is judged. In addition, we acknowledge the process of decision-making as a critical element of professional practice, which thereby necessitates that social workers have the knowledge and skills necessary to interpret the ethical underpinnings of practice.

However, it is managerialism which eventually defines the criteria by which social workers evaluate their effectiveness (Kirkpatrick, 2006; Meagher and Parton, 2004; Rubin and Babbie, 2001). Social work interventions are more strictly controlled and oriented to achieve specified targets that are cost-effective. In addition, the new meaning of accountability, underpinned by the managerial ethos, requires social workers to take a more instrumental and impersonal approach to their work to be accountable to their clients and to the organization through various detailed administrative procedures (Banks, 2007; Meagher and Parton, 2004; Gibbs, 2001; Clark, 2000). Similarly, there is a newer emphasis on outcomes providing "hard evidence". Social work researchers are expected to conduct studies without focusing on value commitments, but rather to produce evidence-based knowledge which is often separated from the recognition of social conditions as ongoing obstacles to social well-being (Gibbs, 2001; Banks, 1998). Nevertheless, managerialism also led to the professionalization of social work (Banks, 2008).

Accordingly, the professionalization of social work and the advancement of social work education have led to a growing interest in social work ethics (Banks, 2008). Although there is already an extensive theoretical literature on social work ethics, only scant research has been conducted on ethical issues since 1980 (Jansson and Dodd, 1998). Nevertheless, it is argued that in a time that the moral agency of the social work profession is challenged by the prevailing managerial ethos, bureaucracy and the fragmentation of the profession, research on social work ethics can enhance the potential of social workers for maintaining a common identity. Moreover, as social workers are professionally engaged to enhance both individual well-being and social justice, social work research must be committed to enhance the mission of social work and the scientific accountability of the profession. Jansson and Dodd (1998) argue that social work researchers should develop studies so as to reinforce the moral agency of the social work profession and support practitioners to develop their capacity for making moral judgments and defend these within their various roles and responsibilities. Social work studies and mainly those with a

qualitative orientation have also the ability to maintain closeness with practice realities. Therefore, social work research must uncover the contextual factors impacting on the moral agency of social workers, and thus substantiate the role for social work in a world with structure oppression.

However, different contexts shape the social work realities in different countries, and therefore, it is not possible to assume that social workers in Greece face the same challenges as in other countries. Likewise, it is difficult to identify a cross-national social work identity without recognising how a local context (e.g. local needs, national laws, employment opportunities and status) affects the profession. On the other hand, globalisation and closer ties with Europe have cross-national effects, and then the social work realities in one country could be seen in light of the political and economic changes that dominate on the global stage (Lyons, 2006).

Greece is a member state of European Union, however, the fundamental structure of the welfare state remains considerably stable. Currently, the social policy literature in Greece indicates that poverty, unemployment and social exclusion are pressing realities for the population while the Greek state spends considerably less than the average of the Member States of EU countries on social protection. Furthermore, the Greek welfare system is traditionally characterized by fragmentation and preferential treatment in the funding and delivery of social protection leading to large-scale inequities (Yfantopoulos, 2004; Sotiropoulos, 2003). Mass immigration and expansion of privatization due to globalization are also part of the economic and social reality of Greece (Petronoti and Triandafyllidou, 2003; Zambeta, 2000).

Not surprisingly, social work in Greece appears to reflect the insufficient social protection in Greece. The welfare state and social work education in Greece have not developed educational opportunities for social workers and therefore, social work's status is likely to remain low. Social work activities are characterized by a "first-aid" pattern and the individualization of problematic situations in contrast to collective intervention. Social work in Greece has not benefited by the international exchange of knowledge and professional experience, although the EU has instituted policies that promote student and professional mobility. In addition, the curricula of social work schools in Greece have no reference to international or European social work, and their focus is on the local and national level (Pediadikaki, 2003). Similarly, social work research is underdeveloped and there is only a scant body of work exploring social work practice in Greece (Dedoussi et al., 2004; Pediadikaki, 2003).

To summarise, social work is a value laden profession and it is ethics that permits us to manage this balance. With this study I would like to contribute in such way that social work will understand its values and ethics at the front line of its practice as social workers are professionally employed to accomplish the balance between societal and personal well-being. In addition, with the establishment or re-establishment of values and ethics at the core of evaluative practices as well as in the formation of what is perceived professional expertise, we challenge the prevalence of evidence-based practice and we develop the potential of value-based social work practice. Only then can social work play a role in the development of a genuine moral discourse on the values that underpin social policy within the political arena of societies. If social workers are incapable of criticizing social policy in reference to its underpinning values, then social workers will become technical agents and their practice will be driven by the prevailing values of a given society.

1.1 Research aims

Since social work is a value-laden profession social workers are obligated to make decisions on ethical grounds and their decisions should not be based solely on bureaucratic procedures and technical rules (O'Sullivan, 1999). Ethical dilemmas are common in social work practice and they often reflect the ambiguities of the social work identity or its ethical engagement with mutually opposed values. However, not all factors that create ethical dilemmas are relevant in all social work contexts. Differentiations in social work education and tradition, social policy and the prevailing social values are only a few of the factors that structure variations in the ways that social workers perceive ethics and their ethical dilemmas.

This study was an exploration of the complex reasoning of ethical dilemmas and problems that hospital social workers face in their daily practice. In fact, social work ethics in Greece has not been researched before. By adopting a qualitative approach which is sensitive to cultural issues, and political and organizational context, I intend to outline the nature of social work ethics and the consequent ethical problematic situations that social workers face in their practice. My aim was to explore the role of social work ethics in Greece by looking through the case of social work practice in the Social Services Departments (SSD) of the public hospitals. In particular, the focus of this study was to outline the role of the ethics in the formation of what social workers perceived as ethically difficult situations and the consequent decisions they make. Additionally, the role of ethics in the formation of social work identity and the ideal of the "good" social worker was also of interest particularly in relation to how ethics affect the evaluative process of practice. Hence, the

following questions were developed to form a study exploring social work ethics in Greek public hospitals:

1. How do Greek social workers conceptualise ethics and their relationship with professional practice (e.g. social work code of ethics)?
2. What is the relationship between values and ethical principles and how do they inform the practice behaviour of Greek social workers?
3. What is the Greek social worker's experience of ethical dilemmas and the ethical decision-making process?
4. How do Greek social workers perceive ethics as contributing to good social work and/or the evaluation of practice?

The research questions evolved during the process of a theoretical review of social work ethics. Theoretically it is argued that social work education is one of the main formational factors of social work identity and is responsible for training social workers to be ethically aware (Clifford and Burke, 2005; McAuliffe, 2005). Accordingly, the establishment of a code of ethics is normally one of the major responsibilities of the professional associations that are the official bodies responsible for the regulation of a profession (Clark, 2000; Banks, 1998). As the Hellenic Association of Social Workers is currently a member of the International Federation of Social Workers (IFSW) it is perceived that HASW is the official body responsible for the promotion of social work ethics. Therefore, possible scenarios were explored between the ways that ethics were perceived and practiced by the social workers and the ways that these were dealt by the social work education and HASW. According to the above theoretical considerations data from HASW and social work academics were also obtained so as to further our understanding on the above research questions.

Findings from this study indicated that the prominent ethical problems of Greek hospital social workers involved the insufficient and ineffective welfare state and the unethical practice of other health and social care professionals. Despite the structural roots of their ethical problems, all hospital social work practice appeared to be focused on micro-level intervention. Collective values were absent from their ethical decision-making while individualistic values such as self-determination and autonomy were dominant within the narratives. A version of the ethic of care also appeared to underpin the ethical decision-making of these hospital social workers. More specifically, their ethic of care resembled one that was embraced in absence of their consideration of the broader political environment. As a result, and consistent with some critics of

the ethic of care, this narrow view appeared to reinforce paternalism and parochialism rather than a more cognitive appreciation of rights and justice as necessary aspects of a caring behavior (Meagher and Parton, 2004). Interestingly, all the participants appeared to determine that it was their personal values that provided important guidance for ethical decisions. Any consideration of professional knowledge and training or the professional association's code of ethics was not apparent.

It is anticipated that the dissemination of this study to Greek social workers is an initial effort to enable social workers to develop their ability to be ethically aware and learn to reflect on the ethical dilemmas of their practice. Moreover, this study encourages the efforts of those who try to establish a common framework inclusive of purpose and standards for the social work profession. In addition, the qualitative orientation of this study highlights the contextual factors that determine the ethical obstacles of social workers who daily try to respond to their clients' needs. Therefore, this study empowers social workers as they were able to identify and describe with their own words the realities of their practice.

Chapter 2

Literature Review

Introduction

Ethical dilemmas are considered as an inherent characteristic of the social work identity and reflect the involvement of social workers in multiple obligations often framed by conflicting values (IFSW, 2005; Banks, 2001; Rossiter, 2001; Clark, 2000). In fact, ethical awareness has currently emerged as a primary social work skill enabling social workers to respond effectively to their professional responsibilities and make ethically informed interventions (Banks, 2001; Rossiter, 2001; Clark, 2000).

Theoretical and empirical investigations into the meaning of ethics and ethical dilemmas in social work practice respond to theories that perceive social work as a value-laden profession and used to accomplish the balance between societal and personal well-being. In addition, as social work is defined in relation to social change, it is important for social work research to determine the contextual factors that constrain the ability of the social workers to promote their professional values and ethics.

The purpose of this chapter is to present the literature review of this thesis. It is grouped into three main sections. The chapter begins with a review of the philosophical and theoretical approaches to ethics as these are the origins of the substantial concepts used within the ethical code. The focus here is to understand the influences of these approaches in the formation of social work identity and practice.

In the second section the social work identity is discussed through the elaboration of its values and ethics. Following is the presentation of fundamental ethical dilemmas as consequences of the inherent ambiguities of social work identity. The emerging skill of ethical awareness as a prerequisite of ethically informed decisions and value-based evaluation are also illustrated through the existing theoretical social work literature. In addition, through a review of the existing empirical studies, the place of social work ethics and ethical dilemmas in daily practice is identified.

As social work has been variously developed and framed in different countries, in the third section social work is discussed with reference to the Greek context which is the focus of this thesis. In particular, social work is discussed in relation to the political, cultural, and social context where hospital social work is currently practiced in Greek public hospitals.

2.1 Philosophical approaches to ethics and their influence in social work

Philosophy with its genuinely critical and analytical approach provides an in depth understanding of the important concepts (i.e. justice, well-being, autonomy) which represent the main content of professional ethical codes. Professional values and ethical principles are underlined by philosophical assumptions about good and evil and perceptions of human happiness. However, the relationship between philosophical ethics and empirical ethics is debatable and often vague (Banks, 2008). This is because philosophy provides a conceptual analysis of ethical concepts or meta-ethical questions rather than prescriptions on how practitioners can apply ethical principles in everyday practice. Nevertheless, professional values and ethics remain meaningless and abstract if they are not understood through the rationale provided by their philosophical origins.

2.1.1 The Greek philosophy of ethics- The genesis of virtue ethics

Western philosophy originates in ancient Greece by philosophers that addressed meanings relevant to human existence. In fact, the word philosophy derives from the Greek language and means "*love of wisdom*". In reference to moral philosophy, Socrates, Plato and Aristotle were those who contributed most to the development of what is currently known as virtue theory. This section provides a brief discussion of the philosophical origins of virtues.

The basic assumption of Socrates was that all men, if they could, would do what was "*good*" and that the sole reason for not doing so was some form of ignorance. Therefore, he believed that all people must have certain capabilities that reflect an excellent knowledge for something. Therefore, Socrates perceived wisdom as being identical with the notion of virtue. Socrates regarded notions like courage or justice as debatable, and his well-known arguments were attempts to find a satisfactory definition. Plato, the most important of the Socrates' determinant followers, tried to establish virtues that would have concrete and absolute meaning, eternal in their duration and universally accepted. He argued that the source of moral values was not based on empirical reality, but on a virtue reality that could only be seen in our minds and souls. Plato

believed that only a virtuous person could be really happy because only a virtuous person had his/her soul in such a condition so as to be happy. Justice, courage, moderation and wisdom were the central aspects of a virtuous person according to Socrates and Plato (Huby, 1974).

Similarly, Aristotle believed that to lack virtues was to lack happiness which was the absolute evil. However, Aristotle developed a completely different approach on ethics and challenged the ideas of Plato and Socrates. Particularly, he argued that nothing is good in its own right and everything is good in relation to something else. He also argued that wisdom or the knowledge of something could be used both for good and for bad purposes; therefore, he was the first who separated the notions of means and ends. For Aristotle, virtues could be reached only if we choose the right means, and the choice of means was within our power.

The virtue theory of Aristotle rejects any notion of principles or moral rules. Right ethical decisions are dependent only on perception of individual circumstances. However, humans learn to make right decisions only if they gain certain virtues by cultivating certain dispositions, and in particular by educating their desires. Moreover, Aristotle made a distinction between acting virtuously and acting in conformity with virtues. This distinction was made in order to reflect the belief that virtue was fundamentally a matter of having the right desires, towards the right objects and in the right degree (Benn, 1998; Huby, 1974).

The theory of virtue ethics provides us with a different meaning of effectiveness in professional practice. Therefore, social work and its effectiveness take on a special meaning as virtue theorists place a special emphasis on virtues and vices and give relatively little explicit attention to moral rules and principles. Virtues are not just statements of principles. Rather they are dispositions to choose well; they are states of character. According to Banks (1995), "*a virtue is a character trait which contributes toward some ideal of the good life, both for individuals and the society they belong*" (pp.35). The majority of character traits that are currently considered as virtues originate from the ancient Greek philosophy of the virtuous human being. For example, current virtue ethics theorists have embraced some of the virtues of Aristotle's and Socrates' ethical theories, including justice, courage and temperance.

Concerning the social work profession, virtue theorists argue that virtues have an important role in the formation of the social workers' professional identity. In particular, McBeath and Webb (2002) argue that ambiguity in the social work profession due to our complex socio-political world

could be resolved by placing virtues in what we perceive as the social worker's identity. Moreover, they believe that doing a task well is not merely a matter of following rules, rather it involves the skills and virtues of a person. Corresponding to this idea, the question of "*what is good social work practice*" is replaced by the question of "*what is a good social worker*".

Virtue ethics give a moral meaning to the social work profession because social workers' actions are not driven by abstract obligations based on deontological rule books. Contrarily, social workers' actions take on a real moral worth as they reflect the importance of the values that the social work profession is supposed to promote. Nevertheless, there is one problematic area based on how social work virtues are established and defined in the first place (Houston, 2003). This idea becomes more complicated when we consider Aristotle's doctrine on *means*, whereby a good life is the means between vice and virtue and that too much virtue could be a bad thing (Benn, 1998). In response to this challenge, McBeath and Webb (2002) propose that virtues must be developed from a conscious analytical process rooted in dialogical exchanges between committed inquirers. They also explicitly suggest several virtues for social workers based on the Aristotle's ethical theory: justice, reflection, perception, judgement, courage, prudence, liberality and temperance.

Nevertheless, by accepting traits of character uncritically as virtues is opposite to the core theory of virtues and perhaps oversimplifies Aristotle's theory about virtues. Even if Aristotle himself explicitly defined some core character virtues, his theory implied a more complicated formation of virtues. Still, his theory gave some guidance on what could be defined as virtue. First of all, his doctrine of *means*, as previously mentioned, proposed that virtue must depend on the circumstances and must be discerned by careful judgement. To reach an absolute trait of character cannot be seen as an end in itself. In addition, a state of character is seen as virtue only if it operates as virtue. For example, courage is not a virtue in the case of a courageous murderer, because murder is not seen as enhancing "*good life*" or human happiness. In this case, therefore, courage is not a virtue because it does not serve its main purpose (Benn, 1998).

The discourse on virtue ethics does not solve all moral problems or dilemmas. However, it enables a revelation of moral and ethical concerns that enhance the action-based account of Kantian and utilitarian approaches on ethics. In particular, it emphasizes our priority on the individual, the social worker as a moral agent who plays a role in the production and reproduction of the public sphere and has powers to affect the structure of social relations contained therein

(McBeath and Webb, 2002). By finding the reasons for their actions, social workers are becoming more than technical agents of the welfare state when policy intentions are uncertain and they judge whether they produce ethical actions or not. Furthermore, virtue ethics place social workers in a position to consider their profession not merely as an abstract duty. Through reflection and self awareness social workers can strengthen their conscience about what they ought to do and to resist imposed organizational constraints.

Virtue ethics and particularly Greek philosophy was always a part of the education in Greece and integrated not only in philosophy courses but also in history, mathematics, science, and literature. More importantly, there are a series of quotes originated by the Greek philosophers that are part of the folk language and verbal expression of the Greeks. Therefore, it is anticipated that Greek philosophy has deeply characterized the Greek culture as it is reflected in every day language. In this sense, Greek social workers are culturally informed about virtue ethics even if virtues are not considered as a special social work skill or approach.

2.1.2 Christianity and ethics

Christianity affected deeply the spiritual and social life of all European countries including Greece. In particular, the Greek Orthodox Church as the official religious institution of Greece for most of the history of the Greek state affected deeply the political and cultural identity of Greek society (Papanoutsos, 1995). For example, the Greek governments were church-oriented since 1967 (Herzfeld, 1993). Later, there were political parties which undermined the pervasive social power of the Orthodox Church. Nevertheless, even in our days, ideologically to be Greek means to be a member of the Greek Orthodox Church.

There are two main influences of Christian philosophy which are important in ethics. First, Christianity gives greater importance to human will at the cost of human logic namely a human being's ability for rational thoughts. Human rationality, despite its critical power, is powerless without God's grace and without the person's good will to be driven to the salvation of his/her soul. The second critical influence of Christianity is the acceptance that the human mind is incapable of solving on its own, the great problems of human ethical life. Therefore, God's authority is needed in order to guide humans to find solutions to difficult or unresolved ethical problems in their lives. Christians believe that humans have the ability to do good deeds and to make choices of goodness. More importantly, humans are free to choose. Therefore, they must

have the will to produce good deeds. This is why human action has a genuine ethical substance because the source is free will and activity. Thus, humans are responsible for their own actions. An action is determined as good not by its outcome, even if it produces something good in the long term. An action is good only if the motive and the intention of the actor is in accordance with the good deed. If the actor's motive is evil then the action is evil too (Papanoutsos, 1995).

It is widely acknowledged that the Greek Orthodox Church has an enormous impact on the political and social arena in Greece. For example, the Orthodox religion and tradition are part of the primary and secondary curriculum in schools while there is a poignant absence of education in other religions. In reference to social work in Greece, the Orthodox Church was always involved in social work education. More importantly, as it is one of the major cornerstones of the welfare state in Greece, the Orthodox Church is the primary founder and manager of many social agencies where social workers practice.

2.1.3 The philosophical approach of Immanuel Kant

Ethical action for Kant was any action derived from what humans perceive as their duty. He also formulated a dual principle, the "*categorical imperative*", which functioned as an indicator of ethical human activity:

1. Always act so as to treat humanity, whether in your own person or in that of others, as an end and not as a means; and
2. Act only on that maxim that you can make a universal law (Rhodes, 1986).

Autonomy and freedom were two absolute values for Kant. He believed that since people were rational beings, they had the ability to create universal laws and follow them. Furthermore, people were self-regulated by their own rules/laws because they were free to determine for themselves without laws imposed by others. Thus, the two notions of autonomy and freedom were identical in Kantian theory and interdependently connected (Rhodes, 1986).

In contrast with other theories on ethics, such as hedonism and utilitarianism, Kant believed that the purpose of ethics was not to teach people to reach for their personal happiness. On the contrary, ethical living for Kant was achieved at the cost of our urges and instincts. However, he also suggested that people should be aware of their personal needs and wills. This was because

Kant believed that when humans were unhappy and had many unsatisfied needs, then it was easier to be tempted to violate ethical laws. In this sense, personal happiness indirectly became the ethical duty of humans (Rhodes, 1986).

Concerning social work ethics, the Kantian ethic of self-determination is one of the most important ethical commitments of the profession. Social workers are educated to intervene in human lives in a way that their actions preserve the right of all humans to determine for themselves. Based on the dual focus of the Kantian theory in autonomy and freedom, the ethic of self-determination reflects a belief that every one is a rational being who can decide on their own about what is good or bad. Therefore, a rational being can also understand the meaning of punishment when their actions infringe on the freedom and the autonomy of others (Clark, 2000). Furthermore, social workers are also committed to act with respect for one's dignity, and this also demonstrates Kantian thinking and its absolute ethical obligation to see every person as an end and not as a means (Rhodes, 1986).

2.1.4 Consequentialism, the Utilitarian approach on ethics

The basis of the doctrine of consequentialism is that an action is determined as good or bad accordingly to its consequences. However, this doctrine leaves open what can be counted as a good or a bad consequence. Utilitarian theorists, based on this first principle, developed various approaches explaining what should be perceived as good consequences. Classical utilitarians believe that the ultimate good is something that most people actually desire, such as happiness or pleasure. Specifically, the doctrine of ethical hedonism and most of the modern utilitarians take pleasure as the ultimate goal to which we should aim.

Mill and his utilitarian theory reject the argument that actions have an inherent moral basis, and therefore cannot be determined as good or evil on their own. However, utilitarians may agree with some of the principles of other ethical theories, but only at the level of their ability to promote the greatest happiness for the greatest number of people. Another theory that underlies the utilitarian theory of Mills is psychological hedonism. The core idea of this theory is that all people have the same need to desire their own pleasure and to avoid pain. According to this, one's actions may include the pleasure of others too, but only because it gives him or her pleasure in the end (Benn, 1998; Clark and Asquith, 1985).

In its simplest form, utilitarianism states that in any situation where there is a moral choice, the right thing to do is that which is likely to produce the greatest happiness for the greatest number of people or the least harm to the world as a whole. Therefore, everyone ought to obey the laws that ensure the balance between the good for the individual and for the society as a whole (Rhodes, 1986; Clark, 2000). However, the different meanings of the notion of happiness complicate the rationale of utilitarianism in our efforts to practice ethical decision-making (Rhodes, 1986). Besides, laws that are historically controversial and do not always reflect the emergence of a current social situation or need, do not always ensure happiness. As Clark (2000) states, the utilitarian approach on ethics provides a very important justification, that of utility, however it fails as a single principle to examine the ethicality of human actions.

2.1.5 Feminist ethic of care

The feminist debate on ethics developed from the famous thesis of the psychologist Gilligan who argued that the view of Piaget and Kohlberg for the moral development of humans was male oriented. In her study, Gilligan showed that the development of moral values in young women was quite different from that of young men. In particular, she argued that men use more formal or universalistic procedures whereas women make more situational choices based on responsibility and commitment to others (Fraser and Strang, 2004). Therefore, feminists introduced the ethic of care into ethics theories and philosophies which previously were focused on the ethic of justice and dominated by a masculine orientation.

Feminist ethics hold specific assumptions about the nature of the good in human interactions and therefore place the ethic of care at the heart of human activity. First, the ethic of care lays emphasis on the interdependence and vulnerability of human existence rather than on the autonomous and independent individuals and their rights. Second, it emphasises the equal moral worth of all persons and the uniqueness of each person. In particular, feminist ethics promote the idea that ethics should not be based solely on theoretical principles rather than reflecting on people's lives. Moreover, all forms of oppression should be acknowledged as historically and contextually specific circumstances that effect human activities. Third, caring is a moral posture or disposition of human beings to behave with an active concern for the good of others. In this respect, emotions, particularly empathy and compassion, are not obstacles for clear and objective moral judgment, but rather the expression of responsibility for the other and their needs (Fraser

and Strang, 2004; Maeckelberghe, 2004; Meagher and Parton, 2004; Koehn, 1998; Abramson, 1996).

In reference to social work, the ethic of care is at the core of social work values, theory and practice since social work's inception (Meagher and Parton, 2004). In fact, the psychodynamic practice theory in social work highlights the importance of the relationship between the social worker and the client (Perlman, 1971). However, it is argued that neo-liberal policy trends and particularly management dominates the nature of what it is perceived as a "good" social work practitioner. In particular, managerial control requires social workers to take a more instrumental and impersonal approach to their work and be accountable not only to their clients, but also to the detailed administrative and task procedures of the employing organization (Banks, 2007; Meagher and Parton, 2004). Similarly, bureaucracy and professionalism for feminist ethics are both oriented to control and to establishing order. Decision-making is an impersonal and abstract process bounded on ethical principles and detached from the contextual dimension of social work practice and the service users (Banks, 2007; Meagher and Parton, 2004; Koehn, 1998).

Feminist theorists argue that social workers must respond to these challenges by restoring care to the centre of social work. However, critical theorists argue that emphasizing the caring aspects of social work ignores *"the complicity of social workers in the reproduction of the oppressive conditions within the practice context and beyond it"* (Healy, 2000, pp.3). In particular, Meagher and Parton (2004) call attention to the *"dark sides"* of the ethic of care. In particular, they argue that some earlier theorists of the ethic of care were anti-political placing a personal relationship, particularly the mother child relationship, as the founding metaphor. Therefore, the identification of the ethic of care with a dyad of a person who cares and the *"present other in need"* does not respond adequately to the macro-level concerns for equal distribution of power and resources (Meagher and Parton, 2004). Similarly, the micro-level care leads to paternalism which sees *"care-givers"* as more capable of assessing the needs of *"care-receivers"*, and parochialism which sees the caring relationships in which people are engaged as most important (Meagher and Parton, 2004). In other words, Koehn (1998) argues that there is some sort of *"political naiveté"* in the version of the ethic of care which focuses solely on inter-personal relationships and she comments:

In deciding how best to care, we must look to an end of our interaction with other members of the community, an end that includes communal justice understood roughly as rendering each member his or her due (pp.37).

However, critical theorists also see some opportunities when social work is engaged to the ethic of care, however, only when used in conjunction with political theory and knowledge on social relationships in macro-social structures. In particular, Meagher and Parton (2004) argue that *"justice without care becomes a harsh and impersonal justice, while care without justice is inconceivable in politicized ethics of care"* (Meagher and Parton, 2004, pp.24).

The contribution of the ethic of care is that it challenges the image of the autonomous person that pursues or masters an independent life. Contrarily, it recognizes the context as able to diminish ones ability for self-determination and autonomy. Therefore, social workers can switch their focus from the assessment of ones abilities to exercise certain competencies to the ways that the context can enable the person to be more autonomous (Maeckelberghe, 2004). Moreover, the ethic of care provides a framework for arguing for decreasing managerial control in favor of an ethical decision-making process that acknowledges the emotional commitment of the relationship between social workers and their clients (Meagher and Parton, 2004).

2.1.6 Postmodernism, ethics and social work

The period between 17th and 18th century, known as modern period, was characterized by the prevalence of science. This period is also known as the *"age of reason"* because at that time science represented something absolute, certain and genuine. Science, with its research of concrete things and strict organized methods of enquiry, managed to gain people's trust and put forth objectivity and rationalism as absolute values. Postmodernism appeared as a rebellion movement against the *"authority"* of scientific reasoning. This movement saw connections between the period of European colonization throughout the world, and the objectivist approach to knowledge, truth and value that characterized modern European thought at the time. Colonialism was intellectually justified by a belief in the objective superiority of modern European values and institutions to indigenous ones. Therefore, postmodernists argued that Eurocentric notions of objective truth, reason and value, were inherently linked to colonial oppression (Benn, 1998; Papanoutsos, 1995).

Postmodernism highlights the uncertain nature of social life and promoted openness to the meaning of how people understand society. For postmodernists there is no objective method to understand the world and any notion of truth is subsequent to the differences of meanings that every person gives. In reference to ethics, postmodernists reject any notion of universal ethical principles. Ethical principles have become a dogma by the continuous efforts of western culture, and have led society to coercion instead of a pure moral discourse. Ethical notions should survive only through negotiation and consensus, although negotiation is not guaranteed to produce consensus. Therefore, the ambiguity and the uncertainty of ethical norms and principles should be acknowledged (Hugman, 2003).

The consequences of postmodern thinking in social work are seen as multiple. In particular, if no knowledge is acknowledged as “*truth*”, then the ideal of professional expertise becomes implausible. But, postmodernists argue that the knowledge and skills of the professional must be subject to validation by the service users (Hugman, 2003). Radicals also agree with the annulment of the expert’s power, however, they still base this idea on their indubitable critical theory of social structures.

Nevertheless, criticisms about postmodern social work have emerged. Critics argue that social work needs a common understanding for social phenomena (e.g domestic violence). In particular, Hugman (2003) argues that uncertainty is not helpful and disorientates the focus of the social workers. It also seems that uncertainty regarding major social problems is an opportunistic way of thinking and obscures the efforts for the elimination of the social problems. Unavoidably in their daily practice, social workers must give solutions, make decisions and they have a social/organizational and ethical obligation to justify these. Therefore, these decisions must be based on terms of knowledge and skills, but also in relation to concrete values (Hugman, 2003; Clifford, 2002; Walker, 2001; Payne, 1999).

2.1.7 Summary

This section briefly discussed the influences of philosophical ethics in social work. It was argued that although difficult to articulate the relevance of philosophical ethics and social work practice (Banks, 2008), professional values and ethics are best understood by identifying their philosophical origins.

It appears that social work has been influenced by the prevailing western approaches on ethics. For example, self-determination and autonomy, both core values of the social work profession and integrated in ethical codes derive from the Kantian approach on ethics. In addition, the Kantian ethical duty to see every person as an end and not as a means explains why social workers are committed to the holistic approach as well as to act with respect to their clients' dignity.

However, other philosophical trends on ethics also appear to be influential in the discourse on social work ethics. In particular, feminist theories have highlighted the existence of the ethic of care which facilitated feminine professional practice, but was ignored by the dominant masculine oriented ethics theories that were focused on the ethic of justice (Koehn, 1998). Another contribution of feminist ethics appeared to be that it highlighted that social oppression may violate the autonomy of humans and limit their potential for self-determination (Meagher and Parton, 2004). In this sense, the power of the social workers to practice according to their ethical principles is limited due to structured injustice and oppression. In fact, anti-oppressive values and anti-oppressive social work practice have currently emerged as the focus of the General Social Care Council (GSCC) code of practice (Parker, 2004). However, there is no evidence if anti-oppressive values have affected social work practice in the Greek context which is the focus of this study.

A few articles have also argued the relevance of virtue ethics to social work (Houston, 2003; Mc Beath and Webb, 2002). The emphasis here is to the individual practitioner and their dispositions to make ethical decisions rather than conforming to abstract ethical rules and principles. In this sense, qualities of character are what determine social work effectiveness rather the outcome of interventions.

Postmodernism challenged any notion of absoluteness and introduced uncertainty at every level of philosophical and scientific thinking. In reference to ethics, postmodernism rejected any notion of universal ethical principles. The central aim of postmodernism is to challenge ethics so that they are not perceived as unquestionable dogma. With the influence of postmodernism, social workers are driven to perceiving ethical practice as an effort to engage themselves in a deep moral discourse rather than following coded ethical principles without any kind of negotiation of their meaning.

Evidently, social work in Greece has been long influenced by the virtue ethics approach originated by Greek philosophy as well as Christian ethics. However, other approaches, and mainly those which have prevailed in the US context have also influenced social work as the social work identity in Greece was directly influenced by the US social work education. The ethical approaches that were discussed in this section have formed a specific set of values and ethics contained in social work ethical codes and integrated in the social work terminology. As the focus of this thesis is to understand the meaning of ethics in the Greek context, ethical principles or virtues should be seen not as abstract obligations, but rather as a continuum of the philosophy of ethics. In the following section, the focus will be on the specific set of ethical principles that underpin the social work identity, which is the content of the ethical code of the social work profession and guide professional practice.

2.2 Ethics and social work

Social work's identity has been commonly characterized as ambiguous; its role in the promotion of social justice questioned and its effectiveness lacking evidence. At the same time, there are others who argue that social work is a victim of an inhuman political and economical system which systematically structures an unjust society to undermine human rights. Ironically, social work as a part of the political mechanism is obligated to contribute to securing these. Ethical awareness, as a professional and/or personal skill, is thought to enable social workers to appropriately answer the question "*who receives the benefit of social work practice*" as a mechanism to evaluate practice, and defend social work's humanitarian character (Bowles *et al.*, 2006; Feather, 2002; Clark, 2000; Fritzsche, 1995).

In addition, people who need social work services are often among some of the most vulnerable in society. This is one of the main reasons that social workers must be sensitive to the ways that they provide their services. Social workers' decisions often have far-reaching consequences for peoples' lives. Therefore, social work practice must be guided by transparent, understandable principles (Parker, 2004). In this sense, social work education should be approached in an ethical, reflective and value based manner so as to ensure that people are not exploited, manipulated or made more vulnerable by social workers' actions. Consequently, social workers must be able to develop a competence in value based and ethical practice that includes values as a core element of their practice (Parker, 2004).

However, multiple ethical barriers or obligations create dilemmas in social workers' efforts to pursue their professional purposes. Ethical dilemmas reflect the complexity of the social work profession in terms of several factors such as its purposes and the multiple loyalties of social workers. This section presents fundamental ethical dilemmas of social work practice in relation to ambiguities and ethical obligations of the profession. In addition, ethical decision-making is also presented as an inherent part of social work practice, especially when social workers act upon their dilemmas in the form of moral judgments or decisions.

2.2.1 Values and ethics and the social work identity

Values have been defined in numerous ways. The Central Council for the Education and Training of Social Workers (CCETSW) (1976) defines values as: "*a value determines what a person thinks he ought to do, which may or may not be the same as what he wants to do, or what it is in his interest to do, or what in fact he actually does*" (pp.14). Feather (2002) defines values as general beliefs about desirable actions and goals. They are assumed to transcend situations and are not equally important for each individual. Values influence and justify particular types of positive or negative attitudes that an individual holds in regard to possible events and outcomes. A similar definition is given by Dominelli (2002), although she argued that a common characteristic of all values is that all are socially constructed and historically specific. In addition, values should not be treated interchangeably with ethical principles. Values should determine the desired ultimate ends, and ethical principles or ethics the recommended approaches to achieve them. This is why ethics are often named as instrumental values (Clark, 2000).

Professional values are those embraced by the consensus of a body of practitioners given their relevance to the profession. This formulation of values is commonly expressed by a stipulated ethical code. They are used to characterize the practitioners' behavior in practice and outline the responsibilities in particular interventions. They also give a common sense of professional identity since practitioners, through values, can talk about similar entities (Dominelli, 2002). In reference to social work, Payne (1996) proposes that values are important to understanding the profession because they reflect the ways that social workers currently think and practice with difficult cases or problems.

Social work values and ethical principles are integrated into codes of ethics. "*Codes of ethics are documents that aim to identify the broad values, principles and standards of ethical conduct on*

which a particular profession is based” (Bowles *et al.*, 2006, pp.75-76). Moreover, as Banks (1995) argues, a code of ethics binds social workers under a common professional identity and publicizes its ideals and intentions. She also identifies four general functions of codes of ethics. In particular, she argues that codes of ethics are a guide for: (a) conduct and ethical decision-making; (b) protection for users from malpractice or abuse; (c) the “*professional status*” of social work; and (d) establishing and maintaining professional identity.

Furthermore, ethical codes aspire professionals as they contain universal statements about the nature of the good society and the virtues of “*good*” professionalism. In this sense, codes of ethics are the means through which the social work profession maintains a common vision despite the historical and political changes and the consequent fragmentation within profession (Banks, 2003). And finally, codes have an educational role as they promote the development of ethical awareness and encourage reflection in practitioners (*Ibid*).

Nevertheless, protecting users from day-to-day social work practice and avoiding the misinterpretation of ethics is not a tangible achievement through the sole usage of a code of ethics. Ethical standards and principles should be seen in reference to a specific context, otherwise serious harm can result (Bowles *et al.*, 2006). Additionally, Sonnenberg (2004) argues that very general codes like those of IFSW and BASW encourage reflection and debate, but give little guidance. On the other hand, very detailed codes tend to be prescriptive and limit the professional freedom of judgement. Therefore, codes of ethics can never ensure ethical behaviour because integrity and morality are qualities that cannot be coerced. Bowles *et al.* (2006) suggest that in order to attain an adequate response to the social work code of ethics, social workers should be able to see ethical principles as interrelated. Following an ethical principle at the cost of another is seen as misinterpretation of the code and can lead to the fragmentation of the social work profession.

In fact, social work is often characterized as a fragmented profession with a variety of purposes leaving it vulnerable to arbitrary definitions of its identity. There are several difficulties in conceptualizing the social work identity including the range and types of problems social workers address, settings in which they practice, levels of practice, interventions and methods used, and populations served (Gibelman, 1999; Banks,1995). Policy and the nature of welfare are also factors related to the social work identity. Policy changes and underpinning ideologies and values pertaining to the welfare state are reflected in the nature of social work. For example, Banks

(1998) notes that social work is enormously affected by globalization, neo-liberalism and the ideology of new management. Specifically, she argues that greater bureaucratic accountability and greater specialization and fragmentation of professional roles are the results of the current political state.

Some believe that social work holds on to a common identity despite its fragmented nature through its values and ethics (Clark, 2000; Banks, 1995). However, as noted previously, social work is also a part and an expression of the welfare state. As the welfare state functions under the capitalistic economic and political systems, it also serves to ensure survival of this system and its values. The welfare system is underpinned by the value of competitive individualism as it functions within capitalism. Therefore, the welfare state supports the existing economic and social order by enabling private capital to remain profitable (Banks, 1995). On the other hand, the welfare state and the social work profession are developed in order to express the social concern for values such as justice and equality. Consequently, social work has an intrinsic role of social controller, and its primary aim to work in the best interest of users falls on the contradictory principles of the welfare state (Clark, 2000; Banks, 1995).

Many of the critics that social work faces reflect the controversies of the welfare state's values. And in many cases, the blame remains in social work and not in the welfare system. Moreover, the debate on values is never transferred to the economic/political system. It is believed that understanding the social work role within the function of the welfare state, and awareness of its underpinning values permit social workers to make a more informed use of their professional role and skills. In addition, this awareness protects social workers from feelings of guilt as a result of the social policy's insufficiencies (Clark, 2000; Banks, 1995).

Despite the difficulties in defining social work and its changing nature, the definition provided by IFSW (2005) could be a starting point in understanding the nature of the social work identity:

The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work.

Human rights and social justice function as a leading pathway of social workers to give a specific meaning to human well-being. Therefore, the elaboration of such fundamental social work values enables the specification of professional purposes, and moreover, these values are a basic part of the social work identity. Human rights are universal and they apply to all people regardless of their race, circumstances or any other characteristic. IFSW (2005) code of ethics identifies all international human rights declarations as guidance that should lead to ethical conduct and the professional purposes of social work. In particular, social workers should respect the inherent worth and dignity of all people. Similarly, social workers should uphold and defend each person's physical, psychological, emotional and spiritual integrity and well-being. That means that social workers should: (a) respect the right to self-determination; (b) promote the right to participation; (c) treat each person as a whole and (d) identify and develop strengths. In reference to social justice, IFSW (2005) outlines five elements of it: (a) challenging negative discrimination, (b) recognizing and respecting the ethnic and cultural diversity, (c) distributing resources equitably, (d) challenging unjust policies and practices, and (e) promoting social solidarity.

Historically, both in the US and UK, discourse pertaining to social work values began in the 60s-70s. During this period the prevailing social work values were individualism and freedom in both of these contexts. The focus of social work was on the individual user as a person and their freedom protected and ensured. Later, in the 1970s there was a growing awareness of structural oppression, and thus collectivism and an emphasis on structural inequalities emerged as a new social work responsibility. In the UK during the 1980s social work was influenced by the ideologies of the New Right. The focus of the New Right ideology transferred the meaning of a person as a whole to its narrowest meaning of a person as a "consumer". It is believed that this change reflected a more narrow sense of individual rights and further concealed the social workers' role in social control (Banks, 1995).

Furthermore, critics about social work's ethical codes argue that they are individualistic in approach and they have no clear ideological stance towards distributive social justice. In particular, Briskman (2001) comments:

...we need to be clear about the ideological stance we are embracing. In particular, we need to take care that we are not co-opted by the prevailing discourse with its focus on individual rights and responsibilities. This necessitates clearly articulating what is meant by the conception of social good (pp.7).

Political, as well as economical values, are crucially important to how social services and the welfare system are constructed. A good example of this is what occurred in the 1980s-90s when government tried to make popular the values of capitalism and the privatization of nationalized industries and public services by encouraging people to buy shares in these industries. The purpose of this movement was for people to take a stake in the capitalistic system, and thus engage even more closely to the core values of capitalism (Abercrombie and Warde, 2005). However, Payne (1999) argues that social work avoids embracing political, economic, or aesthetic values, probably in order to attain scientific status. Nevertheless, since social work is a profession constructed through legislative decisions it cannot exclude itself from political discourse by staying artificially politically neutral. In this sense, ethical action towards social justice entails political action.

Reamer (1982) argues that social work has ethical and unethical aspects. The ethical aspects of the profession include questions about the obligations and duties of practitioners, and questions about what is ethically right and wrong conduct. The unethical aspects of the profession include questions about the effectiveness of particular intervention techniques, the proper way to prepare process notes, methods for assessing the nature of a client's problems, or ways of carrying out a cost-benefit analysis. However, Clark (2000) believes that standards of ethics in professional practice are not a separate question from standards of technical knowledge and skill, but rather intimately related. Practice that fails to reach reasonable standards of technical skill is just as much unethical as practice that does not respect general principles of professional morality. In fact, Timms (1983) argues that ethics are the source from which social work techniques derive. Moreover, some argue that science and its theories about human behavior and related intervention techniques are never value free. Therefore, perceptions of what is "good" or "bad", and what we call value judgments are always intertwined in so called scientific activity (Seedhouse, 2005; Rhodes, 1986).

The defense of the social work profession is an effort that potentially falls into the trap of defending the values that underpin and structure the unjust welfare state. Many believe that social work should not let the system use it as a "scapegoat", and therefore it should avoid taking the blame for the unjust policies. However, social workers may work unconsciously under a system that may produce unjust policies and practices. In this case then, we cannot claim that social work as a profession strives for social justice or equality. In this sense, the obligation of the social worker to be ethically aware of their role and identity emerges as a professional

responsibility. In fact, ethical awareness is stressed as a specific skill in the current social work literature (Clark, 2000; Speicher, 1998; Banks, 1995).

2.2.2 Social work education and ethics

Since ethical awareness is considered as a social work skill, then social work schools have the main responsibility to provide students with the appropriate educational opportunities (Clifford and Burke, 2005; McAuliffe, 2005). However, literature on social work ethics provides little information about the place of ethics within the curriculum and what educational processes are necessary for the training of ethical awareness skills.

Overall, social work in Greece is underdeveloped and this is partly because it lacks postgraduate education and research. Moreover, social workers in Greece have limited opportunity to follow international developments within the profession (Dedoussi *et al.*, 2004; Georgoussi, 2003; Stathopoulos, 1999; Kalinikaki, 1998). Within this context, social work ethics is an underdeveloped aspect of practice. Not surprisingly, from a review of the social work schools' curricula, only two out of the four have a course for the social work ethics, which is held for one semester, one hour a week.

In reference to social work education in the US, Dodd and Jansson (2004) described the American traditional three step model of teaching ethics to students. In step one, academics often begin by discussing the nature of values, the development of values within the profession of social work, and different schools of ethical reasoning. In step two, students learn to recognize ethical issues in their professional environment and develop an understanding of why it is so important to address ethical issues in practice. In the third step, the code of ethics of the National Association of Social Workers is usually discussed.

In reference to Australian undergraduate social work education and ethics, McAuliffe and Ferman (2002) made four suggestions based on a qualitative study of social workers. First, they proposed that students should learn ethical language to be able to appropriately articulate their positions on issues and dilemmas. Furthermore, a language of ethics would enable a shared meaning in relation to complex value issues and promote a deeper analysis of ethical dilemmas. Second, they suggested that students should be familiar with the available models on ethical decision-making to be able to clearly identify conflicting ethical principles and an explicit justification of

their actions. Third, they argued that the elaboration of the ethical code should not be missing from the curriculum, and students should have the chance to critique the code and examine its weaknesses through a range of scenarios. Lastly, they highlighted the importance of ethical dialogue. Ethical issues and dilemmas should not be dealt in isolation, but rather by an unconstrained dialogue characterized by openness, trust and mutuality between students and academics.

Focusing on social work education in English universities, Clifford and Burke (2005) suggest that curriculum should bring together the teaching of social work ethics with the teaching of anti-oppressive values. In this sense, teaching social work ethics must highlight and acknowledge the role of power in shaping and determining social relationships, and the unequal power relations between individuals and organizations. The authors argue that social work education on ethics should stop relying only on utilitarian and Kantian approaches, which are individualistic in scope, and should take into account more collective approaches. For instance, social workers cannot engage in an ethical dialogue without taking into account the differences in power among participants, and how this power determines their points of view on ethics. Moreover, student social workers should understand the importance of the multidisciplinary work on ethics and the involvement of service users in ethical discourse. Another critical point in the Clifford and Burke (2005) argument is that academics should strive to minimize the existing divide between the academic arena and practice realities. In order to achieve that, teachers should take responsibility for raising ethical issues about racism, sexism, harassment and other matters so students can learn about the struggle to live by the recommended values.

Dodd and Jansson (2004) suggest that ethical reasoning is not sufficient for social work practice and students should be educated in ethical advocacy. Ethical advocacy involves ensuring that clients' needs and perspectives are adequately represented in ethical deliberations, both through social work involvement in individual cases and their efforts to become more involved in ethical deliberations. Schools should prepare students to confront the difficulty to engage in ethical discourse and ethical decision-making in social work organizations. The authors indicate that social work schools seem to ignore the fact that social workers are often excluded from ethical deliberations in their workplace, therefore, students must be taught how to get involved. Consequently, teaching of ethics should include teaching of strategies for social workers in order to achieve an equal involvement in ethical decisions.

2.2.3 Value-based evaluation of social work practice

As a value-laden profession, ethics should be perceived as an inherent part of what is seen as social work effectiveness. Social workers should include the examination of their professional values and ethics as an inherent part of their evaluative practices. In addition, since ethical awareness is one of the social work skills, practitioners should be competent to examine the ethical dimensions of their practice.

Evaluation is a form of practice that aims to assess the effectiveness of interventions in terms of their aims and objectives (Adams *et al.* 2002). Evaluation is also defined as making a judgment about the value of something. It involves the use of criteria and standards. In this sense, professionals can evaluate the ethical and moral assumptions behind their practice (Goldenberg, 2005; Seedhouse, 2005). All evaluation activities have the potential to help social workers become better helpers and more flexible in their work with clients. Practice decisions also have the potential to harm clients. Therefore, evaluation is necessary if practice is to be considered as ethical (Staudt, 1997). The meaning and importance of values, rather than numerical worth, as the center of the evaluation process is currently supported by many authors (Taylor, 2006; Goldenberg, 2005; Seedhouse, 2005; Dominelli, 2002; Everitt and Hardiker, 1996; Schon, 1987).

Goldenberg (2005) and Seedhouse (2005) disagree with the argument that evaluation and judgments could be made using value-free methods. They argue that evidence and values are forever entwined, and that all decisions or judgments are a balance of evidence and values. In particular, what we perceive as evidence in evaluation is a product of a broad spectrum of knowledge, including scientific evidence, personal experience, personal values, economic and political considerations, and philosophical principles. Nevertheless, people seem to ignore values or seemingly regard their decisions and judgments as value-free.

Furthermore, evaluation is recognized as a significant managerial strategy for ensuring the efficiency, economy, effectiveness and accountability of organizations and projects operating in the market place. Moreover, policy or politicians can utilize evaluation in order to demonstrate success at a time of acute social and economic failure. This fact perhaps obligates social workers to strive to identify the ways that policy makers utilize such evaluations. A new emphasis on hard evidence for the outcomes of social work interventions is widely documented, and it is seen as influenced by the ideology of New Management which relies more on evidence-based knowledge

rather to value commitments (Taylor, 2006; Dominelli, 2002). However, as social workers are committed to structural purpose and social change, they should be able to criticize and judge the appropriateness of the prevailing evaluative criteria posed by current social policy. An uncritical adherence to evaluative criteria threatens not only the purpose of social work, but also its professional identity.

2.2.4 Fundamental ethical issues and dilemmas in social work

An ethical dilemma in its narrowest definition is “*a choice between two equally unwelcome alternatives relating to human welfare*” (Banks, 1995). However, ethically problematic situations are inherent in social work practice, irrespective of whether they are always acknowledged. According to Banks and Williams (2005), ethically problematic situations in social work practice can be distinguished as ethical issues, ethical problems, and ethical dilemmas. The usefulness of this distinction is to enable reflection on practitioners’ thinking, stance, personal values and emotion rather than focusing on the problem itself. Based on their distinction, an ethical issue is any situation where a social worker is occupied not only with what they can do from a legal or technical perspective, but also with what they ought to do from an ethical perspective. An ethical problem is any situation where a social worker knows what they ought to do, but their moral decision is difficult to apply. Finally, an ethical dilemma is when a social worker must decide between two equally unwelcome alternatives which may involve a conflict of moral principles, and therefore the final choice will violate one of them to some degree. From this point of view, an ethical dilemma can be transformed into an ethical problem once a decision has been made, and this transformation will then reflect the social worker’s conscious or unconscious ethical decision-making process. A transformation of an ethical problem or issue into an ethical dilemma is also possible, and this may reflect the social worker’s recognition of her multiple moral obligations and the complexities of the ethical issues (Banks and Williams, 2005).

The IFSW (2005) has determined four problem areas responsible for the development of ethical dilemmas in social work practice. These are: (a) the loyalty of social workers is often in the middle of conflicting interests; (b) social workers function as both helpers and controllers; (c) conflicts between the duty of social workers to protect the interests of the people with whom they work and societal demands for efficiency and utility; and (d) resources in society are limited. A range of ethical dilemmas is also raised by the tension between the ethics of autonomy, self-determination

and paternalistic practices. These ethical dilemmas drive social workers to think of circumstances where they are obligated to intervene in the lives of others and the limits that such interventions will have.

Paternalism is often thought of as the opposite of autonomy, a negation of the subject's ability to exercise their autonomy. On the other hand, autonomy derives from the acknowledgment that all people are rational beings and as such they have the right to freedom. However, autonomy relies on two conditions: the capacity of the person to reason and act rationally, and the social provision of the resources and opportunities to exercise this capacity (Bowles *et al.*, 2006). Autonomy also means that people cannot act independently without considering the rules, both moral and statutory, of a given society. Paternalism is sometimes seen as a negative value and its positive aspects are often ignored. In fact, autonomy is often achieved through paternalism. For instance, the government may decide to intervene, exercising paternalism, in the operation of the market to ensure the equitable distribution of resources sufficient to enable people to be autonomous (Bowles *et al.*, 2006).

In reference to self-determination, the IFSW (2005) determines it as: *"respecting and promoting people's rights to make their own choices and decisions, irrespective of their values and life choices, provided this does not threaten the rights and legitimate interests of others"*. This means that a person has the right to be self-determined even if they choose to engage in self-destructive behavior, but under the condition that their choice is informed. However, self-determination and the freedom of one's choice must be restricted when another's right to well-being is at stake (Reamer, 1982). Social work interventions have always, by definition, impacted on the autonomy of others. Paternalistic actions, by definition, also involve breaching privacy and freedom. However, these actions have the potential to lead people to self-determination by making informed choices and having more fulfilling lives.

Another range of ethical dilemmas is raised due to the process of distributing services and resources. The limitation of the welfare state and the limited resources available to people in need is a well documented ethical concern for social workers who must decide what criteria should be used to distribute services and resources. Reamer (1982) identifies four distributive criteria for the social workers. First is the principle of equality. According to this principle all people should have equal access to services and resources. However, using different interpretation equality also means that resources should be distributed according to the needs of

each person. This principle also recognizes that each person is different and has different needs. This leads to the second principle which is the principle of need. This principle states that social workers should consider and measure the relative importance of various needs and support and distribute resources accordingly. The third criterion is the principle of compensation. Social workers should also consider cases where individuals or groups, having been deprived of services in the past, are suffering the effects of this deprivation in present generations. As a result, social workers should consider how to compensate these generations to stop the ongoing reproduction of inequality. Notions such as positive discrimination derive from the principle of compensation. The last criterion is the principle of contribution. A simple interpretation of this principle is that services and resources should be distributed to individuals in proportion to the contribution they have made.

Ethical dilemmas often involve issues related to the boundaries of the client-social worker relationship. Professional boundaries are seen to exist in order to protect the client from the social worker and to establish the professional nature of the relationship. Clients are vulnerable to social workers' influence as they are more powerful given their role is legitimated by an organization. Therefore, social workers are responsible for resisting the abuse of this power and to practice in an ethical manner (Johner, 2006). Dual relationships, for example, have recently been a central focus of discussions in the social work literature and are regarded as one of the ethical issues of practice. Dual relationships occur when social workers relate to clients in more than one relationship, whether professional, social, or business. They are considered as situations with a potential for exploitation. However, some consider positive benefits from dual relationships. For example, some argue that dual relationships offer protection against the damage done within the traditional model of therapy because they do not reinforce the therapist's power advantage (Mayer, 2005). Examples of actions that indicate dual relationships include when a social worker is involved in the personal and social life of a client, promoting client dependence, reversing roles with clients, when a social worker is almost always available, gift giving, providing nonprofessional services, mutual acquaintances such as friends, and joint affiliations and memberships.

Managing dual relationships in social work present many challenges especially in small communities where dual relationships are more commonly found. Maintaining client confidentiality and privacy is seen as a specific challenge (Galambos *et al.*, 2006). Confidentiality as an ethical principle expresses the human right of privacy. Privacy refers to the degree of control that a

person has over what happens to information about them. In reference to social work, confidentiality is one of the primary ethical obligations of the practitioner and is related to boundary issues. Abrogation of confidentiality should happen only when harm to other people or to the client is likely to happen. However, decisions on information disclosures become even harder especially when agencies or pressure from laws for the disclosure of information taken in confidence. In such cases, consequent role conflicts for social workers occur and complicate practice.

Reamer (1982) distinguishes two categories of dilemmas in reference to social workers' relationships with colleagues and employers. The first category includes what is referred to as whistle blowing, namely exposing questionable practices among colleagues. The second category includes instances when a practitioner must decide whether to violate an agency regulation or administrative policy in order to safeguard the welfare of a client, a colleague, or oneself. Compelling, but competing values are almost always inherent to such situations.

Whistle blowing refers to an action when it meets three criteria: (a) the act of notifying powerful others of wrongful practices in an organization (b) the action is motivated by the desire to prevent unnecessary harm to others; and (c) the action is of an employee or former employee who has privileged access to information (Greene and Latting, 2004). Whistle blowing is often seen as a form of advocacy and adheres to basic ethical principles of the profession which explicitly encourage social workers to expose any unethical conduct of colleagues or organizational practices that violate human rights (IFSW, 2005; NASW, 1999).

Ethical dilemmas also emerge when professional integrity or autonomy conflicts with social policy. Professional integrity refers to the social worker's obligation to act in a manner befitting his/her knowledge and status in society. Professionals should take responsibility for their actions and ensure that their actions are in line with the social work ethical code. These include being committed to ongoing knowledge and skill development, avoiding the use of special knowledge and skills for inhuman purposes, not abusing the relative powerlessness of the users, not bringing into disrepute the good name of the profession through malpractice, and monitoring and challenging agency policies and practices which may be contrary to the ethical code (Banks, 2001).

Professional autonomy refers to the power of professionals to make their own considered decisions and judgments based on their expertise and ethical values. However, it is widely acknowledged that professional autonomy is restricted for social workers in contrast with other professionals such as lawyers and doctors. This is because social work is often practiced in bureaucratic organizations that have specific rules and procedures governed by a hierarchical structure (Banks, 1995; Reamer 1982).

As a moral activity, social work is obligated to find the ethicality of its actions beyond the stipulated policy or organizational regulations. In fact, Banks (1995) suggests that laws indicate what social workers can or cannot do through legitimate actions. However, laws are insufficient to indicate what social workers are obligated to do from an ethical perspective. Therefore, ethical dilemmas emerge when social policy or agency regulations are viewed by social workers as violating the welfare of their clients. In such cases the usage of professional autonomy is seen as welcome despite the fact that it is also seen as a negative value given it triggers issues of power in the relationship between the social worker and client. In fact, social workers are ethically engaged to protect their clients from their own power as malpractice. Additionally, social workers are professionally and ethically engaged to see the welfare system not as it is now, but as it should be to sufficiently cover human needs. In this sense, the engagement of social workers to simultaneously address social change and limited welfare resources create complicated ethical questions such as is it ethical for social workers to work within the current welfare system, and questions about the ethical distribution of limited resources. Notions of equality and social justice are inherent in these ethical deliberations.

Although there is a growing body of literature that deliberates the types of ethical dilemmas that social workers are currently faced with, there can be no predetermined solutions. This is so because it is recognized that there are a variety of factors involved that frames each situation differently. Therefore, an ethical dilemma can be likened to a mosaic made up of factors that construct the picture of the decision situation for the social worker (O'Sullivan, 1999). Nevertheless, ethical decision-making models have been developed to build a framework for the various interacting elements of the ethical dilemmas that need fitting together to permit social workers to thoughtfully deliberate.

2.2.5 Ethical decision-making in social work

O' Sullivan (1999) defines decision-making as a process of constructing a choice. Decision-making occurs where there is some degree of recognition of a need or a desire to make a choice. Making decisions is an inherent part of social work practice no matter what the specific practice field or task. Social work decisions are often problematic balancing acts based on incomplete information, time constraints, pressure from different sources, uncertainty as to the likely outcome of the different options, and the constant fear that something will go wrong and being blamed (O' Sullivan, 1999).

Ethical decision-making models are systematic ways of thinking through ethical dilemmas. Every model is based on underlying value assumptions derived from a specific or several philosophical approaches on ethics. Therefore, a model should not be chosen uncritically. On the contrary, social workers need to acknowledge the strengths and limitations of the ethical theories that underpin these models. An ethical decision is a process that entails the effort to balance social work's values, (i.e. making moral judgments), the consideration of the goals and responsibilities of social work's profession, and a decision about how to act (Bowles *et al.*, 2006).

Irrespective of the ethical decision-making model that practitioners use for solving their dilemmas, ethical awareness is seen as a primary skill for social workers. This awareness is referred to as a condition where the practitioner is aware of the ethical principles underlying their actions and encounters, and ethics as live elements within their practice. Ethical action is the result of the practitioner's ethical consciousness/awareness (Speicher, 1998). In fact, Reamer (1982) and Speicher (1998) suggest that for social workers to be able to analyze dilemmas in a thoughtful and systematic fashion, they need to be able to understand the various strategies that derive from philosophical approaches on ethics. Furthermore, they need to be able to acknowledge the strengths and limitations of these approaches as they represent specific methods for justifying values. Additionally, social workers should be able to see ethical dilemmas or issues not as a crisis, but as an opportunity to improve the ethical framework within their practice. To obtain this view of ethics, social workers should be skillful in critical reflection.

Critical reflection requires a high level of personal awareness so they can recognize prejudice or personal interpretations and ideas involved in professional practice. It also requires an ability to critically analyze the environment and the political context that structures ethical decisions.

Overall, the purpose of critical reflection is to improve professional practice by identifying deep-seated assumptions such as previously unquestioned cultural norms. The reflective process is focused on power and it is linked with the basic ideas of critical theory. In this sense, critical reflection must incorporate an understanding of personal experiences within social, cultural and structural contexts (Fook and Askeland, 2007; Bowles *et al.*, 2006).

There is a growing interest on social work ethics and an extensive theoretical literature already exists. However, scant empirical research has been conducted on ethical decision-making (Jansson and Dodd, 1998). Bowles *et al.* (2006) also argue that there is a poignant lack of any research into whether ethical decision-making models work.

In particular, a body of three empirical studies looked at the nature of ethical dilemmas that social workers deal with in various settings. All studies, except one, used qualitative approaches and participants were not guided to reflect on predetermined ethical dilemmas. Despite the variety of social work settings and ethical contexts, similarities in the responses of social workers can be detected. In particular, Conrad (1988) with a survey in the US and McAuliffe (2005) using a qualitative approach in Australia, found that among the most serious ethical dilemmas experienced by the social workers were those that involved conflicts between organizational and professional values, as well as funding constraints or policy issues. Conrad (1988) also determined that the intervention phase of the social work process produced the greatest number of ethical conflicts with issues around confidentiality. Contrarily, Banks and Williams (2005) who qualitatively explored the nature of ethical dilemmas of social workers, and youth and community workers in the UK found several main ethical issues/ dilemmas including issues relating to how much choice service users should exercise, the rationing of time and resources, and maintaining professional integrity.

Three studies also indicated that overall, social workers were not able to use ethical language, and they could only broadly identify their ethical dilemmas and/or problems. In particular, Kugelman (1992) qualitatively explored the role that social work ethics plays in informing social work behavior as compared to other influences of an extra-ethical nature. A fictional case was used about an old woman, with cancer and a psychiatric history, who refused an operation. The majority of the social workers did not rely on an ethical analysis of the dilemma. However, those who analyzed the dilemma on ethical grounds appeared to be guided by their commitment to self-determination, and more importantly, they persevered in advocating for the patient. In contrast,

those who relied on technical considerations discontinued advocating. Similarly, Banks and Williams (2005) found that only one small proportion of social work students articulated an ethical dilemma as a conflict of values that involved alternative choices. In addition, students' accounts had no elements of decision-making. In fact, the researchers noted that students referred to broad issues, such as drugs and alcohol or physical conduct, for the description of ethical dilemmas. Moreover, McAuliffe (2005), using an action research model, implemented the concept of Reamer's ethical audit¹ in 11 organisations in Australia and recorded the outcomes. The researcher found that participants admitted that their involvement in the study marked the first time they had to think about and discuss ethical issues in practice. Specifically, practitioners claimed this was the first time they used ethical language, and the first time they began to see various and differing perspectives on controversial situations. The ethical audit procedure also demonstrated that it was an effective tool for the review and modification of the policy relevant to daily practice, and therefore deemed to enhance the quality of services.

In terms of the impact of ethical dilemmas on social workers, two studies have indicated various short and long term effects in their personal and professional lives. McAuliffe (2005) interviewed thirty Australian social workers and found several difficult emotional conditions associated with the experience of an ethical dilemma. These emotional conditions included stress, depression, agitation and irritation, isolation, overwhelming feelings, paranoia, anger, frustration and decreased tolerance for both clients and colleagues. An important emotional condition was also associated with feelings of "*unfinished business*". Some physical symptoms were also expressed by participants. The most common physiological response reported was physical exhaustion. Other physical symptoms described by participants were insomnia, high blood pressure and immune system problems. The same emotional conditions as a result of ethical dilemmas were also noted by Banks and Williams (2005). As far as the long term impact of ethical dilemmas is concerned, McAuliffe (2005) found that the participants identified impacts on their attitudes and awareness, practice, and personal relationships. In concrete terms, some acknowledged the value of the social work profession; however, some discredited the humanitarian role of social services organizations. For others, the realization of the political and power dynamics had a positive impact to strengthen their personal commitment to social work. There was also an increased awareness of the importance of the clarified roles and responsibilities in the workplace and a greater awareness of the importance of boundaries issues in relation to clients, colleagues

¹ Reamer's ethical audit is a method that examines the familiarity with known ethics-related risks in practice as well as the organisation's procedures and protocols for handling ethical issues, dilemmas and decisions.

and managers. It was important to note that four social workers made the decision to leave direct client work as a result of the long term impacts of ethical dilemmas, while another four left their respective places of work with feelings of 'unfinished business'. The social workers who resigned from their job or from the profession had little support either from colleagues or supervisors at the time of experiencing the ethical dilemma.

Findings from the study of McAuliffe (2005) also indicated that participants used a variety of mechanisms in order to be able to cope with stressful ethical dilemmas. Some tried to make light of the incident with humour and others were attentive to physical fitness and self care. Another strategy employed by other social workers was to focus on tasks that needed to be achieved on a daily basis so that the bigger picture would not become overwhelming. Yet others denied the reality of the situation by ignoring the case and moving to another case or by using more extreme forms of denial. Social support was proved to be a very important factor involved in the ethical dilemmas, as many of the participants who felt considerably isolated in their places of work and who experienced high levels of stress were simultaneously unable to access good social supports. Conversely, negative effects were fewer for those who had good social supports and they were able to work through the ethical dilemma quickly.

One study, although not particularly concerned with the exploration of social work ethical dilemmas, importantly indicated the value preferences of the social workers. As ethical decision-making involves moral judgements these findings indirectly suggest possible factors related to ethical decisions. In particular, Furman *et al.* (2007) who qualitatively explored potential ethical dilemmas as a result of an immigration law found that only few MSW and BSW responded to macro level concerns, while social justice and community organisation intervention were notably missing from the data.

The value preferences of social workers are considerably important especially when related with the findings of a qualitative study that illustrated the ways that individual ideologies and beliefs impact social work practice. In particular, Sullivan (2008) explored social work practice with older people in UK community care. Findings of this study indicate that social workers' ideologies and perceptions dictated their practice while different meanings introduced by their clients were ignored. More importantly, social workers' perception of their duties appeared to be originated and controlled by organizational rules and policy. At the same time, social work ethics appeared

to be loosely applied and clients were excluded from the ethical decision-making of the social workers.

The attitudes and beliefs of US social workers about sexual involvement with clients were quantitatively explored by two studies. Jayaratne *et al.* (1997) found that 43.7% of the social workers believed that feeling sexually attracted to a client was appropriate, and 52.4% acknowledged feeling sexually attracted with their clients. However, only 1.1% of the social workers declared having sex with a former client. In contrast, Mittendorf and Schroeder (2005) using an exploratory survey found that all of their respondents believed that erotic contact between social worker and client was usually harmful to the client and always inappropriate. However, many of the social workers (54%) affirmed that they had clients who reported having had sexual contact with a previous therapist. These respondents acknowledged having had a total of 245 clients who reported having sex with their previous therapists. Importantly, of those social workers who believed that one or more peers had initiated sexual contact with clients, only 15% reported these violations of ethics to an ethics committee or licensing board. This finding is considerably important as whistle blowing is currently considered as one of the ethical responsibilities of social workers which is related to their ethical obligation to protect their clients from malpractice. However, there was no empirical study examining the issue of whistle blowing and whether social workers ethically embrace whistle blowing practice.

Importantly, the above studies detected several factors related to the development of social work ethical dilemmas, however, in various contexts. Policy issues, cost-effectiveness and organisational values appeared to be strongly involved. Nonetheless, further research is needed in order to understand the factors effecting the ethical decision-making process of the social workers. In addition, some studies indicated that, overall, the ability of social workers to ethically analyse their cases possibly leads to a stronger engagement with advocacy and recognition of important factors (i.e social policy, organisation rules) that affect practice. However, there are no studies exploring why social workers do not acknowledge conflicts in values in the first place or their prior education on social work ethics. In addition, further research is needed to explore the role of social workers' ideologies and/or value preferences that impact on ethical decision-making.

Although two empirical studies indicated the emotional impact of ethical dilemmas on social workers, there are no studies indicating the ways that emotions affect the ethical decision-making

process. However, studies have clearly shown that social workers dealing with ethical dilemmas experience difficult emotions. Therefore, it is anticipated that these emotions may function during the whole process of decision-making and consequently affect the decision or the action that social workers take.

Although these studies were not focused in the exploration of the nature of the social workers' ethical dilemmas, some assumptions are worth noting. The fact that some social workers who experienced ethical dilemmas ended up discrediting the humanitarian purpose of social organisations, strengthens previously discussed studies which indicated that organisational values and policy in contrast with professional values are one of the major sources of ethical dilemmas for social workers (McAuliffe, 2005; Conrad, 1988).

2.2.6 Ethical decision-making in health care settings.

A body of empirical studies has focused specifically on ethical dilemmas and ethical decision-making of social workers in health care settings. All of these studies focused on specific ethical issues and mainly on those that involved end-of-life care or decisions, patient discharge, and the decisional capacity of older people who experience cognitive impairment. Specifically, in a study conducted in the US, Csikai (2000) surveyed 63 social workers to explore ethical dilemmas in end-of-life situations, the conflicting values in these dilemmas, and participants' prior education on ethics. Thirty seven percent of the respondents believed that ethical dilemmas were rare or never occurred, and 47% indicated that they sometimes faced ethical dilemmas when involved in end-of-life decision-making. The most common ethical dilemma the social workers faced was confusion or conflict because there was no advance directive and questions of competency of the patient. Issues of confidentiality and requests for information regarding assisted suicide arose much less often.

In reference to the physician assisted suicide, Manetta and Wells (2001) surveyed a convenience sample of 66 social workers attending a workshop on suicide and found that half of all participants were opposed the physician assisted suicide and an equal number of participants supported it. However, only 29 of the 66 social workers provided information regarding the circumstances under which they would support or not a physician assisted suicide. Interestingly, more than half of the participants in both opinion groups did not know the physician assisted suicide law at the time of the survey. More interestingly, findings from both studies indicated that

the majority of the social workers had the minimal education on ethics, were not familiar with the relevant policy about physician assisted suicide, and none declared being familiar with the National Association of Social Workers (NASW) guidance on end-of-life decision-making (Manetta and Wells, 2001; Csikai, 2000). The fact that a great number of social workers did not acknowledge the existence of ethical dilemmas in conjunction with their minimal education on ethics suggests that ethics education may enable social workers to recognize the multiple ethical issues of their practice. This is also consistent with the findings of the study of McAuliffe (2005) who concluded that training in ethics assists social workers to acknowledge the ethical dimension of their practice (section 2.2.2, pp. 35).

In reference to the nature of ethical dilemmas in health settings, some studies appeared to be consistent in that cost containment cases and dilemmas that involved commitments to their employers versus the best interest of clients were rarely faced by the social workers. In particular, Proctor *et al.* (1993) asked 16 social workers in a large American urban teaching hospital to identify from a list of 15 ethical complications the ones they had encountered in planning the patients' discharge. Thirty-one (57%) of the ethical dilemmas arose between the pursuit of client's best interest and fostering maximum client self-determination. In addition, conflicts between serving the client and maintaining loyalty to colleagues occurred in 22% of ethical dilemmas. Boland (2006), using four vignettes, surveyed 239 social workers working in American hospitals. Findings of this study indicated that most of the respondents (94.6%) identified as ethical dilemmas medical cases as opposed to cost containment cases. In fact, the majority of respondents chose cases depicting ethical tensions, such as decisions to prolong or end life, or disclosure of confidential information for ethical resolution. Similarly, Foster *et al.* (1993) surveyed 255 American hospital social workers and found that the cases in which social workers reported having encountered ethical concerns were issues relating to quality of life, followed by privacy and confidentiality, interpersonal conflicts, disclosure and truth telling, value conflicts, rationing of health care, and discussing treatment options. In fact, participants indicated that they encountered issues related to rationing health care resources more than they felt prepared to, and as a consequence they do not participate in accordance with the issues being raised.

Proctor *et al.* (1993) observed that the low frequency of dilemmas that involved conflict between worker commitment to the employing organization and serving clients' best interests was surprising given the current cost-conscious US hospital environment. In fact, findings of a study conducted by Kane (2004) showed that the majority of 116 MSW students in Florida believed that

managed care restricted services that might benefit clients and was more focused on profits than clients. Yet, the majority of students (62.1%) also believed that social work values were not difficult to apply in US agencies of any kind.

Two other studies were particularly concerned with the factors that influence the ethical decision-making of social workers when they decide whether to support the autonomy of older people. Healy (1998) using a mixed method approach examined cognitive status, safety and caregiver burden and the degree that these factors influenced social workers' support for autonomy. The three most frequently mentioned factors influencing participants' decisions were the evaluation of cognitive capacities (92%), followed by safety/risk factors (73%), and then caregiver/family issues (50%). Overall, respondents showed a relatively low level of support for autonomy. In a later study, Healy (2003) using a qualitative approach explored the existence of ethical tensions embedded in the decision-making processes of home health care social workers as they evaluated decisional capacity of the elderly experiencing cognitive impairment. Findings of this study suggested that there was a particularly strong ethical tension when social workers experienced pressure from other professionals as well as when they were uncertain about the decisional capacity of their clients. Clinical uncertainty was influenced by 4 major factors: (a) when the person had a partial cognitive impairment; (b) when the person had a mental health problem; (c) when there was interplay of health and mental health problems; and (d) when the aetiology of the poor decisional capacity of a person was unclear. When the social workers were certain that an elderly person's lack of decisional capacity was contributing to an unsafe situation, their action was very strong in support of beneficence, toward securing safety and in resisting pressure of other professionals. However, when social workers were uncertain about their judgments, they sometimes re-evaluated their own decision-making. Thus, balancing autonomy and beneficence was perceived as a very difficult course of action.

The involvement of social workers on ethical committees has also been empirically documented. Csikai and Sales (1998) surveyed 85 social workers who were members of hospitals' ethics committees and 85 chairs of the same ethics committees of which the participant social workers were members. Generally, social workers and chairs held highly congruent expectations regarding the relative importance of various social worker contributions to the ethics committee. However, social workers desired significantly more involvement in almost all areas of committee activity than chairs felt they should have. Both social workers and their chairs felt that social workers should be most heavily involved in case consultation activities, slightly less involved in

policy development and review, and much less in educational activities. Similarly, Csikai (2004) explored social workers' participation in the resolution of ethical dilemmas in hospice settings. The findings from the 110 hospice social workers suggested that social workers' participation in ethical committees was moderate by providing only information related to the clients' circumstances, and therefore staying outside the real ethical discourse of the cases brought to the committees' meetings. Nevertheless, social workers, even if they have minor roles on ethical committees, must independently make decisions on cases with ethical implications. This is particularly relevant given ethics committees typically meet on an infrequent basis.

In contrast with the studies discussed in the previous section (2.2.5, pp.43), the majority of the studies in health care contexts were quantitatively approached. Specifically, only one qualitative study was found to explore the ethical decision-making process of social workers, but focused on a particular ethical issue. Although, there are some large-scale studies indicating what social workers identify as ethically problematic in their practice, little is known about social workers' attitudes and ethical decisions on about the contextual factors involved in ethical decision-making.

2.2.7 Summary

In this section social work's ambiguities were discussed through the elaboration of its values and ethics. Social work is a profession difficult to characterize as there are a variety of factors that frame the professional entity. These include the range of organizations where the social work profession is practiced, the variety of social problems that social workers address, and the policy and the nature of the welfare state. However, social work values and ethics provide the way for social workers to identify themselves as a separate professional entity. Social workers are able to define and articulate the specific content of their professional purposes, such as social change and human well-being, through the language of ethics. Furthermore, the imposition of values into social workers' evaluative process is seen as an effort to control what the current political system demands to count as "*good social work practice*". This effort will hopefully enable humanitarian values and ideals to take a proper scientific stance and a practical place in the dominant ideology of the neo-liberal "*what works*".

Ethical dilemmas reflect the ambiguities and the complexities of the social work profession in terms of its multiple obligations, its commitment to mutually opposed ethics, and the dual

professional purpose to ensure both individual and the societal well-being. In addition, limited welfare resources require social workers to ensure equal distribution of these as they are ethically engaged to promote social justice. This commitment requires them to make moral decisions on who deserves to be benefited or not. Similarly, as social workers are ethically obligated to protect and enhance the well-being of their clients, issues of power and the possibility of dual relationships are ethically problematic. In addition, workers are obligated to ensure that their clients are both protected from any harm and their potential for self determination and autonomy enhanced. However, social workers are simultaneously obligated to protect their employer and follow any regulatory rules. When these rules or the practise of colleagues are thought to violate or obscure the benefit of their clients, then ethical dilemmas emerge and social workers must try to balance their multiple obligations and the consequent conflicting ethical principles. Balancing conflict among such responsibilities is an effort that necessitates moral judgments and ethical decision-making. Therefore, ethical skills are considered as prerequisite for social workers to be able to maintain a critical attitude towards their dilemmas. In particular, ethical awareness and critical reflection have been proposed as skills which enable social workers to determine, control and enact the values that the profession ideally promotes (Bowles *et al.*, 2006; Speicher, 1998; Banks, 1995; Reamer, 1982).

Social work ethics is an important, but infrequently researched aspect of practice. In fact, Jansson and Dodd (1998) argued that the empirical studies of social workers on ethics in health care are minimal. However, a focus on social work ethics in health care settings seemed to have emerged particularly in recent years. This is probably because researchers believe that health care is the most ethically problematic context for social work practice. Nevertheless, the majority of these studies are relevant to US social work settings while the empirical studies relevant to European countries are considerably few in number. Not surprisingly, none of the empirical studies were specifically relevant to Greece.

Studies conducted in a variety of social work settings indicate that overall, social workers appeared to adhere to individualistic values such as self-determination than to collective ones such as social justice (Woodcock and Dixon 2005; Banks, 2005; Kugelman, 1992). In addition, even when social workers acknowledged policy as opposed to social work values they did not respond to macro level concerns in terms of action (Furman *et al.*, 2007). Targeted studies on social work ethics in health care showed that the majority of workers acknowledged ethical dilemmas in cases which involved medical issues such as end-of-life care, and decision-making

capacity of older people rather than cost containment problems (Boland 2006; Foster *et al.*, 1993; Proctor *et al.*, 1993).

Importantly, many studies indicated a relative weakness in social workers to ethically analyze of their practice. In particular, ethical dilemmas were broadly defined by the social workers and did not reflect elements of value conflict and decision-making (Banks and Williams 2005). Kugelman (1992) and Manetta and Wells (2001) also found that social workers, when they considered their ethical issues and dilemmas, were not able to justify their decisions or beliefs on ethical grounds. In fact, it appeared that social workers rarely used or knew the ethical code of NASW or specific ethical guidelines for issues such as physician assisted suicide (Manetta and Wells, 2001; Csikai, 2000). However, the ability of social workers to ethically analyze their practice appeared to be strongly related to policy interventions and a social advocacy orientation in social workers (Furman *et al.* 2007; McAuliffe, 2005).

Evidence emerged that ethical dilemmas have short term and long term consequences for social workers. Experiencing difficult emotions as a result of ethical dilemmas were found by both Banks and Williams (2005) and McAuliffe (2005). However, the way that emotions affect the ethical decision-making process remained less understood. In fact, ethical decision-making was relatively unexplored.

Studies in health care settings were concerned with specific ethical issues that social workers faced. In particular, the ethical perspective of end-of-life decision-making and social workers' discharge planning were most often examined. Only two studies, but not in health care settings, used qualitative approach and allowed participants to demonstrate and reflect upon their own dilemmas. A common finding of these studies was that ethical dilemmas often involved a conflict between organizational and professional values (McAuliffe, 2005; Conrad, 1988).

Taking into account the reviewed studies, it remains poorly understood how ethics contributes to good social work practice, the obstacles that prevent social workers from engaging in ethical practice, and the extent to which practitioners understand and practice ethical decision-making. In addition, findings from Mittendorf and Schroeder (2005) indicated that only 15% of social workers reported on ethics violation by other professionals raising questions about the ethical responsibility to protect clients from malpractice.

Social work is a profession well determined by a series of values and ethical principles that underpin every aspect of its theory and practice. Our professional terminology is full of notions that imply specific values and ethical obligations. However, it is not really empirically known whether these values and ethical principles are reflected in daily practice. The information gained from this review, confirms that a study using a qualitative approach to enable participants to determine their own perceptions and experiences of ethical dilemmas in their particular cultural context would be extremely appropriate. The following section which comprises an exploration of the cultural, political and social work context in Greece is particularly important in order to contextually understand the findings of this study.

2.3 Exploring the context of social work ethics in Greece

Social work is constantly developing and changing its nature, purposes, practices, and professional and theoretical parameters. Since it has this much diversity, social work research must be viewed as an ongoing exploration, description and analysis of the context where practice takes place (Gibbs, 2001). All of these factors create and sustain a rich and diverse agenda for qualitative research as context should not be treated as a *"taken for granted"* feature of social work (Shaw and Gould, 2001). In this sense, context has a strategic significance in understanding the meaning of social work ethics in Greece.

Universally, the potential for development within social work profession is continuously evolving. Nevertheless, social work has been variously developed and framed in different countries. In particular, social work in Greece seems to be framed within the traditional South European welfare model and the gradually emerging European social model, while globalization and its underpinning ideologies continue to affect it as well (Guillen and Palier, 2004).

This section provides a discussion on the political, cultural, and social context where hospital social work is currently practiced in Greek public hospitals. In particular, social work in Greece is discussed with reference to its history, the new globalized environment and consequences in Greek society and for the social work profession. Europeanization and the nature of the Greek welfare state are also discussed as well as the issues of social protection. Following this is a description of the National Health System (NHS), and a brief description of the public hospital administration system and its social services departments.

2.3.1 The history of social work in Greece

Social work has a deeply contextual nature as practitioners work among people and their environments. In addition, social work is engaged in promoting social justice and social change, and therefore, the focus of workers becomes one of changing the environment or aspects of it. In this sense, to understand the profession and the role of applied ethics we must have a clear idea of the context in which social workers practice (Bowles *et al.*, 2006). Although social work has changed since it was first established in Greece, it is important to briefly describe its historical evolution. This is followed by a brief review of its work status in Greece.

When the Second World War started in 1940, Greece was enslaved and the population experienced deprivation. At the end of the war, a civil war began and people continued to suffer from the consequences. During this period, however, the reconstitution of the country started. The welfare program of Marshal, founded by the American government, undertook the development of public works and community development programs (Stathopoulos, 1999). American consultants and volunteer organisations who had come to Greece to help with the reconstruction of the country argued that the effectiveness of these programs was not good enough. The need for trained staff to deliver the social programs was subsequently identified and the first social work school established by the American College "Pierce" in 1945. Three years later in 1948, the Christian Association of Youth in Greece with the support of the International Christian Association and the support of the "Royal Welfare of Greece", founded the second social work school. The third school was founded by the "Royal National Institution" and the fourth was founded by the Greek Orthodox Church. In 1950 the Hellenic Association of Social Workers was founded, and in 1959 the first law was passed describing the role of the social work profession. Three years later in 1961, a second law described the settings where social work could be practised.

At this time, leftists were provoking social workers and arguing that since social work schools were funded by Liberals and Royals the ideals of the profession were not democratic and social workers were not close to the working class. In addition, with the church's involvement in two schools, social work in Greece was viewed more as an apostolate activity rather than a distinct profession (Stathopoulos, 1999).

There are two committees in Greece for the development of the social work profession. The first was established in 1956 by the Orthodox Church in collaboration with the Unitarian University Service Committee of the US. In the first years of its establishment the committee actively engaged in social work education in Greece. In particular, it financially supported the translation of some of the basic social work texts from the US, organized the first educational seminars for social workers, and developed the curriculum in consultation with social work academics from US universities. Similarly, the second committee was founded by the Orthodox Church in 1979 and supported the development of the profession. Both committees continue their function to date, but with limited activity (Kalinikaki, 1998).

Currently, there are four schools of social work in Greece which can provide a license for practice. All of them are established as Higher Schools of Social Work (HSSW) and they provide a three and a half year training course followed by a six month placement for practical experience. Due to the National Educational System in universities, students enter social work schools at the age of 18 or 20. Older students in social work schools already have a degree from another school. The social work schools are not multicultural as the majority of students are Greeks. Only a small portion of social work students are from Cyprus, and an even smaller portion of students are children of expatriate Greek families who return to Greece for their studies. This is promoted by the Greek government by allowing children of Greek emigrants to enter any university they like so as to support their families on return to their homeland (Pediaditaki, 2003).

There is no official data for the number of the employed social workers. However, Dedoussi *et al.* (2004) estimate that over 1000 social workers are employed in the health sector nationwide. In addition, the status of the social workers in health sector is low, as medical services in Greece remain doctor-orientated and the multidisciplinary approach is rare (Dedoussi *et al.* 2004). In fact, Dedoussi *et al.* (2004) indicate several factors that determine the low status of the profession. They state that there are a limited number of vacancies for qualified social workers and, in the private sector, it is rare for employers to offer more than one or two posts for social work. And finally, continued education is not a requirement and is rarely provided by employers.

Dedoussi *et al.* (2004) describe the profile of the typical social worker in Greece:

A typical social worker in Greece is a middle-aged married or single woman working for the last 10 years in health or social services, who rarely finds the time or the money to attend scientific meetings despite the fact that s/he may have at least one other degree qualification before training in social work. S/he is employed at staff grade and has little or no prospects of promotion. Central policy on social workers is lacking, and the profession is lacking, and the profession is in the early stages of self- organizations (pp. 274).

In addition, results from Georgoussi (2003) survey which explored the nature of the daily work of social workers, indicated that activities were characterized as “*first aid*” and no work related to planning, research, supervision, or consistent record-keeping. Moreover, PEDIADIKAKI (2003) argues that social work’s character is very confusing to the majority of the Greek citizens.

To summarize, social work in Greece was deeply influenced by the liberal ideology that prevailed in Greece, by the United States and the Christian Orthodox Church in Greece. In particular, the first social work academics were educated in US and the establishment of the welfare state was funded and formatted by the directions of the US government. Simultaneously, the Christian Orthodox Church with its power to influence and intervene in the political affairs of Greece managed to form the social work identity as a philanthropic activity. Therefore, social workers remained, for many years, uneducated in critical or radical social work practice. And although social work was considered as a moral activity, its purposes remained disconnected with the aims of social change. As social work is mainly practised within the limited welfare organisations founded by the state, it remains a professional with low status. Educational opportunities for social workers are considerably limited, and only those who are able to fund themselves have the opportunity for advanced education in European or American universities (Dedoussi *et al.*, 2004; Georgoussi, 2003; Stathopoulos, 1999; Kalinikaki, 1998). It is vitally important that social work ethics is understood in relation to the Greek context in which social work is practiced. Although the HASW is currently a member of the International Federation of Social Workers (IFSW), the ability and competence of social workers to practice social work ethics are considerably dependent on the diversity of contexts.

2.3.2 Social work and the welfare state

The Greek welfare state is representative of the so called Southern European Welfare Model. Matsaganis (1999) defined the basic characteristic of the model as follows:

1. A highly fragmented and corporative income maintenance system, displaying an internal polarization and privileges for concrete social class interests, and coexisting with gaps in social protection.
2. A low degree of state penetration in the welfare sphere and a highly collusive mix between public and non-public players and institutions.
3. A strong influence from the Church.
4. The persistence of clientelism
5. A differentiation from the corporative traditions in health care and the establishment of National Health Services based on universalistic principles.
6. The lack of an efficient, rational, Weberian type administration, and the weaknesses of civil society resulting in exercise bureaucracy and regulation.
7. The prominence of political parties as the main aggregators of social interests.

The current nature of the welfare state in Greece started to form in the 1970s, when the dictatorship collapsed and a democratic state slowly established. However, at this time the priorities for the Greek government were mainly economical development military strength (Stathopoulos, 1999). During the '80s the government started to develop the public welfare state, and simultaneously started to empower the role of local authorities. In 1981 the country joined the European community as a full member while at the same time the socialist party (PASOK) came to power. Gradually, the European Union (EU) started being a key determinant in every area of national policy. The considerable influx of European funds had as a consequence the development of new interests at national and local levels, whilst at the same time created new opportunities for governmental manipulation regarding the distribution of these funds (Pediaditaki, 2003; Zambeta, 2000). Nevertheless, the European Structural Funds were only partially absorbed, resulting in welfare state reforms remaining mostly on paper. This was due to the unqualified public service's lack in new management techniques in conjunction with the low incentive for productive and efficient utilization of public resources. Furthermore, the high rate of inflation,

combined with mismanagement led to increasing public deficits and economic imbalances (Yfantopoulos, 2004; Sotiropoulos, 2003).

During the past decade Greek society has undergone dramatic socio-economic, political and cultural change. In the 1990's the task of the inclusion of Greece to the European Monetary Union was a professed goal for almost all the political spectrum (with the exception of the Communist Party). The view that the Greek economy should be modernised and adapt to the general European trends in order to meet the Maastricht criteria, though it had hard socio-economic consequences, was not seriously doubted by the major social actors (i.e. big political parties or the trade unions). The main policies that followed during and after the 1990's were oriented towards the European nominal convergence. However, despite the attempt for the establishment of new modernized political structures, the reproduction of clientelism and of non-institutional forms of social consensus remain as some of the permanent features of Greek political culture (Zambeta, 2000).

The welfare state in Greece is currently administered through a complex system of public and private institutions. More than 175 insurance agencies and institutions are functioning, supervised by six different Ministries with a multiplicity of social objectives and an overlapping of services (Yfantopoulos, 2004). However, with the integration of Greece into the EU the Greek government created new staff and line administrative hierarchies which would be more flexible than the sprawling central services of the Ministry of Labour and Social Security. New institutions were created as new policy tools in order to enter Greece into the logic of EU-driven social policies. Measurable targets, absorbing earmarked funds within reasonable time limits, following up the implementation of legislated policies, and evaluating the efficiency and effectiveness of attempted measures started to settle into the new policy agenda of Greece (Guillen and Palier, 2004).

Nevertheless, despite promoted reforms for the Europeanization of the welfare state, it is argued that the fundamental structure of the Greek welfare regime remained comparably stable. The Greek welfare system is traditionally characterized by fragmentation and clientelism in the funding and delivery of social protection, leading to large-scale inequities. There is a predominance of cash benefits over other kinds of transfers or services, and a preponderance of pensions among all cash benefits. In addition the Greek state has selectively benefited from insurance funds of specific occupational groups (Yfantopoulos, 2004; Guillen and Palier, 2004; Sotiropoulos 2003). Moreover, as Herzfeld (1993) argued, Greek bureaucrats are reluctant to accept responsibility for offending the powerful. In this way, the deficiencies of the welfare system remain unchallenged.

Social protection in Greece ranks very low in comparison to European standards. Specifically, Greece is among the countries of the Southern European block (Italy, Greece, and Portugal) that spend considerably less than the average of the Member States of EU countries on social protection (Sotiropoulos, 2003). In addition, Greece is the only EU country which has not developed a minimum income scheme to protect citizens from poverty and social deprivation, while 21% of the population is at risk of poverty. The poverty rate is above 33% for the elderly and very old in Greece, in contrast to the equivalent figure for the EU which is 20%. This is partly because the minimum pension benefit is below the poverty limit. In addition, new groups of people that are perceived as vulnerable have started to form. For example, the “*generation of 700 euros*” is an expression that is currently used in Greece and characterizes 25-35 years old citizens who are overworked, underpaid, debt ridden and insecure. Poverty is more apparent in rural areas and unemployment, and access to the labour market and social services appear to be the major contributing factors. However, informal social networks and the family as the nucleus of the Greek society still play an important role in preventing poverty and social exclusion (Yfantopoulos, 2004).

Another important characteristic of the Greek culture is that blood is the basis of the Greek race. As Herzfeld (1993) indicates, in Europe blood had, by the early nineteenth century become a symbol of kinship that was able to convert social relationships into a national culture. In addition, Greece is a country where ideologically to be Greek means to be a member of the Orthodox Church. Taking this into account in the logic of competition over resources, being Christian can become a highly relative and contestable quality (Herzfeld, 1993). Therefore, blood and the Christian religion are symbols of a collective identity that serve to discriminate those who belong to the Greek nation from those who belong in other nations.

To briefly summarize, the Greek welfare state undertakes the most important actions for the social work profession. Social work activities are characterized by “*first aid*” and the individualization of problematic situations, in contrast to a collective treatment. In addition, social work in Greece lacks, to a great extent, the critical approach which is necessary for the qualitative enhancement of the profession (Pantazis, 2007; Georgoussi, 2003). Therefore, it is doubtful how social work can contribute of the reformation of the welfare system in Greece.

2.3.3 The social work profession within a globalized environment

Globalization is one of the most common terms used to characterize the new social reality and modern life. Although the term is not well defined, it is widely used to connote a global integration in which diverse people, economies, cultures, and political processes are increasingly subjected to international influence. Globalization is particularly correlated with the economical activities of western countries and the technological advancements in transport and communication. Due to its nature, globalization affects every aspect of human life (social and political structures, welfare state, culture, demography, education, employment, family, world ecology, personal lives of individuals) because it creates multiple and extensive world networks and procedures that overpass national borders (Midgley, 1997).

Current literature suggests that globalization has developed social problems including unemployment, poverty and economic instability, increased immigration, racism and ethical conflicts, economic and social exclusion, human trafficking, arms and drugs trade. In addition, some argue that the motivation behind globalization was for the domination of the west and has subsequently eliminated the local cultural differences mainly in the countries of the Third World (IFSW, 2005; Ferguson, 2004; Midgley, 1997).

Within a globalized environment, social work has also changed enormously. In terms of its methods, the focus of some social workers has turned from case work to community development activities. More importantly though, social work has been affected by the economical values and principles that underpin the current welfare state internationally. Agencies that function with the terms and purposes of businesses are currently those which provide social services. In effect, social workers are currently pressured to function under the managerial control and managed care policy. In fact, the impact of globalization, privatization, new managerialism and technocratization on social work have been extensively documented. For example, Gibbs (2001) says that in New Zealand it is normal for social workers to talk of “*core business*”, “*maintenance of mission*” and “*budgetary control*”.

Globalization in Greece brought a considerable capital accumulation in certain sectors of the economy (e.g. banking, mass media). In addition, privatisation processes have been put forward in various sectors that were traditionally under public ownership control (e.g. banking,

transportation, telecommunication and energy). This process started in the early 1990's under the New Right government and has continued by the PASOK (Zambeta, 2000). Furthermore, through the violation of national borders and the transfer of populations, Greece was rapidly transformed from a country of a high national and religion homogeneity to an increasingly multicultural society. Currently, partly due to its geographical position, Greece is the country of arrival for many immigrants and refugees. Most of them see Greece as a geographical bridge to economically developed European countries. However, many of them remain or they are sent back to Greece due to the refugee European Law of Amsterdam. Despite the fact that immigration has become a matter of concern for the authorities for almost a decade, it is still impossible to trace the exact numbers, places of origin and social characteristics of immigrants living in Greece. The fact that not all of them are documented prevents the collection of accurate data; official estimates differ largely from information deriving from non-governmental organisations (Greek Council of Refugees, CARITAS, etc.) or the numbers immigrants give (Petronoti and Triandafyllidou, 2003; Zambeta, 2000).

Generally, the effect of globalisation on Greek culture has not been extensively documented. However, Voulgaris (2006) suggests that the Greek identity is currently characterized by "*cultural conservatism*" as a by-product of the historical process of its formation during the "*long XIX century*". Cultural conservatism in Greece is currently provided by the dialectic between globalisation and the national identity, as well as the disjunction between state and nation that this dialectic produces. In addition, Zambeta (2000) notes that globalisation and Europeanisation is considered by Greek citizens as threatening for the traditional national culture. In this context Greek language and the Orthodox Christian religion are considered as the crucial distinctive elements of being Greek. Therefore, nationalism and xenophobia are some of the unavoidable implications of this discourse.

Globalization also promotes the international exchange of knowledge and professional experience. Industrialized countries are recognizing the need to provide their students with a global consciousness and with experience in other countries in order to compete in the global economy. The EU has instituted policies that have increased the number of students studying outside their home countries, but within the Union. With the expansion of the EU and the implementation of the Bologna initiatives, academic structures are harmonized within the European countries. Nevertheless, international higher education has been turned into a big

business. The US, UK, Germany and France attract foreign students from developing and newly industrialized countries, with 55% coming from Asia. In particular, the US is a major attraction for foreign students while American students study abroad in modest numbers (Altbach, 2004).

Although these EU programs for student mobility started in 1988, only in recent years did the social work schools in Greece start to have access to these programs. PEDIADIKAKI (2003) states that approximately 12 social work students use these programs each year and approximately 10 social work academics know how to handle such programs. The basic obstacle for Greek students to use European educational exchange programs is the financial hardship. In addition, not many foreign social work students choose Greece as the destination for their education. Language difficulty is the main factor that stops foreign students from coming to Greek social work departments.

Social work in Greece is rarely represented in international conferences or other types of collaborations (research, education, international social work activities). In addition, the social work curriculum has no reference to international or European social work, and the focus is on the local and national level. Interestingly, social work in Greece is almost absent from international and European social work literature. Even more interesting, Greek social work literature is minimal, while there is a complete absence of empirical studies for basic issues of the social work profession in Greece (PEDIADITAKI, 2003). Given this lack of empirical work, little is known about the ways that globalization has affected the profession. To conclude, social work in Greece maintains a traditional way of functioning although the profession has changed significantly in the US and European countries (PEDIADIKAKI, 2003).

2.3.4 The National Health System in Greece

The current National Health System (NHS) of Greece was funded in 1983 for the first time. Its public character was based on the principle that all people deserve equal access to health services and technologically advanced health care. With the creation of the NHS, Greece gradually started to advance its services based on the health model of other west European countries (LIARPOULOS, 1998). The last transformation of the NHS was in 2001 with an aim to deal with the ineffectiveness and deficiencies of the NHS, including the centralization of health services, and the excessive power of doctors (ALEXIADIS, 2003).

Despite the efforts for developmental changes, current literature indicates that the NHS has never become effective or efficient (Mossialos *et al.*, 2005; Ballas and Tsoukas, 2004; Liaropoulos, 1998). Some of the major problems and characteristics of the NHS that are documented in the current literature include:

1. *Centralized NHS*- This characteristic leads to major resource and health services inequalities on a geographical basis. In fact, local district hospitals are often understaffed and have poor capital infrastructure. The 180 rural health centres constructed by the 1983 reform have serious operational problems, staffing is insufficient and there is a lack of technical equipment (Mossialos *et al.*, 2005; Ballas and Tsoukas, 2004; Liaropoulos, 1998).

2. *Unethical practices*- Although private practice for public hospital doctors has been forbidden since 1983 (except for university hospital doctors and doctors working for the army), many doctors have illegal private practices. In fact, since 2002 the government has attempted to legalise limited private practice for hospital based doctors. The government's philosophy which accompanied the creation of NHS was banning patients from choosing their doctors, something which contributed enormously to the growth of a black market of bribes for doctors and nurses. With many doctors being (illegally) handed the well-known *fakellaki* (little envelope stuffed with cash) by patients, there developed an interest in maintaining these practices. This also means that doctors need to influence the entry of patients to hospitals, bypassing the queue, and such preferential treatment rewarded with additional payments. The situation grew worse over time as doctors' unions have been concerned with advancing of their members' interests and have done little to help increase the transparency, efficiency and effectiveness of the system. Being the most influential group in the NHS, doctors defined NHS problems in their own, exclusively medical terms, thus effectively controlling foundational discourse in the NHS. In the face of these types of unethical practises government decided to boost doctors' income. However, corruption has still increased significantly (Rovithis, 2006; Mossialos *et al.*, 2005; Ballas and Tsoukas, 2004; Liaropoulos, 1998).

3. *Expansion of the private sector in health care*- Several factors gave rise to the expansion of the private sector in health care. The lack of sufficient technology in public hospitals and health centres resulted in social insurance or the NHS paying the private sector for patient use. Long waiting lists in public hospitals also meant people went to private hospitals for elective surgery or

other diagnostic/ laboratory services such as gynaecological tests, X-rays, or nuclear medicine. In fact, Greece is the country with the highest private expenditure among the EU member states (Yfantopoulos, 2004). The substandard quality of mental health services in public hospitals also led people to use private mental health services. In addition, most primary care consultations are provided by contracted office based doctors and dentists. Moreover, it is likely that many NHS and insurance funded doctors receive informal payments from private centres to channel patients for diagnostic or laboratory tests (Mossialos *et al.*, 2005; Ballas and Tsoukas, 2004; Liaropoulos, 1998).

4. *Lack of management control and accounting systems-* Public hospitals lack clear decision-making guidelines about where money should be spent. This is true both in the case of investments in new facilities and, even more so, in the case of consumables. There is no formal procedure, or even a budgeting system, for buying equipment on the basis of need. Rather, it all depends on idiosyncratic decisions by the hospital chairman. Authors also indicate that managers who were appointed to run hospitals, or chairpersons appointed to run the Regional Health System (PESY) tended to be political appointees – mostly members or sympathizers of the ruling party. Most heads of public organizations were, and with a few exceptions continue to be, similarly appointed in a clientelistic fashion. Top management positions in public organizations in Greece have traditionally been reserved for government supporters or sympathizers. In reference to the National Health System, Liaropoulos (1998) says: “*Manpower planning, technology assessment and quality assurance are non-existent activities, and the whole system is run on political criteria. Hospitals are still run by untrained career civil servants, and members of the boards of directors, each headed by a doctor, are political appointees with no interest in efficient operation*” (pp.166).

The NHS in Greece is also characterized by non-effective systems of organising and coordinating medical records, tracking how health resources are used, and measuring and monitoring the outcome of care. This problem is exacerbated by the fact that most doctors do not keep medical records in private practice even if they are contracted by health insurance funds, and if they do, these records are inaccessible. In addition, there is no actual assessment of needs for supplies and equipment, and procurement is usually based on doctors’ opinion (Rovithis, 2006; Mossialos *et al.*, 2005; Yfantopoulos, 2004; Ballas and Tsoukas, 2004; Liaropoulos, 1998). In comparison to other European countries, Greece also maintains the lowest number of employees in the health sector (Polyzos and Yfantopoulos, 2000).

A noteworthy development was the establishment of Regional Directorates (PESYs) in 2001. The legal status of each individual hospital was abolished with PESYs acting as intermediaries between the minister of Health and hospitals. Regional directors were given the power to influence personnel allocation by allowing, for example, personnel to move across departments on across hospitals. Today, the National Health System consists of 128 city hospitals and a number of associated rural area health centres organized into 17 PESYPs.

In 2002 the government gave permission to doctors to provide health services and diagnostic tests beyond the regular hours. The purpose was to advance hospital productivity and competitiveness by allowing doctors access to medical equipment, and giving citizens access to the doctor of their choice. However, citizens are obligated to pay for health services. Therefore, it is doubtful whether this measurement reduced unethical practices except to privatize the health services in another manner (Alexiadis, 2003).

As described above, the NHS in Greece is characterized by multifaceted deficiencies. Nevertheless the health status in Greece, in comparison to other European countries, is ranked high with increasing life expectancy and decreasing infant mortality. Some of the factors that have contributed to the improved health status include: improvements in living standards, the Mediterranean diet and better access to health care and pharmaceutical therapies (Yfantopoulos, 2004).

Every public hospital is administrated by its Administration Manager and Board. The Administration Manager is the main person responsible for the organization, coordination and control of all services in the hospital. S/he also participates on the Administration Board with the chair of president. S/he has the authority to form a scientific board for the hospital, and his/her main responsibility is for the efficient use of hospital income and property. The purpose of the Administration Board is to deal with the hospital's problems. It is responsible for proposals in reference to the budget and development planning. It is composed of five members: the general administration manager, three managers of the three departments of the hospital, (administration, medical and nurse departments), and the president of the scientific board. The scientific board is composed of 6 doctors with various positions in the hierarchy of the hospital's medical department, a scientist who is not a doctor but is a member of the hospital's medical department, and a nurse. The main responsibility of the scientific board is to consult with administration board about any scientific issue in the hospital. It also organizes and controls every educational

program for health care professionals in the hospital and it deals with the ethical issues of the hospital (Alexiadis, 2003).

2.3.4.1 Social work in Greek public hospitals

Social work is practised in Social Services Departments (SSD) of public hospitals which were first established by the Minister of Health and Social Care in 1956. In 1978, the responsibilities of social workers in hospital settings were specifically defined by a law: *“the social worker in the health sector contributes to the provision and therapy of emotional or socio-economical problems which are results of physical or psychological damage to people, difficult environmental conditions or problems in their personality which make diagnostic or therapeutic action difficult”* (Pandazakas and Mendis, 2002, pp. 98).

At the 2nd Congress of social workers in 1981, the role of the hospital social worker was redefined as supportive to the scientific team of a hospital. Specifically, the role of the social worker was to inform the other health professionals about the social history of patients and their special problems. One other aspect of their role was to ensure the patients’ social environment was supportive and responsive to their health needs. Lastly, social workers were to activate resources from the state for further support as appropriate.

The responsibilities of the SSD in hospitals were redefined again in 1986 with a relevant law which is still active today. The current role of the social workers in hospitals is defined as: *“the responsibility and care of the patients who are hospitalized for every social problem that affects them, the search and exploration of the reasons which cause these problems in each case but also the care for the elimination of these problems in the wider scope of the state’s policy”* (P.D 87/86; Pandazakas and Mendis, 2002, pp. 97-98).

Until 1986, SSDs were parts of the administration department of each hospital. With the newer law of 2001, SSDs belong to the medical department of the hospital (Pandazakas and Mendis, 2002). Some hospitals that have not yet revised their rules and continue to place the SSDs in the administration division. However, it is anticipated that in the near future these SSDs will be part of medical departments.

2.3.5 Summary

Social work has been practised within the public hospitals of Greece since 1956, due to an initiative of the Minister of Health and Social Care. The role of social work in public hospitals initially reflected the traditional case work with the complete absence of purposes that involved structural changes. The purpose of social work interventions were introduced in policy 30 years later in the definition for hospital social work. However, given the complete absence of education in critical practice, the limited involvement of social workers in international educational programs, and limited theoretical and empirical social work literature, it is doubtful whether social work practice followed the changes proposed by its definition. It is also worth noting that the role of the hospital social worker is defined in a law dated in 1986 (Pantazis, 2007; PEDIADIKAKI, 2003; Pandazakas and Mendis, 2002).

Despite the fact that social work has not changed significantly from the traditional model, the political, social and organizational context of hospital practice is continuously affected by both globalization and Europeanization. In particular, Greece is pressured to enter the logic of EU-driven social policies. Nevertheless, the welfare system in Greece is still characterized by fundamental structures of its traditional welfare model and particularly by fragmentation and clientelism both in funding and the delivery of social protection (Yfantopoulos, 2004; Guillen and Palier, 2004; Sotiropoulos 2003). In fact, poverty, inequality and social exclusion are serious social problems in Greece and social protection ranks very low, at least in comparison to other European countries (Yfantopoulos, 2004).

Health care is provided by the public sector (NHS), social insurance agencies, and the private sector. In Greece, the responsible body for national strategy as well as for overall health policy issues is the Ministry of Health and Social Solidarity which sets priorities at a national level, defines the extent of funding for proposed activities and allocates health resources. Moreover, it is responsible for health care professionals and coordinates the hiring of new personnel, subject to approval by the ministerial cabinet. In Greece, the establishment of the NHS was realized in 1983 aimed at the removal of economic barriers to accessible, equitable, and comprehensive health care coverage for all citizens. Since then, several reforms have been introduced with limited success to ensure efficiency and equity (Rovithis, 2006; Mossialos *et al.*, 2005; Yfantopoulos, 2004; Ballas and Tsoukas, 2004; Liaropoulos, 1998). In particular, some of the major problems in the NHS include: centralization of health services, unethical practice of health

professionals, expansion of the private sector in health care services, lack of management control and accounting systems. The NHS also suffers from a deficit of specialized staff, poor distribution of personnel and inadequate training, all resulting in low productivity and customer dissatisfaction (Polyzos and Yfantopoulos, 2000). Not surprisingly, Greece is the country with the highest private expenditure for health services among the EU member states (Yfantopoulos, 2004).

The above section offered a brief reflection on the changes and the current challenges of the welfare state in Greece by focusing particularly in the public health sector. Although the Greek context has not been extensively explored, the context in which social work is currently practised in public hospitals was presented.

Conclusion

In this chapter it was argued that every human activity, including those structured as policy, are moral since they are underpinned by values and meta-ethical assumptions about good and evil and perceptions of human/social well-being (Bowles *et al.*, 2006; Seedhouse, 2005; Goldenberg, 2005; Adams *et al.* 2002; Schon, 1987). Social workers are employed by organizations that either promote social values or tackle social problems. However, social workers are also educated to function as moral agents and as such they do more than simply serve their employers organizational needs. Importantly, social work is a science. This means that social workers accumulate knowledge gained through research and develop advanced skills to promote social work aims through systematic interventions that can be evaluated. Therefore, social workers acquire the power to make autonomous decisions and judgments based on their expertise and professional values or aims.

Social workers are often accused of being “*technical agents*” as they serve the bureaucratic organizational rules and structures that may produce unjust policies and practices. Moreover, social workers are part of the welfare state that is framed under dominant economic, political, and social values (Meagher and Parton, 2004; Banks, 2001; Clark, 2000). Although social workers are not the only professionals who are deemed to reproduce social structures, they are the only professionals whose core purpose is broadly defined as social change. Therefore, their identity as scientists is debatable since social workers must demonstrate their ability to be critical in reference to the social/ political/ economical structures of society and their underpinning values and ideals. Moreover, they must be able to defend their professional values and vision in terms of

how these ensure human and social well-being. Since there is no universally acceptable truth of what is human and/or social well-being, then social workers must also be able to explicitly articulate their philosophical and theoretical assumptions that construct their perceptions of well-being.

The review of social work theories indicated that social workers are expected to deal with complex ethical dilemmas in practice due to their engagement with equally welcomed and often conflicting values and multiple obligations often framed by conflicting interests. Indeed, findings from empirical studies on social work ethics outlined the nature of ethical dilemmas in some practice environments, including hospital contexts, in the US, UK and Australia. However, social workers appeared not to be overly concerned with collective values, such as social justice, they could only broadly define their ethical problems, and they were not competent with ethical analysis and language. This knowledge is valuable to those who are concerned with the advancement of social work into a profession competent to make structural changes, and a collective of ethically aware practitioners who are able to identify the underlying values in their practice environments and interventions.

The evolving interest in research, although often underpinned by the managerial ethos (Webb, 2001), challenges social workers to put forward their own criteria of what is important for further evaluation as exploration. Therefore, empirical studies on social work ethics highlights the moral dimension of practice by reviewing how professional values are applied in real practice environments. In particular, existing studies on social work ethical dilemmas enable practitioners to recognize the contextual factors as well as their personal/professional ideologies and values that structure their interventions (e.g ethical decisions) (Bowles *et al.*, 2006).

Despite the fact that there is a growing body of empirical studies on social work ethics, no study was identified as being relevant to the Greek context. However, this is probably just one of the elements that captures the underdevelopment of social work in Greece. In particular, the literature on social work and social policy in Greece indicates that social work is currently bound to a welfare state that is not sufficiently capable of providing adequate social protection to Greek citizens. Not surprisingly, within this context social work still has a low status, and lacks postgraduate education and research that could enhance the scientific competence of social workers.

Nevertheless, social workers must respond on a daily basis to their clients needs within a context where its fundamental welfare structures are characterized by fragmentation, clientelism, insufficient and inadequate funding. How Greek citizens experience these structures in their every day lives and how social workers practice their ethical engagements within these structures is less understood and virtually undocumented. However, the main purpose of this study is to focus on the social workers' experiences of these structures as these are related with their ethical commitments to enhance both social justice and individual well-being.

In the following chapter social work ethics will be discussed in relation to critical social work practice which theoretically underpins this thesis. It is anticipated that the critical approach on social work ethics expands our understanding from the broad conceptualization of philosophical ethics to a more relevant conceptualization of ethics in social work. This understanding highlights the role of social work in promoting social justice, and also acknowledges that social workers practice within a context of national laws, international and national policies and particular cultural characteristics (Banks, 2008).

Chapter 3

Theoretical foundations: social work ethics and critical social work practice

Introduction

Current codes of ethics are comprised of a series of opposed values and ethics, which social workers are expected to promote equally (IFSW, 2004; NASW, 1999) ensuring that both individual and social needs are met. In fact, social work ethics is an emerging subject area that enables practitioners to re-establish social justice at the center of their professional aims. Social work values and ethics help practitioners deal with social change, allowing them to see beyond the situation at that moment in time and perceive a more effective route to achieving their aims. However, it is believed that ethical theories are not sufficient to guide social workers in the structural context of their work. In particular, Banks (2008) argues that ethical practice is often decontextualized in the existing social work literature. In particular she says:

There is a tendency in some of the ethics literature to focus on the individual practitioner making difficult ethical decisions in cases that are sometimes constructed in ways that are decontextualized, both from the character and motives of the individual people involved and from the organization, policy, political and social context. This influences how practitioners conceive of and demarcate the domain of 'the ethical' and their perceptions of their ability to act (pp.1244-1245).

Policy issues are not only disconnected from ethical social work practice, but it seems that social work has been ignoring its structural role. In particular, it is well documented that social work was always more dedicated to the micro-level practice at the expense of its professional obligation to social change (Dudziak, 2002; Gibelman, 1999; Payne, 1999; Figueira- McDonough, 1993; Beck, 1959). Therefore, social workers remained uneducated about the political and economic framework in which they function. This resulted in the disregard of the more contextual and policy-related issues in either their ethical decision-making or value judgments (Banks, 2008).

The purpose of this chapter is to outline the ways that social work ethics are intimately related to policy analysis and practice. Furthermore, it is argued that the critical approach to social work practice provides an adequate framework allowing practitioners to respond to the moral aspect of the social work identity and its consequent ethical tensions. The chapter is grouped into two main

sections. The first section begins with a discussion of the dialectic relationship between politics, ethics and ideology. Examples of current social policy and the dominant ethical and ideological doctrines will be discussed so as to outline this point. It is argued that policy practice is an intrinsic part of social work identity that should be addressed because social justice is its core purpose. Therefore, political consciousness and action emerge as essential elements of the “*morally active practitioner*”.

In the second section the critical approach will be introduced as a framework for social workers, which enables them to understand their ethical engagements within specific local or wider contexts. Because the aim of critical practice is the pursuit of just social arrangements, it responds adequately to social work’s structural role.

3.1 Politics and ethics

For Aristotle, a human being is firstly a political and secondly a social and economical being. He argued that since humans are not “*Gods or beasts*”, they are inseparably connected by society. Unlike that of animals, human society is seen as the sum of its individuals connected by stable and organized relationships that are usually defined by institutions and laws and preserved by the enforcement of those laws. It is a political society (Kouskouvelis, 1997).

In this sense “*politics*” is everything that has to do with a differentiated society structured by those who lead and those who are led. And since the two previous categories exist, oppression and power also come within the definition of “*politics*”. Every political system is structured by political actions and political relationships that continuously evolve. In short, politics could be defined as any actions taken on public issues through legal procedures and/or for the distribution or re-distribution of power (Kouskouvelis, 1997).

It seems that there is a dialectic relationship between politics, ideology, values and ethics. Morone (1997) argues that public policy is shaped by the moral images and the stereotypes of a given society. However, he also argues that the politics of morality is not often analyzed. Similarly, Rothstein (1998) argues that political and moral logics are intimately connected and should be treated in a single context. Values and ethics originate in philosophical as well as ideological assumptions about “*good*” and “*evil*” in human behavior and outline the nature of a “*good society*” (Banks, 2008; Clark, 2000). Both values and ideologies also contain some form of

belief or faith. On the other hand, ideology could be broadly defined as a sum of notions that construct a generalized perception about the way that humans function. Ideologies may entail a system of values originated from specific, although not necessarily conscious in each person, philosophical, religious or scientific dogmas or beliefs- ideas (Kouskouvelis, 1997).

For example, Morone (1997) illustrates the way that values and ideologies constructed the American society. He argues that the structures of the economic and political system in the US (e.g. the competitive economic market, the absence of a national public health insurance system) has been enforced by the prevalence of liberal policy and its underpinning ideology. In particular, individualism which places a high value on human independence rather than interdependence is emphasized. As with every other theory about human nature, individualism also entails philosophical assumptions. For example, Kemp (1974) argues that Hume and Smith established individualism according to their theories about individuals' intrinsic right and urge for freedom and autonomy. According to their theories individuals have an intrinsic sense of "*natural obligation*" to justice and that individuals are motivated to set up rules of justice as a kind of self-interest. Since individuals are social beings they are intrinsically motivated to "*sympathize with others*". Therefore, social justice will be established "*naturally*" as individuals are free to pursue their own motives and interests. However, it is also argued that individualism diminished values relevant to the "*common good*" such as caring, reciprocity, community building, generosity and cooperation (Healy, 2007; Solomon and Higgins, 1999; Morone, 1997).

Philosophers observed that the development of human behaviour was shaped by their social environment and mainly competitive in nature. From these philosophical origins collectivism grew into what we now know as collectivistic or socialist theories. However, the scope of these philosophical theories on collectivism was not to enhance an abstracted "*common good*" at the cost of individuals' freedom and happiness. For example, Walsh (1974) argues that Hegelian philosophy points out that an individual's liberation can be found in the multiple opportunities of satisfaction that mutual relationships and common action bring. In addition, as individuals are social beings they cannot attain a substantive self-consciousness unless they sense their selves as united with "*others*" and society. This argument is also rooted in Greek philosophy that perceived human beings as necessarily connected to society. Individuals who are alienated by their social nature are seen as deficient- "*idiots*".

Similarly, Marx developed the theory of “*materialism interpretation of history*” and he argued that human beings cannot be understood in isolation from the social arrangements in which they live and the place which they occupy within these arrangements (Kamenka, 1969). The main contribution of Marx was that he bridged politics, state, and authority with economy. In fact, the whole idea of Marxist theory could be a single proposition, that the general character of the social, political and spiritual processes of life are determined by the mode of production in material life (Kamenka, 1969). Therefore, Marx believed that economy is superior to politics. For Marx each society has a mainly economic base. Therefore, the class structure of a society is determined by the struggle of the classes to control the means of production. Interestingly, in Marx’s theory all kinds of ideological beliefs (e.g. political, moral, religious) are determined by the class structure – as this structure changes, ideology and morality change.

Socialism emerged from Marxist theory and promoted a different political and moral outlook. Socialism investigates the social obstacles to human happiness and how they can be removed. Therefore, a series of values emerged and challenged the dominant social values that were reinforced by the logic of capitalism. Socialism promoted ideas of community, pleasure, and success through collective action and challenged the capitalistic value of a “*successful*” person who attains economic or political power (Galper, 1980). Furthermore, socialist doctrine was that “*the majority of people should take control of their own society in their own best interest as they see that interest*” (Galper, 1980, pp.30). Therefore, socialism promoted democracy as a value and political system, equality in the distribution of social resources, anti-oppressive values and social solidarity (Galper, 1980).

In relation to the current political and economical system and the role of social policy, Iatridis (2002) argues that in a state which operates within the structures of a free market, two elements are in continuous tension: (a) the citizen as a person with rights, responsibilities and needs and; (b) the economic dynamics which are related to the stakeholders of the free market. Social policy mediates in the relationships between the two, ensuring that those who dominate the market will also cover citizens’ needs and rights. However, with the dominance of liberalism and its relevant individualistic values, an inviolate line between the public and private realms was imposed, minimising the opportunities for social policy interventions (Morone, 1997).

Similarly, Iatridis (2002) believes that what defines the content and the activities of social policy is mainly the dominant ideology. Therefore, there are different definitions of social policy. For

example, one view sees social policy as only dealing with the activities of the welfare state, that is, issues such as poverty, physical or psychological problems and social security. At the other end of the scale, a comprehensive definition involves all the issues that affect society such as those relating to economics, politics, administration, ideology, and social and psychological conditions.

It is believed that both social policy and the welfare state that function within a free market are oriented to cover the needs of the economic policy. Therefore, the nature of social policy is powerfully defined by the economic policy. Iatridis (1985) exemplified this point by indicating that if economy needs an increase in unemployment to stabilize the markets, then the economic logic will dominate the values of social policy that are opposed to unemployment. Both social work and the welfare state will then just support the unemployed and also accept the social reality. However, social values appear to reinforce liberal politics and individualism in current societies. In particular, Rothstein (1998) indicates that the individualistic outlook of large social groups is continuously increasing at the expense of duties and commitments that had prevailed earlier, both in the family and in social life generally.

Social work is an institution that can never escape the impact of society, being bound by statutory duties to promote specific policies. However, it is argued that as a social force it has a role to play in changing world social structures. This role requires a critical understanding of the ways that the political, economic and social arrangements, ideologies and values construct society (Adams, 2002).

3.1.1 Social policy and social work

Social work is a profession currently defined as working for the promotion of social change so as to ensure a just society and the wellbeing for all individuals (IFSW, 2004; NASW, 1999). In other words, the social work profession is called on to deal with the impact of social structures on groups, individuals and communities, whilst simultaneously working to change those very same structures (Adams, 2002). Although there is no explicit denial of this dual responsibility, it seems that social work still struggles to find a proper balance between them. This is because social work has shown a lack of interest in broad social policy. In particular, Payne (1999) argues that social workers do not respond adequately to the macro-level objectives of the profession. He also

comments that social work seems to consider economic values as alien or inappropriate to welfare work, although they are necessary for the promotion of economic justice. In fact, in much of the social work literature it is argued that the profession should see economic security as forming the cornerstone of social change. Accordingly, Gibelman (1999) argues that social workers seem more devoted to the “*psychotherapeutic enterprise*” rather than to structural purpose and social change.

Social work has never been able to attain its role in social policy development. Beck (1959) argued that the first effort at special training for social change methods was developed around the second decade of the twentieth century. However, social work education remained dominated by the psychoanalytical theory which did not lend itself to social change. Therefore, there was a persistent failure in social work to demonstrate its ability for social reform. Interestingly, Beck (1959) argued that community social work at that time was a process of “*hidden manipulation*”.

An adherence to a basic set of humanistic and democratic values in social workers made them ever responsive to human needs (Beck, 1959). However, the advancement of radical and critical approaches reinforced the growing awareness of underlying causes of social problems (Adams, 2002). Inevitably, this also led to the recognition of the ambiguous role for social work as a political mechanism that contributed to securing the structures of unjust society (Banks, 1995). In fact, policy changes and underpinning ideologies the welfare state are reflected in the nature of social work (Adams, 2002). For example, Banks (1998) notes that social work is enormously affected by globalization, neo-liberalism and the ideology of new management. Specifically, she argues that greater bureaucratic accountability and greater technocratization, and the fragmentation of professional roles are the results of the current political state.

However, criticism about the controversial role and identity of social work served to strengthen its image as an aspect of public policy. Politics started to be acknowledged as the context of social work practice, and the dialectic between politics and practice started. Nevertheless, it is argued that social workers still prefer to remain “*apolitical*” by not engaging in political action. In fact, Dudziak (2002) ascribed this stance as an effort to divide the “*social*” from the “*political*” dimension of things by only acknowledging the “*social*”. She illustrates this point very clearly:

If our mandate is social justice, then the polis or the “political” in all its myriad meanings is already present. Yet as a profession not only do we not embrace the

polis, we seem to work very hard to avoid it. Much social work in Canada seems to work out of an imagined and idealized space of "neutrality". It is as if we think it is possible to bring about social change without action on its behalf. Such action is necessarily political. Yet it seems we prefer to disassociate the social from the political, if that is possible (pp.2).

Dudziak (2002) also argues that social workers avoid being engaged in political action because of the fear of conflict. She particularly argues that criticism is socially construed as something negative which necessarily leads to conflict. This stereotyping reinforces the professional image of social workers as "*positive*" and "*caring*" helpers.

In the context of globalisation and the dominance of neo-liberalism, the emergence of politically active social work practitioners and a stronger commitment to social justice and structural purposes are more intense than ever (Ferguson, 2004). Although, social workers as citizens may be social reformers, this status should also be the basis of their professional activity (Beck, 1959).

The welfare state has changed massively during the twentieth century. The underpinning ideologies of globalization continue to affect every aspect of human life. Globalization is underpinned by neoliberalism, the economic ideology that has been promoted by the World Trade Organisation (WTO), the World Bank, and the International Monetary Fund (IMF). Neoliberalism is based on a set of three fundamental types of freedom: freedom of investment; freedom of capital flow; and freedom of trade in all goods and services including living organisms and intellectual property (Ferguson, 2004). These types of freedom have brought enormous changes to societies, mainly for the poorest parts of the world. For example, Ferguson (2004) indicates that after 1990s the global gulf between rich and poor has grown, with the richest 1% now having as much income as the poorest 57%. Poverty and its consequent social problems including immigration, social exclusion, human trafficking, are now pervasive problems in the EU. Moreover, it seems that new policies emerge with supposed neutral ideological starting points which, however, foment neo-liberalism. For example, Ferguson (2004) argues that the political movement of the New Labour in UK embraced the neo-liberal economic value of the free market and led social policy to be shaped by the priorities of marketisation and managerialism. In fact, Meagher and Parton (2004) argue that managerialism has risen to dominance in most advanced liberal societies in the Western world, particularly North America, UK and Australia. Due to managerialism, social work interventions are less likely to be open-ended or therapy oriented.

Crucially they are separated from recognizing social conditions as key obstacles for change or well-being (Gibbs, 2001; Clark 2000; Banks, 1998).

Greece is also affected by globalization not only due to its nature, but also because Greek governments welcomed neo-liberal policies. Another key determinant in the national policy of Greece is its membership in EU. Nevertheless, despite the promoted reforms for the Europeanization of the welfare state, it is argued that the fundamental structure of the Greek welfare remained comparably stable due to local realities (Yfantopoulos, 2004; Sotiropoulos, 2003).

Social work has a deeply contextual nature as it is engaged to promote social justice and social change; therefore, the focus of the social workers becomes one of changing the environment, or aspects of it (Bowles *et al.*, 2006). Political awareness enables social workers to recognise the contextual factors that determine social work's ability to bring about structural changes. Furthermore, it appears that when social workers are able to perceive their practice contextually, then they are able to deal with disappointment or frustration when they encounter needs that cannot be met due to structural obstacles. In fact, Sen (1999) argues that individual's abilities are not sufficient to bring structural changes since social systems exert a powerful control over an individual's freedom to influence the world.

Interestingly, Preston-Shoot (2003) argues that when social workers meet with inadequate policies, features of their practice emerge that could be seen as side effects which increasingly dissolve the human and ethical character of social services. Ethical compromise, for example, is one consequence of this process. Preston-Shoot (2003) argues that in the face of these challenges social workers should be trained to adopt a political role by maintaining knowledge, ethical commitments and skills.

3.1.2 Politics and social work ethics

Values and ethics function as a guide for social workers giving specific meaning to the human and social well-being for which they strive. Therefore, the elaboration of social work values and ethics enables the specification of professional purposes, and moreover, they are a basic part of social work identity. Ethical awareness, as a professional and/or personal skill, is thought to enable social workers to answer the question "*who receives the benefit of social work practice*" as

a mechanism to evaluate practice, and defend social work's humanitarian character (Bowles *et al.*, 2006; Feather, 2002; Clark, 2000; Fritzsche, 1995).

Authors who are concerned with social work ethics indicate that they should be perceived as intimately connected with politics especially in relation to the structural objectives of the profession (Banks, 2008; Bowles *et al.*, 2006; Maeckelberghe, 2004; Meagher and Parton, 2004; Clark, 2000; Healy, 2000). However, notions such as the "*ethical aware practitioner*" often tend to focus on the individual practitioner rather than their ability to act on given structures. In this way, social work ethics are decontextualized, and then, instead of being activated as the base of social work's activity they remain as "*mental abstractions*" (Banks, 2008; Clark, 2000). However, it is also suggested that without emphasizing the role of social workers as moral agents, they become technical agents of the welfare state and they are prone to adhere to unethical structures and policies (McBeath and Webb, 2002). In short, it seems that values and ethics provide the moral worth of social work practice, including political action. This means that unless social workers operate from an ethical base, they are liable to seek social change by following a demagogue advocating ideas unrelated to the social work's fundamental values of social justice and human rights (Beck, 1959).

Banks (2008) argues that in social work literature there are no apparent linkages between social work and politics. This argument is also reinforced by the fact that the majority of studies on social work ethics that were reviewed appeared to be concerned only with micro-level social work interventions. Similarly, Payne (1999) argues that social work avoids embracing political, economic, or aesthetic values, probably to attain scientific status. Nevertheless, since social work is a profession constructed through legislative decisions it cannot exclude itself from political discourse by staying artificially politically neutral. In this sense, ethical social work practice should not be seen solely as a disposition to act ethically, but crucially it must involve opposing dominant policies that are inimical to good ethical outcomes (Bowles *et al.*, 2006).

Stipulated policies or organizational regulations cannot provide social work, a moral activity, with the ethical justifications for its actions. Social workers are, however, called to respond to social justice even though there is no general agreement on these fundamental concepts (Briskman, 2001). Thus, to respond adequately social workers should be able to articulate a clear vision of what is perceived as "*social good*", and embrace its responsibility to have a clear ideological

stance. The approach which places social justice as the leading value and aim of social work practice is critical practice.

3.2 Critical practice and social work

Critical practice originates from radical and structural traditions that provide the perspective that social, political and economical structures influences human behavior. Therefore, human suffering could only be understood within specific contexts. In addition, critical practice is underpinned with social theories that emphasize that society does not exist in an unchanging or slowly changing social order, but that it evolves or may be subject to revolutions (Payne *et al.*, 2002). This is why the main characteristic of critical practice offers the prospect of transformation by not being bound by the status quo (Payne *et al.*, 2002). According to critical theories, human beings may act to change general social forms by the use of power. Power for critical theorists is used both for the maintaining the status quo in the face of a threat of change but also is a means of change. In fact, Webb (2001) argues that change is about producing conditions, effects and situations different to the status quo.

Thinking critically is a way of thinking that enables practitioners to uncover the hidden assumptions and the ideological underpinnings of human activity, as well as the collective representations of the world. The essential elements of critical thinking include: reflectivity, openness, understanding and exploring language, considering the content of our judgments and questioning ideology. Through this process practitioners are able to make structural connections between individual behaviour and the wider contexts where humans act (Payne *et al.*, 2002). In particular, reflectivity is the ability of a person to analyse and understand others' experiences and influences (Miehls and Moffatt, 2000). This means that all people can change through the experience of others' meanings and ideas. Moreover, through reflectivity a person has a better understanding of himself or herself in relation to the prevailing social situation. Consequently, practitioners are better able analyse people's problems by viewing them in the appropriate context. Crucially this process entails the recognition of the taken-for-granted beliefs that are transmitted from generation to generation and internalized through early socialization within a particular cultural context. Due to their nature, sociocultural beliefs tend to be persistent and resistant to change. Therefore, they must be understood if social change is within social work's scope of action (O'Sullivan, 1999).

Overall, critical social work practice means a continuous and thoughtful consideration of the ways that our everyday actions are part of continuing streams of either social change or stability (Payne *et al.*, 2002). This questioning approach leads to critical action which is about making change efforts from within organisations. Initially, when social workers transform understandings by making them critical, they become relocated in their wider context. Subsequently, understandings are revisited continually. This process advances the potential for social workers to discover oppressive features, and then develop an emancipatory and empowering potential for their actions. This is integral to continuing critical action (Payne *et al.*, 2002).

It has emerged that critical practice is concerned with human emancipation, which means liberating people from whatever causes them to suffer unnecessarily (O'Neill, 2005). According to critical theories, unnecessary suffering is caused by the social, political and economic structures that create and reproduce inequalities between groups. These structures are oppressive as some people enjoy greater liberties than others in their effort to realize their full human potential. Emancipatory practice guides people to recognise their oppression and its causes so empowering them to liberate themselves (O'Neill, 2005; Payne *et al.*, 2002). Thus, the aim of critical practice could be defined as the pursuit of just social arrangements as represented by the value of social justice (Clark, 2000).

The following section is a discussion about the relevant values of critical social work practice. It focuses specifically on social justice, which could be seen as both the aim and the core value of critical practice. As a large and complex aim and value, social justice is discussed in relation to its consequent values, such as equality and human rights, which are often seen as emphasizing individuality (Clark, 2000).

3.2.1 Critical practice and its values

Critical practice does not necessarily encompass a different set of values and ethics than those prescribed in the ethical documents of social work. However, it highlights the importance of particular sets of values and leads social work to critically think about its ethical engagements (Dominelli, 2002). One of its most important characteristics is that critical practice places values and ethics in context to enable their meaningful implementation in everyday practice. Critical practice challenges individualization given it usually neglects that individuals are part of wider groups. In this sense, ethics such as self-determination can be perceived as an inappropriate

ethic when related to specific cultural contexts where individuals' problems are collectively sanctioned (Healy, 2007).

Another important characteristic of critical practice is that it appreciates the political nature of values. Therefore, understanding power relationships enables more empowering forms of practice, which is also one of the main targets for critical practice. However, empowering social works' clients can also be an ethical challenge for practitioners especially when clients can exercise their authority over the more vulnerable, (e.g. domestic violence cases) (Dominelli, 2002).

For Dominelli (2002) promoting social justice constitutes the key difference between traditional practitioners and critical ones. There is, however, an inherent ambiguity in the way that social justice can be defined. This is because there is a tension between collectivity, emphasized by social justice, and individuality which is emphasized by human rights. However, as Clark (2002) argues, human rights and social justice are not necessarily opposed as ultimately "*justice can be defined precisely as the satisfaction of rights, and the satisfaction of rights as the necessary outcome of truly just social arrangements*" (pp.39).

This tension is best addressed when individuals are understood as citizens (Clark, 2002). Citizenship suggests that all individuals should be considered as equally entitled to rights and duties as supported, enmeshed and realised by society. It requires citizens to recognise each other as mutually obligated and equally responsible (Clark, 2002). However, citizenship does not end with formal legal provisions and duties. The identity of humans as citizens aims to abolish private relations of domination, and therefore support the functions needed for individual autonomy and prosperity. Furthermore, citizenship encourages real participation of all people in the decisions that govern their lives, which is actually one of the main components of social justice (Solas, 2008).

However, social work's identity has been commonly characterized as "*ambiguous*", its role in the promotion of social justice questioned and its effectiveness lacking evidence. At the same time, there are others who argue that social work is a victim of an inhuman political and economical system, which systematically structures an unjust society to undermine human rights. Ironically, social work as a part of the political mechanism is obligated to contribute to this (Dominelli, 2002; Banks, 2001; Clark, 2000). In addition, ethical dilemmas are compounded by legal, organizational

and practice requirements that further constrain the practitioners. Consequently, social control is an intrinsic part of the social work identity, and this is a paradox especially when social work is considered as an agent of social change (Rossiter, 2001).

Rossiter (2001) argues that it is not easy for social workers to be sure how their role supports or challenges social structures. She suggests that social workers should continuously try to recognize the ways in which they participate in the formation and the reproduction of oppression. She argues that social workers should be critically examining their practice to evaluate its consequences by questioning whether social work has a place for “*ethical innocence*”. Although this questioning is genuinely ethical, its answer necessitates political awareness.

Similarly, Briskman (2001) challenges the ethical code of IFSW by arguing that this code does not help social workers to determine whether they must practise by pursuing the best possible “*good*” or contrarily by pursuing the target of the least possible damage. In ethical terms, if social workers must pursue the best possible “*good*” then they must challenge social stability imposed by those who have the power. Acknowledging the division of society into powerful and powerless leads to the conclusion that structures are imposed by those who have the power to marginalize and oppress. If this is true, then social workers should ensure that these competitive social systems have a voice in the public domain, and engage in social activism to empower those who can bring about structural changes.

Critical theorists argue that social work values and ethics should be regarded only in conjunction with political theory and knowledge on social relationships in macro-social structures (Meagher and Parton, 2004). For example, the ethic of care challenges the image of the autonomous person who pursues or masters an independent life as opposed to interdependence. In addition, it provides a framework for challenging de-humanization of social services by recognizing the essential role of emotional commitment to the relationship between social workers and their clients. However, the ethic of care can also be used for the promotion of policies that encourages domiciliary care over services provided by the state (Kirkpatrick, 2006). Therefore, the ethical analysis of care possibly helps to understand micro level relationships and decisions, but from a critical perspective it does not explain the ethics of macro level practice.

Critical practice has also encompassed critical reflection as a transformative learning process that aims to prepare practitioners to challenge and change dominant power relations and structures (Morley, 2007). Reflective practice enables practitioners to improve their practice by understanding and learning to articulate the theories, the unquestioned values and norms that inform their practice. The combination of critical theories and reflection raises practitioners' awareness about the political dimensions and processes implied in the construction of knowledge. Moreover, the purpose of critical reflection is to analyze, resist and change constructed power relations, structures and ways of thinking (Osmond and Darlington, 2005).

Critical reflection is attuned with the commitment of critical social work practice to social change, social justice, and anti-oppressive practice as it enables practitioners to appreciate the political and social context of their clients' experiences. Moreover, it enables practitioners to gain insight into how their own values and beliefs may contribute to dominant power relations and therefore to the oppression of vulnerable people. This is highly important for social workers in terms of their ambiguous role (see also sections: 2.2, pp.29; 3.1.1, pp.76). In this respect, Morley (2007) argues that critical reflection minimizes the potentially unintentional contradictions between social workers' practice and their emancipatory intentions.

Conclusion

Political practice was always the neglected side of social work intervention (Gibelman, 1999; Payne, 1999; Figueira- McDonough, 1993). It appears that this was reinforced by stereotypes in relation to what constitutes a scientific status and the image of a caring profession. Payne (1999) argues that science is believed to be a value-free activity. As such, social workers excluded themselves from the political discourse, staying artificially political neutral; to attain scientific status. Furthermore, Dudziak (2002) argues that humans are educated to believe that conflict is a negative value and should be avoided as it may detract from the image of a "caring" and "positive" social worker. As Figueira-McDonough (1993) argues, even in countries where welfare policy is most advanced and social workers have gained considerable recognition as service deliverers, their presence at the level of policy development and program leadership is hardly recognized.

Nevertheless, social justice has always been a leading value for the social work profession. In response to this objective, social workers should be equipped to build a clear conception of

justice against which to compare the prevailing situation. However, ethical analysis alone is not adequate for progression towards social justice, its implementation requires a commitment to policy practice that includes policy analysis and social action.

Critical practice emerges as an important approach to social work as it also identifies the profession as promoting greater social equality and interventions beyond the personal level (Payne *et.al.*, 2002). Furthermore, the critical analysis of social work ethics uncovers the ambiguities in social work due to a framework of structured inequalities and social injustice in which the profession operates (Rossiter, 2001). To this end, the contribution of critical reflection appears to be paramount.

Values associated with a critical social work practice can shape progressive action which is committed to understanding power, inequality, and the subjective experience of well-being. Macro political values associated with socio-economic understandings of social policy, such as redistribution of resources, is critical theory's contribution to the construction of the morally active practitioner. In this sense, ethical social work practice is about social workers becoming ethical activists. This means social workers actively challenging the structures that do not support human well-being (Bowles *et.al.*, 2006).

Chapter 4

Study Design

Introduction

The central aim of this study was to explore the role of social work ethics in Greece by looking at the case of social work practice in the Social Services Departments (SSD) of public hospitals. In particular, the focus of this study was to depict the role of ethics in the formation of what social workers perceived as ethically difficult situations and the consequent decisions they made. In addition, the role of ethics in the formation of the social work identity and the ideal or “good” social worker was also of interest to further understand how ethics are involved in the evaluative process of practice. As noted in previous chapters, social work ethics in Greece is an under researched area.

To reiterate, the following questions were developed to focus on social work ethics in public Greek hospitals:

1. How do Greek social workers conceptualise ethics and their relationship with professional practice (e.g. social work code of ethics)?
2. What is the relationship between values and ethical principles and how do they inform the practice behaviour of Greek social workers?
3. What is the Greek social worker’s experience of ethical dilemmas and the ethical decision-making process?
4. How do Greek social workers perceive ethics as contributing to good social work and/or the evaluation of practice?

In order to adapt these questions to the Greek context of social work practice, the word “*ethics*” was replaced with “*deontology*”. According to Banks (2003) the usage of the word “*deontology*” instead of “*ethics*” is typical for some southern European countries. Furthermore, the exact Greek translation of “*ethics*” is too abstract and has no reference to ethical rules of professional practice. Instead, “*deontology*” is a word that is used in social work education and is commonly known among professionals, and essentially refers to what is understood as social work practice ethics. For example, Greece uses the term “*deontological code*” instead of “*ethical code*” of practice.

Additionally, the term “*ethical decision-making*” is absent in the Greek social work literature, and there are no translated papers or books describing this term as a specific professional process. However, it is generally agreed that all social work practice involves decisions inherent with ethical dilemmas that are managed, although not prescribed as in professional terminology (Reamer, 1982). It was anticipated, therefore, that descriptions of what Greek social workers determined as ethical dilemmas or issues would likely give meaning to what the UK and US social work literature define as ethical decision-making. The specific questions of this study were formed because I agree with the important argument of Shaw and Gould (2001): “*social work is a practical moral activity and, as such, its judgments and rationalities need to be explored and debated (p.113)*”. In fact, there is agreement in literature that social workers practice among conflicting interests, and as such complicated ethical dilemmas are common in every day social work practice (IFSW, 2005; Rossiter, 2001; Briskman, 2001; Clark, 2000). Therefore, the moral agency of social work is currently emerging as necessity for the profession to challenge ideologies and/or the practice realities such as the managerial ethos and bureaucracy that leads the profession to fragmentation (Banks, 2008; Jansson and Dodd, 1998). In addition, social work education in Greek universities has given little attention to ethics while there is a complete absence of social work literature on ethics relevant to the Greek context.

4.1 Qualitative research methods and the case study approach

A positivistic approach to research assumes that factors that construct social reality can be controlled, therefore can be quantitatively measured. Ideas, speculations and philosophical thinking can be appreciated only if they can be tested through the empirical examination. Consequently, positivist researchers separate themselves from the world they study, and more importantly they believe that quantitative methodologies can be designed in a way that research questions, data and its analysis can be formed in a value-free way (Healy and Perry, 2000). In addition, for the proponents of positivism social reality is single, tangible and can be observed as separate phenomena which are produced by specific and measurable causes. The positivistic approach also assumes that the relationship between causes and effects of social phenomena is clear (Frey, 1994).

In contrast, interpretivism holds that truth is a particular belief system held in a particular context. For interpretivists actions are oriented not in any mechanistic fashion of stimulus and response, but actors interpret and give meaning both to their own and to others’ behaviour. In this sense,

researching this constructed reality depends on interactions between interviewer and respondent, and therefore, the interviewer is perceived as one of the study's participants (Hughes and Sharrock, 1990). The interpretivistic position is that reality is complex and uncontrollable and that knowledge is not universal, and therefore must be viewed as situational and context specific (Gibbs, 2001).

Interpretivism is more interested in discovering and understanding how people perceive and experience the world on an internal subjective basis. In this sense, they believe that social reality cannot be fully understood without the subjective interpretations of reality (Rubin and Babbie, 2001; Healy and Perry, 2000; Hughes and Sharrock, 1990). Although positivistic approaches attained a dominant position especially after 1990's when evidence-based practice emerged, qualitative approaches remain important especially for those studies in which attitudes and behaviors can be best understood within their natural settings (Rubin and Babbie, 2001).

The study design of this thesis was directed by the interpretivist paradigm which privileges qualitative methods because these methods are more likely to capture multiple realities, human meanings and group interactions from the participants' perspective. More specifically, social workers were provided with the opportunity to define, for themselves, the real context in which ethics and values brought meaning to their professional practice. The findings of this thesis are also perceived as an idiographic interpretation of the reality of a small group of social workers who practice in a specific cultural, political and organizational context. In this sense, it is not anticipated that the findings of this thesis can produce time and context-free generalizations.

Qualitative research methods have developed from the perception that human social behavior is always imbued with values. Therefore, a particular historical society cannot be reliably known when the researcher isolates ideas, feelings or social purposes as does not present and reveal the complexities of social reality. In this sense, objectivity for qualitative researchers is not accomplished by researcher efforts to remain out of the specific context. Contrarily, researchers try to enmesh themselves into the context to allow research facts or truths (Hughes and Sharrock, 1990).

Qualitative studies are oriented from interpretivism and the naturalistic paradigm which emphasize the difference between the human beings and the objects of natural sciences, and asks for the study of meaningful social action. Shakespeare *et al.* (1993) suggest that this

involves more than observing the social world; it requires interaction with the social world. In fact, they propose that the researcher must be part of the process, and needs to understand the symbolic nature of social action in the search for meaning. Therefore, in qualitative studies there is a strong emphasis on the detailed description of social settings, events, and individuals as qualitative researchers reinforce that social behaviour can only be understood in relationship to the context. Another characteristic of qualitative studies is that they use multiple methods such as interviewing, observing, and gathering documents. In qualitative studies social phenomena are seen holistically and the research questions are formed progressively according to the interactive process between the researcher and participants (Rossman and Rallis, 2002).

In this study I wanted to describe the simultaneous interaction of many factors that shape ethics and social work practice in Greek public hospitals. Therefore, studying the interdependence between social workers and their environment was seen as a necessary condition for meeting the goals of this study. In this sense, the exploration of the political, cultural and organizational context of social work practice in Greece, described in section 2.3 (pp.54) was extremely important in order to understand the meaning of social work ethical dilemmas as an aspect of the social work reality in Greece. Importantly, empirical data was also obtained from social work academics and the HASW which are significant parts of the social work context in Greece.

Furthermore, if social work ethics have something important to say about resolving difficult practice situations then ethics should answer what practitioners ought to do, but in reference to the concrete and real situations that social work is practised. Therefore, the role of the researcher is to highlight the specific context and the relevant factors that create difficult ethical considerations for social workers. In other words, a study on social work ethics should appreciate the nature of the settings in which ethical dilemmas and issues arise. The contribution of case study research is that it permits social work ethics to be understood contextually, to reveal practice realities and to obtain a more realistic perspective of professional practice.

Qualitative methodology at this point recognizes and breaks the artificial borders that separate the moral, from the social, cultural, political and the personal. Processes such as ethical decision-making should not be considered as a straightforward application of a prescribed formula, but rather as a process that is sensitive to particular situations and processes where human creativity is involved in handling moral problems (Hoffmaster, 1992). Qualitative data can reveal what theoretically this thesis supported - that values and ethics are inherent in social work practice

even when ethical language is not used (Taylor, 2006; Seedhouse, 2005; Goldenberg, 2005; Adams *et al.* 2002; Everitt and Hardiker, 1996; Schon, 1987).

It was also anticipated that participants' depth descriptions in semi-structured interviews would give them space to articulate ideas and concepts that, under a different set of rules, might never be shared. When the study population is perceived as vulnerable, this also takes on an ethical dimension which constitutes an ethical responsibility for the researcher to create a path by which vulnerable people will be heard in the public domain. Although social workers are rarely characterized as a vulnerable population, this study provided them with an opportunity to speak about their reality in their own words. In addition, the analysis of the Greek social work journal showed that practical issues related to practice were rarely published. Additionally, the studies reviewed from English journals were not relevant to Greek context. Therefore, it was very important that through this study Greek social workers had the opportunity to articulate their thinking about their own experiences. As Shaw and Gould (2001) state:

... qualitative research can support values of decreasing inequalities and increasing life chances of all citizens by documenting inequalities in lives and analyzing precisely how social structures and social policies enhance and restrict opportunities for individuals and group (p.15).

Brody (1993) also supports the importance of empirical studies in bioethics and medicine. He indicates that by discovering the ethical issues that actually arise in practice, a moral evaluation of ethical policies may be enabled. In reference to social work ethics in health care, Jansson and Dodd (1998) argue that in contrast with the extensive theoretical social work literature on ethics, scant empirical research has been conducted on ethical issues since 1980. In addition, they stress the importance of contextual factors that affect the ethical deliberations of social workers. They argue that researchers should analyze the extent that ethical decision-making process is influenced by organizational factors, and that the examination of specific factors that encourage or discourage ethical deliberations is crucially important. Although, these authors do not support the absolute use of qualitative research methods in social work ethics, their identification of the importance of contextual factors make qualitative methods relevant for this study.

Qualitative studies have long been criticized because of their focus to intense empiricism and overly interpretative analysis of data which cannot easily be accounted as "evidence". However, as applied social work ethics in Greek public hospitals had not been previously explored, a

qualitative study would enable the identification of relevant variables or questions that need exploring. In contrast, positivistic methods which test and explore predetermined variables or hypothesis would already have an inherent bias towards personal thinking or interpretations of the researcher (Conley and O'Barr, 1990).

This study adopted a single case design in which the case was the practice of social workers in public hospitals in Greece. Similar to other qualitative studies, case studies are more likely to be appropriate for "how" and "why" questions. However, there are no research questions typical to case studies as they do not favor any particular form of data (quantitative versus qualitative). A case study is a research approach that explores a contemporary phenomenon within its real-life context usually using multiple sources of evidence. The exploration of the complex interactions between the phenomenon under study and its context often necessitates the usage of multiple sources of data and the exploration of multiple units of analysis (Yin, 1993). In addition, a case study emphasizes detailed contextual analysis of a limited number of events or conditions and their relationships (Soy, 1996). Fieldwork is carried out in targeted fashion by focusing on the evidence deemed relevant and within a time-limited fashion (Yin, 1993).

There is one basic set of research designs for case studies: single case studies and multiple-case studies (Yin, 1993). In single case studies there is one unit of analysis. However, within the single case may still be incorporated subunits of analysis, so that a more complex or embedded design is developed (Yin, 1993). The subunits can often enhance the insights into the single case. Three rationales can justify the usage of a single case design. First is when the research question is to confirm or extent a clear set of theoretical propositions. In this way, a single case is chosen which meets all of the conditions for testing the theory. A second rationale for a single case is where the case represents an extreme or unique case. The third rationale for a single case is where the case serves a revelatory purpose. This means that the purpose of the study is to provide insights into a phenomenon or a situation previously inaccessible to scientific observation. The case study is therefore worth conducting because the descriptive information alone will be revelatory (Yin, 1993).

To summarize, the purpose of this study was to obtain a deep understanding of the meaning of ethics and ethical dilemmas in social work practiced in public hospitals in Greece. It was also argued that both social work practice and ethics are socially constructed and situated in the historical, political, social and cultural context. Therefore, this study adopted a case study design

to explore social work ethical dilemmas in relation to the contextual factors that construct the reality of social work practice in Greek hospitals. In this respect, the description of the Greek context, mainly presented in section 2.3 (pp.54), is extremely important so that ethical dilemmas can be understood in terms of this particular social work context.

4.1.1 Data collection methods and a case study approach

Case studies usually use multiple methods for data collection. In this study I chose interviews and the analysis of documents (Yin, 1993). Specifically, the primary source of data were interviews with practitioners, academics, and a retired hospital practitioner who was now a representative member of the HASW. These latter participants were included to shed light on the interrelated activities that influence the ways that hospital social workers perceive and behave when faced with ethical dilemmas (Yin, 1993). The purpose of this data collection choice was to view social workers' practice experiences, specifically where the ethics and values of the profession are actually realized and take on a concrete meaning. I anticipated that this understanding would be best obtained through detailed descriptions of the social workers' experiences. The variation between how social workers perceive ethics, and the nature of the relationship between social work and its ethics were main research concern. For this purpose, a design based on the principles of qualitative methods and the usage of semi-structured in-depth interviews was believed as most appropriate.

Another issue related to the research focus was also the notion of "*good*" social work practice. Since this notion has a variety of elements which are rarely made concrete and are not easily measured, and interpreted differently by the variety of theories and ideologies, this study supported this idea by avoiding "*good*" social work practice as a static and universally common combination of elements. In short, I tried to understand "*good*" as a socially constructed notion, containing a variety of elements and relationships among them, and related to beliefs situated in specific social, cultural and personal contexts (Fook and Askeland, 2007).

Therefore, semi structured in-depth interviews were used to be able to deeply understand the role of ethics in the concrete context of practice, and the participants perceptions of "*good*" social work practice. As social work is often characterized as a contextual profession, the qualitative approach and its methods fully acknowledge the contextual character of the profession (Bowles *et al.*, 2006).

Data was also collected through a review of the Greek social work journal “Social Work” which is published by the HASW. I decided to review the journal because this is the only existing scientific publication for social workers in Greece, and the majority of its articles are written by social work practitioners or academics in Greece. Furthermore, HASW is the official and the only existing association which represents the body of social workers in Greece. “Social Work” is available through the HASW on university libraries. It is not available electronically.

4.2 Ethical considerations

Ethical issues are an inherent part of conducting a research, especially regarding the relationship between researchers and participants. Ethical considerations were thoughtfully examined at all stages of this study by following the ethical guidelines provided by the Ethics Committee of Brunel University who also granted approval for this study. For the interviews no formal ethical approval was received from the Greek participants as ethics committees are not the norm there. Approval and consent was obtained from larger organizations, and when not necessary, from individual participants.

An information sheet describing the research aims, expectations of participation, and the process of the study was provided to all prospective participants (Appendix 2). Participants were also provided with a copy of the approval letter by the Ethics Committee of Brunel University (Appendix 7). Written consent was also obtained from each participant that formed the basis of the initial agreement between the participant and the researcher (Appendix 3). All letters provided to the interviewees were in Greek which was their fluent language.

Interviews were conducted at the participant’s place of work. Private rooms to hold the interview were chosen by the participant. The interviews were audio taped and later transcribed, and these materials along with the consent forms were stored in a locked filing cabinet. Computer files were stored on a password-protected personal computer.

I reassured all participants that the aim of the study was not to make judgments on their practice, but rather to depict the reality of their practice. The researcher maintained a non-judgemental attitude and demonstrated respect for each participant. No pressure was exerted on participants to reveal something they do not want to communicate. The anonymity of participants was also kept to ensure against any harm to their personal or professional reputation. I occasionally

expressed personal opinions, but thoughtfully and with care as this could possibly exert psychological pressure to participants. None of the participants declared being psychologically pressured or deceived.

4.3 The sample

Qualitative studies such as this, which stress in-depth investigation in a particular context, typically use purposive sampling. In this sampling strategy the credibility and accountability of the study is not based on the sample's size as the goal is depth as opposed to breadth. Therefore, the sample is sufficient enough when the researcher judges that s/he has reached the required depth or situation. Furthermore, in purposive sampling the sample is composed of participants who can provide the rich information necessary for the purpose of the study and meet identified criteria of interest (Bailey, 2007).

My initial target was to complete at least twenty interviews with hospital social workers. However, I had great difficulty obtaining letters of approval from hospitals, and I finally stopped at fourteen because at this stage no further new themes appeared to be emerging. I also determined that an exploration of social work academic's accounts of ethics and as those of the HASW would allow a deeper understanding of ethics in social work practice as hospital participants continuously made reference to their education and professional association. Therefore, I decided to supplement my data with a group interview with university-based social work academics, and one interview with a member of the Hellenic Association of Social Workers (HASW).

The focus of the data obtained by the interview with the representative of HASW was on issues that had already emerged from the interviews with the hospital social workers, but also to explore HASW's contribution to the promotion of social work ethics in professional practice. It is worth noting that the representative of HASW was very active in the association, and had several years experience in hospital practice. In addition, I reviewed the journal of the HASW in order to examine how the HASW and social work practitioners encounter ethical issues through the Greek social work literature.

My purpose of the group interview with the social work academics was to examine the ethical dilemmas that they or their students faced in their practice. For example, I was interested in

knowing how the academics managed ethical issues that students experienced in practice learning.

Purposive sampling was used in order to ensure that all hospital social workers had obtained a BA in social work, and had a minimum of one year postgraduate work experience. For the social work academics, each participant had obtained a higher education qualification and had to be supervising students in practice settings. To ensure that this group interview would not be biased by hierarchical power and lessen the possible consequences of disclosing of personal experiences, participants had similar job classifications.

4.3.1 Research sites

The hospital social workers who participated in this study were employed by six public hospitals which are all subjected to the structure and services prescribed by the National Health System of Greece. The social work academics were employed in the social work department of a Technological Institute (TEI), located in one city in Greece. The university was founded in 1983 and the social work department was formed in 1984. Every year approximately 130 students start their studies in the department. The education of the social workers lasts for four years, divided in eight semesters. The last semester is a full time practice in a social work placement. The department offers students only a BA degree and there are no MA programs. The Hellenic Association of Social Workers (HASW) is located in Athens, although it has regional committees in twenty four cities in Greece.

4.3.1.1 Athens

Athens is the capital of Greece having a population of more than 3,700,000 and is the largest city in the country. This constitutes 34.3% of the overall population of Greece (Iosifides *et al.*, 2007). Athens dominates Greece mainly because of its population size, the concentration of industry and the centralized administrative system. Iosifides *et al.* (2007) argue that Greece, and in particular Athens, was a mass immigration destination in the early 1990s. More than 800,000 immigrants live in Greece, although it is estimated that this number does not reflect the real figure as many immigrants avoid registering in the census.

Four of the six hospitals in this study were in Athens. Three of these hospitals were general hospitals with approximately 60-100 beds. They each employed one social worker. The fourth hospital in Athens was a 1000-bed child mental health hospital that provides both medical and psychiatric services to the public. This hospital employed ten social workers who primarily work in the psychiatric departments. Overall, five of the participants in this study were working in a hospital in Athens. The representative of the HASW had also worked in a hospital in Athens, and she was a member of the central committee of Athens².

4.3.1.2 Patra

Patra is the capital of the Prefecture of Achaia. It is one of the most important cities in Greece and it is the biggest city of Peloponnesus. It is the fourth biggest city in Greece after Athens, Piraeus, and Thessaloniki, with almost 160,000 people. Patra has the biggest harbor in West Greece and connects Greece with Italy and Peloponnesus with Ionian islands of Greece. Patra has two general public hospitals, one child hospital and one special hospital for pneumonic diseases. Patra is also a city that has many immigrants due to its harbour.

Two of the hospitals in this study are located in Patra. One is a university hospital with more than 1500 beds and twelve social workers. The final hospital is a 400 bed general hospital employing 8 social workers. Nine of the participants were employed in a hospital in Patra.

4.3.2 The participants

The current study focused mainly on social workers working in public Greek hospitals. As the qualitative design of this study permitted multiple sources of data, interviews with three social work academics and one interview with a representative of the HASW were also obtained in order to shed light on issues that emerged from the interviews with hospital social workers. Table 1 outlines the number of interviews held and the participating organizations³:

² Further description has been omitted to protect the identity of all participants.

³ Identified information of the sites was not shared in order to protect confidentiality and anonymity. All names of the organizations as well as of the interviewees appear as pseudonymous.

Table 1: Participating organizations and number of interviews (n=18)

Organisation	Number of Interviews
Giannis Hospital, Athens	1
Eleutheria Hospital, Athens	1
Kipseli Hospital, Athens	1
Pedeli Hospital, Athens	2
University Hospital, Patra	4
Agios Hospital, Patra	5
Association of Social Workers	1
Social Work Department, P University	3*

*Group interview

The characteristics of the hospital social workers are set out in Table 2. From these workers, ten of them were female and four were male. Seven of the participants declared that they were Managers of the Social Services Departments (SSD), however, four of them were also the only employed social worker in hospital. As there were no other social workers in hospital, the Administration typically conceives these social workers as managers of departments. Only three of the fourteen social workers had an MA degree in social work. However, social workers who worked in mental health departments, or in one case in the child mental health hospital, had complementary education in various psychotherapeutic approaches such as systemic, cognitive or psychodynamic psychotherapy. In particular, four out of fourteen social workers were working in the psychiatric departments of hospitals. However, two of them had previously had long experience practising social work in other physical medicine units of the same hospital. The mean age of the hospital social workers was forty three years old. The mean total years of social work experience of the hospital social workers was 14.4 years and the mean years of experience in the hospitals was 9.9 years.

Four of the hospital social workers were previously nurses working in the same hospitals where they now work as social workers. This is not surprising as it reflects a law in the public services in Greece which enables those who change careers and are already employed in a public organization to be automatically eligible for transfer to another department as long as they hold the appropriate degree. This fact reflects a multiform reality. First of all, employment in public organizations in Greece is always preferred because it offers stability and security (i.e. legalized

guaranteed employment). Second, the respondents conceived nursing as more difficult than social work. When I asked the social workers the reasons for a career change they mentioned the difficulties of working shifts as nurses, the heavy and intense workload, and the shortage of employed nurses in hospitals. In fact, all of the respondents decided to obtain a social work degree to be transferred to the SSD and promoted to a better job with better working conditions including the security guarantees of the public sector. Only one social worker described herself as an active member of the Hellenic Association of Social Workers; however eight of them were registered members of it.

Table 2: Characteristics of hospital social workers

Name	Gender	Age	Work Experience (Years)	Hospital Practice (Years)	Education	Job Title	Unit of Practice	HASW Member	Active member of HASW ⁴
Chara	Female	32	9	1	BA MA	Manager SSD	All units	NO	-
Rena	Female	45	21	18	BA	Manager SSD	General medicine Obstetrics	NO	NO
Aristos	Male	43	10	17	BA Training in psychotherapy	Social worker	Psychiatry	NO	NO
Giannis	Male	36	4	4	BA (social work) BA (nursing)	Social worker	Oncology Skin unit	YES	NO
Eleftheria	Female	38	14	6	BA	Social worker	Oncology Kidney unit	NO	-
Eleni	Female	46	24	14	BA Training in group work	Manager SSD	Psychiatry	YES	NO
Maria	Female	44	2	2	BA (social work) BA (nursing)	Social worker	General surgery Intensive Care Unit	NO	-
Alkistis	Female	43	2	2	BA (social work) BA (nursing)	Manager SSD	All units	YES	NO

⁴ Typically a non-active member of HASW is registered in order to receive the journal published by HASW. In contrast, active members of HASW usually are actively participants in HASW's activities, meetings and elections.

Name	Gender	Age	Work Experience (Years)	Hospital Practice (Years)	Education	Job Title	Unit of Practice	HASW Member	Active member of HASW
Lena	Female	56	32	32	BA (social work) Training in psychotherapy	Social worker	Psychiatry	YES	NO
Sotiris	Male	37	11	6	BA MA	Social worker	General surgery Intensive Care Unit	YES	NO
Tina	Female	37	14	11	BA Training in psychotherapy	Social worker	Psychiatry	YES	NO
Elpida	Female	45	8	8	BA (social work) BA (nursing)	Manager SSD	All units	NO	-
Periklis	Male	56	31	15	BA	Manager SSD	General medicine	YES	NO
Stiliani	Female	44	20	3	BA MA	Manager SSD	All units	YES	YES
Efi	Female	46	21	21	BA	Social worker	General medicine	YES	YES

The three social work academics that participated in the group interview were all female. Their mean age was 53 years. All of them were supervisors of social work students in various placements including community work in a Borough, police department, non -profit organizations for the provision of substance abuse and school placements. Two of them had a MA degree in Education with Adults and one of them had a BA in social work. Interestingly, none of them had research qualifications.

The representative of the HASW was a woman working in a public hospital. She was middle aged and had more than twelve years of activity in the Association. She had a BA degree in social work and twenty one years of experience working in one public hospital. She was a member of the Administration Board of the HASW and the journal "Social Work" which is HASW's publication. The Administration Board is elected every two years by the general meeting of HASW's members. Members of HASW must be qualified with a BA in social work and no further training is necessary for renewal of registration. At the time the interview was conducted Efi was an Administration Board member for eight years.

As there is no data describing the whole workforce of social workers in Greece, little can be determined with any certainty about possible linkages between the sample and the overall characteristics of Greek social workers. Nevertheless, all except one of the hospital social workers indicated that they had graduated from Greek Universities. The lone social worker had graduated from the American College in Greece. All of the academics and the representative of HASW were also graduates of the social work departments of Greek universities. Only five of the nineteen participants had a MA in social work and only 4 of the participants were male. Overall, the participants seemed to fit in the description of the typical social worker, described by Dedoussi *et al.* (2004) (section 2.3.1, pp.55). Specifically, the typical social worker in Greece is described as a woman working for more than 10 years in a health or social services. She is employed at staff grade with no prospects of promotion and she rarely attends scientific meetings as continuing education is not a requirement and rarely provided by employers.

4.4 Data Collection

To reiterate, there were four the main sources for the research data:

- 1) fourteen interviews with hospital social workers;
- 2) one interview with a member of the Hellenic Association of Social Workers;

- 3) one group interview with three social work academics; and
- 4) Examination of the articles of the journal "Social Work" published by the Hellenic Association of Social Workers (1990-2007).

The rationale for multiple sources of data was because qualitative methodology and the case study approach perceive reality as something that is formed by a simultaneous effect among various factors not orderly settled (Mason, 2004; Yin, 1993). Moreover, different data sources enabled an exploration of different parts of a phenomenon and provided opportunities for testing different explanations provided by the analysis of the data obtained from more than one resource (Mason, 2004; Yin, 1993). For example, in this study social work education emerged in the interviews of all hospital social workers, therefore the decision to obtain social work academics' accounts on ethics, and issues relevant to practice provide a deeper understanding of the ways that social work education affects practice. The interview of the representative of the HASW and the review of its journal allowed a better comprehension of ethics in practice as professional associations are primarily responsible for the promotion of ethics through their production of ethical literature and educational programs to enhance professional expertise.

Moreover, as this study was designed as a case study, the behavior of hospital social workers when faced with an ethical dilemma was explored by focusing on possible replications with social work education and the HASW (Yin, 1993). These replications were theoretically generated as social workers are educated on ethics during their training and one of the main responsibilities of social workers' associations is to promote ethical codes for the profession (Banks, 1998). Moreover, the ethical code constitutes an essential part of social work and the professionals can defend their practice on the ethical grounds endorsed by their profession.

4.4.1 Securing the sample

Initial communication with the hospitals in Greece began in January 2007. Public hospitals in Greece have no Research Ethics Committees, and there is no specific process for the management of research requests. As a result, my request for a letter indicating the hospital's approval that I recruit my sample from among their employees made some hospitals reluctant to participate. Interestingly, even though some of the social workers interviewed had participated in other research projects, they had never been requested to sign a consent form. This overall unfamiliarity with the processes associated with research ethics and resulting reluctance

impacted on the recruitment of the sample. In total, twenty hospitals were approached. In Patra, there was less concern regarding these matters. I approached two hospitals in Patra and both provided me with a letter of approval. In Athens, I approached fifteen public hospitals and received two letters of approval. With these four letters I started to collect my data. Two more were later received from hospitals in Athens and was able to pursue my work towards data collection.

In all cases I had an initial contact with the manager of the social services department of the hospitals from which I had received approval. In this meeting I introduced myself and the purpose of my study. I provided them with written information about my expectations of participation and requested a private room for the interviews. In one case the manager arranged for me to meet all of the social workers to directly introduce them to the study. In all other cases, managers allowed me to have individual contact with each social worker in their department. Information sheets and consent forms were provided on all occasions. Through this process I managed to conduct nine interviews from two hospitals in Patra, including two managers of the social services departments, and five interviews from four hospitals in Athens. Four of these social workers were also managers of the social services department.

In terms of the group interview with three academics from the social work faculty of the Greek university, there was no ethical procedure required. Thus individual verbal and written consents from the participants were sufficient to conduct the group interview. Voluntary consent forms were obtained and the group interview held in a private room at the university. I decided to approach one teacher who had more than thirty years of teaching experience plus experience in practising social work in settings including hospitals and welfare organizations. I asked her to suggest colleagues who may be interested in participating in the study. From the names she suggested I purposively chose two academics with many years of experience working as supervisors in student placements. Their views also had a special interest for me as they had executive roles in the division; therefore they had a broader view of all social work placements and supervisors of the division. In reference to the interview with member of HASW, I purposely chose to interview one member with a long working experience in a hospital setting. In particular, the participant had twenty one years of experience in a public hospital in Athens, and twelve years of experience as an active member of HASW.

I also approached the HASW to introduce myself and the study. I was directed to a member of the Administration Board of the Association who also had many years of experience practising social work in a hospital setting. As participation in the Association was voluntary, there was no ethics procedure required for members to participate in research, thus an individual verbal and written consent form was sufficient for me to hold the interview. The interview was held in a private room in the offices of the Association.

4.4.2 Pilot work

A pilot interview with a social worker from a psychiatric hospital in Greece was conducted prior to the final formation of the research questions. After this interview, a discussion on qualitative research interviewing was held with my supervisor and guidance was provided accordingly. As a result of this interview an improved list of interview questions emerged as well as more appropriate prompts. The pilot interview was not part of the final sample.

4.4.3 The interviews and reflections on them

The purpose of interviewing hospital social workers was to obtain an understanding of the ethically difficult situations of their daily practice. In addition, I wanted to outline the ways that values and ethics intervene in the evaluative process of practice. In reference to the interview with the representative of the HASW who was also a practitioner working in a public hospital, my purpose was to have her reflections on the issues that were elicited from the interviews with the hospital social workers. The purpose of the group interview with social work academics was to permit descriptions of the ethically difficult situations of their practice, and to explore social work education as a formational factor for the social work identity (Payne, 1997).

Data were collected through semi-structured in-depth interviews, of approximately one to two hours duration with each of fourteen hospital social workers and one member of the HASW. A group semi-structured in-depth interview was used with three social work academics lasting approximately two hours.

The hospital practitioner interviews were designed to elicit the participants' accounts of their social work practice, described in their own words, to capture the deep meaning of their own experiences (Marshall and Rossman, 1999). Social workers were asked to provide me with

descriptions of cases that they thought were difficult or ethical problematic. I typically used prompts to allow them to discuss their decisions in more depth. In addition, they were asked to provide descriptions of a “good” social worker and the ways that they evaluate their practice. In appendix 4 the interview schedule for hospital social workers is presented.

The interviews were characterized by warm and friendly interaction. As I am a social worker with experience of the context in Greece, the participants seemed at ease to engage with me in a dialogue about our profession. This may have also discouraged participants to discuss some issues in any detail as they may have assumed already knew a lot about their practice. I did, however, notice that during the interviews my enthusiasm to learn about their practice seemed to encourage participants to continue speaking. The order of the questioning was varied at times often where the participant wanted to start talking or when I wanted to bring to the interview something that the participant had said during our initial communication. Most interviews were concluded by a broad question asking them to highlight something that we had already said, or even something new that they felt would be important for me to know.

In some cases, participants asked me to provide them with a definition of “ethical dilemmas” prior to or at the beginning of our interview. In such cases, without giving a definition, I explained to them that the aim of the study was to depict the meaning of that term in real practice, and that I did not want to verify a theoretical term or to test their knowledge of theory. Moreover, during the interviews all proposed definitions by the interviewees were accepted and I let them reflect upon their own definitions.

The group interview with the three social work academics was held in a small seminar classroom in the school of social work. The interview was audio recorded and a similar schedule of questions was used (Appendix 5). I started the interview by asking them to describe for me what kind of ethical dilemmas or issues they encounter in their practice as social work academics, and then, I asked them to describe for me ethical dilemmas that their students bring to their attention. Although I started the interview with these questions, after only one description of a dilemma the discussion turned to the issue of whistle blowing. When elaborating on the initial dilemma the participants raised this issue they focused on it. Like focus groups, this seemed to be the result of the interaction between the participants which triggered their thinking (Shaw and Gould, 2001). I found two factors that appeared to contribute to the ease with which participants disclosed sensitive information relative to their practice. The first is that group interview allowed the

participants to function collectively and establish as a group the nature and the extent of a consensus around an issue (Shaw and Gould, 2001). The second was that I was a graduate from the social work department where the participants were employed. The participants and I were sharing a common identity of membership in a specific academic community, although in different roles. This fact constituted a kind of personal relationship and the characteristics of the researcher played an important role to the formation of the participants' behavior (Hammersley and Atkinson, 1995).

The interview with the representative of the HASW was conducted in a private room in its offices. I started the interview by asking the social worker to describe to me where she worked and her relationship with the HASW. I continued the interview by asking her about practice in relation to social work's ethics and values, and I asked her to reflect upon some issues that hospital social workers had raised. The interview lasted almost 2 hours. During the interview Efi commented that I was an "emotional type", and later she stated that our relationship had change into one at a "personal level". Efi's comment possibly indicated a possible emotional proximity with the researcher. Importantly, emotional proximity with the participants can be an essential part of qualitative inquiry as it indicates that the researcher has succeeded in building a relationship with participants to elicit delicate information about the internal operation of a particular group. However, researchers should be also cautious because participants may use emotional proximity to limit the observations and criticisms of the researcher (Hammersley and Atkinson, 1995).

In this study all interviewees had different roles as they were from three different groups (hospital social workers, social work academics, member of HASW). However, the issues that were discussed were the same. Thus, the differentiation of their roles provided different interpretations on issues and protected the validity of the findings.

4.5 Data analysis and management

All interviews were audio-taped. Individual interviews were all transcribed whilst for the group interview detailed notes were kept without the full transcription of the interview. The transcription was undertaken by the researcher and a second careful hearing of the tapes were undertaken to check the accuracy of transcription. Parts of the individual and group interviews were translated into English by the researcher whose fluent language is Greek. For checking the accuracy of translation into English one interview was given to an academic social worker whose fluent

language is Greek and has a ten years educational experience in a university in the US. A section of a transcript is provided in Appendix 8.

Data analysis is a process that enables the researcher to read the accumulated data that counts as evidence to the research questions. Although indexing or cataloguing data are often perceived as a practical necessity in order to sort and order data, it is not interpretatively neutral. This means that analysis is a process that provides constructions of meanings and explanations which are consistent and systematic as long as the underlying theories used for the interpretations are explicitly presented (Mason, 2004).

This study followed the principles of Yin (1993) for the development of a case description. In fact, rich qualitative data elicited by in-depth interviews were used to describe the nature of ethical dilemmas of social work practice in hospitals by highlighting the contextual factors involved. However, using theoretical frames as well as the different contexts involved (HASW and social work education) some general explanations are also provided in reference to the descriptions of the hospital social workers.

This section provides a description of the data analysis process of the interviews and the review of the social work journal of HASW. The following subsections detail the important aspects of the analysis including a description of Yin's approach on case study analysis, coding data and case study notes.

4.5.1 Empirical description and thematic analysis

The collection and analysis of the data followed the principles described by Yin (1993). In reference to the data collection these principles include: (a) using multiple sources of evidence; (b) creating a case study data base; and (c) maintaining a chain of evidence. For the data analysis, Yin (1993) argues that a general analytic strategy is needed prior data collection. The role of the general strategy is to help the researcher choose the most appropriate analytic techniques. In particular, this study followed a descriptive strategy of analysis since the focus of the study was to provide an in-depth description of the meaning of ethics and ethical dilemmas of the social workers. However, the descriptive insight along with multiple data sources helped to identify some causal links, patterns and interrelated themes. Since this study was designed as a case study the accounts of hospital social workers on ethics and ethical dilemmas were explored.

However, through the exploration of the broader context of social work (HASW and social work academics) a deeper understanding of the ways that social workers perceive their ethical commitments and ethical dilemmas was obtained (Yin, 1993). Causal links were also identified due to the usage of the descriptive approach. The descriptive insight enables deeper understanding of explanations that involve complex contextual realities and patterns that cannot be enumerated (Yin, 1993). As part of a general strategy Yin (1993) proposes three specific analytic techniques: pattern-matching, explanation-building, and time series. These techniques, however, are more relevant to the studies that are designed for hypothesis-testing and propositions. Instead, the analytic method used for this study was thematic analysis.

The identification of themes was one of the core purposes of data analysis. In fact, thematic analysis is appraised as a foundational method and widely used for the analysis of qualitative data (Braun and Clarke, 2006). Thematic analysis is the construction of themes that emerge from the stories of the participants and provide a comprehensive picture of their collective experience when linked together in a meaningful way (Aronson, 1994). Emerging themes and links between the sub-themes are essential for the holistic understanding of explanations provided by the rich qualitative data.

Interpretation is an essential part of qualitative studies by offering a new perspective gained after extended reflection. Its aim is to reveal complex issues rather than reducing them to simple explanation. Furthermore, interpretation is not only involved at the final stage of the study, but is also involved at the data collection and data analysis stages. Even the way that data is coded and the ways that the researcher decides what counts or not as evidence in the construction of meanings involves interpretations (Mason, 2004; Shakespeare *et al.*, 1993).

For this study, establishing credibility involved the efforts of the researcher to represent in the findings the meaning of the research issues provided by the particular participants. Furthering this, the aim of this study was not to locate universal truths rather to highlight the contrary, that truths are contextually formed and situated in factors that characterize the personality and the social / organizational context of the participants (Mason, 2004; Shakespeare *et al.*, 1993). Although generalization was not seen as the aim of this research, findings may provide a framework of ideas and considerations upon which people interested in social work practice and identity can reflect on their own social work practice.

4.5.2 Analyzing interview data

Analysis of individual in-depth interviews with hospital social workers included the identification of social workers' understandings and practices in ethically difficult situations, as well as the description of the evaluative criteria they used for their practice. From this process patterns of social work understandings and practice behavior emerged and are discussed in the following findings chapter. In addition, the nature of ethical dilemmas and problems were identified and described, as well as the examination of the relevant factors which may contribute to the development of ethically difficult situations. The analysis of the interview with the representative of the HASW was analyzed in the same way. Coding and keeping memos were assisted by the NVivo 7 software program. The rationale for using a software program was to assist in the indexing of the number of categories emerged by the data (Mason, 2004). In particular, the use of NVivo enabled the organization of the large amount of data obtained by the interviews. Furthermore, the storage of text in an organized database enabled comparisons within the data. From this process connecting relevant data segments to each other and forming categories were more efficiently addressed.

The process of the analysis of individual interviews began with the verbatim transcription and the repeated reading of the scripts which led to the identification of important themes. Some initial codes were generated through this process. Codes are the initial categories specific to segments of data that appeared to have relevance to the research questions. Coding the data continued more systematically by breaking down the transcribed interviews into small codes with the use of NVivo software. Through this process more than four hundred codes were constructed including a small number of codes initially created from the research questions. The use of NVivo enhanced comparison among the scripts, the identification of similar answers among the participants and important themes. Differences among the data were also identified and therefore sub-codes were created so as to maintain their distinguishing characteristics. Writing memos was an essential part of the data analysis. As the process of qualitative analysis involves considerations upon content rather than necessarily the frequency of a concept or an idea, memos functioned to enable me to remember and outline my personal reflections in reference to the meaning of data. In addition, by writing memos I was able to connect or make comparisons among codes of data (Mason, 2004). Codes were sorted into potential themes and I collated all the relevant coded data extracts within the identified themes (Braun and Clarke, 2006). The identified themes were defined, named and analysed in relation to the relevant research

questions. Building an overall picture of the data included the consideration of the ways that themes fit together. By returning to the contextualised data I verified whether the identified themes actually reflected the meanings evident in the data (Braun and Clarke, 2006). Finally, the data analysis involved the research narrative. Examples of the Greek hospital social workers' accounts were selected and presented so as to illustrate the arguments in relation to the research questions in this thesis (Braun and Clarke, 2006). The selected accounts were the ones that most clearly presented the theme for the reader.

For the analysis of the group interview with social work academics the data from the interview was selectively transcribed. General tensions and behaviors of academics toward some specific issues were identified and field notes were kept from the numerous audio hearings of the group interview. In contrast, all individual interviews were fully transcribed verbatim.

4.5.3 Analyzing the social work journal

The review of the journal started from the publishing year of 1990 to 2007. Notes and photocopies from journal articles relevant to my study were kept and analyzed accordingly. The review started from the year of 1990 as the researcher's background as a social work student in Greece and her previous familiarity with the journal helped her to assume that there are not many published articles relevant to the social work ethics. Each edition contains 4-10 theoretical and/or research articles. During this period, seventy editions were published and sixty seven were located. The journal is only available in paper copy and three editions were missing from the HASW or university library. Each article's title and abstract was reviewed using the following key words: ethics, values, ethical dilemmas, ethical decision, morality, moral judgment and human rights. With these key words only nine articles were identified (see Table 3). The review of the journal articles followed a thematic analysis in which the researcher was looking for themes relevant to social work ethics (Boyatzis, 1998).

As there were only nine articles detected being relevant to social work ethics an attentive and repeated reading was possible. Each article was analysed separately but no comparisons were made among them. The major focus of the document analysis was to detect and interpret thematic categories from the content of the articles. Therefore, small texts from the articles were copied or highlighted when necessary so as to understand the meaning of the articles. Particular attention was paid to the theories used from authors for addressing their topics. When these were

not explicit I was reading the references used so as to gain a sense of where the author is “coming from”.

Conclusion

This study was underpinned by the naturalistic paradigm and interpretation that suggests a specific way of thinking about how social reality can be understood and studied. Consequently, this thesis adopted a qualitative methodology. Particularly, this study was designed as a single case study and followed several commitments all relevant to qualitative case studies. One important commitment was to study the social work ethical dilemmas in a specific cultural, political and organizational context of a small group of social workers who all work in public hospitals in Greece. Therefore, purposive sampling was employed to ensure that all participants would share particular context realities.

In addition, as this study was underpinned by the naturalistic paradigm the aim of this study was not to produce generalizations or clear relationships between causes and effects. Contrarily, the focus of this study was to highlight the complexity of the ethical dilemmas that social workers face in their daily practice, and the simultaneous interaction of numerous factors that construct the ways that the social workers dealt with ethical dilemmas. However, the single case study design provided more focused fieldwork, and data from two other subunits of analysis (HASW and social work education) was collected to shed light on their influence on the ways that social workers perceive and behave towards their ethical dilemmas.

The usage of in-depth interviews in this study gave space to the participants’ voices to articulate with their own words how they perceive and experience their reality. The selection of in-depth interviewing was also in line with the basic aim of this study which was to explore the meaning, not the frequency, of the ethical dilemmas experienced by the particular group of social workers.

The collection and analysis of the data followed the principles described by Yin (1993). In particular, this study followed a descriptive strategy of analysis since the focus of the study was to provide an in-depth description of the meaning of ethics and ethical dilemmas of social workers. In this study there were four main sources of research data:

1. Fourteen interviews with hospital social workers;
2. One interview with a member of the Hellenic Association of Social Workers;
3. One group interview with three social work academics; and
4. Review and exploration of articles from the journal "Social Work" published by the Hellenic Association of Social Workers.

From these data a thematic analysis enabled the identification of the emerging themes, patterns and links between the different sources of data that altogether provided a meaningful understanding of social work ethics and ethical dilemmas in public hospitals in Greece. The process of data analysis, including verbatim transcription of the interviews, keeping memos and notes, was done with the assistance of the NVivo software program. This process enabled the construction of meanings and the revelation of patterns of social workers' behaviors and differences among them. In addition, one of the purposes of data analysis was to enable the presentation of social and organizational factors, and characteristics of the social workers.

This study was also designed in accordance with the guidelines of the Ethics Committee of Brunel University. This ensured that the dissemination of the results of this thesis will not harm any participant. All participants were voluntary and were fully informed of the aims of the study. Written consent was obtained from all participants, and approval letters from the administration boards of each public hospital.

The presentation of the findings that follow with the next two chapters is a systematic effort based on the naturalistic paradigm and case study approach to understand the ethical dilemmas of social workers who practice in public hospitals in Greece. In addition, the findings are presented to show how ethics play a part in what is perceived as "good" social work practice.

Chapter 5

Social Work Practice in Greek Public Hospitals: The meaning of ethics and ethical dilemmas

Introduction

Social work practitioners, through their daily practice, implicitly and explicitly promote specific values that underpin the role of the profession as it is defined internationally (IFSW, 2005). Unavoidably, this process also includes moral judgments, although not always conscious ones (O' Sullivan, 1999). Additionally, social workers practice with restricted professional autonomy given that they work within political, social and organizational systems that unavoidably structure their work.

Ongoing development within the social work profession signifies changes for both social and professional value systems as they are closely interlinked, but not necessarily the same. Therefore, a conflict in values is to be expected because each express different interests and needs (Clark, 2000). From this point of view, it is necessary to understand the social and cultural environment in which the professional social work is practised. In addition, values and ethics develop a strong underlying meaning as they are expressed through daily practice.

The purpose of this chapter is to present findings from the analysis of the interviews with hospital social workers. The representative of HASW that was interviewed spoke both as a member of the association and as a hospital social worker given her long working experience in a hospital. Therefore, her interview is included when relevant in this chapter. The chapter is grouped into three main sections. This chapter begins with the presentation of expressed values and ethics (i.e. instrumental values) that form the social work identity for these practitioners. Following is the review of the role of social work in these hospitals to demonstrate how these values are reflected in daily practice.

In the second section, described ethically problematic cases are presented to highlight the factors creating these problems and the subsequent decisions made by social workers. Ethical dilemmas are then explored where social workers acknowledged a conflict between two alternative choices to resolve a problem, that is, the conflict between two different values or ethical principles. The factors that social workers identified as obscuring the resolution of their ethically problematic

situations are also presented as they are crucial to the deeper understanding of their ethical decision-making process.

The third section explores the role of ethics in the formation of what social workers perceive as “good” social work practice, and describes the characteristics of “good” practice and the criteria used to evaluate it.

5.1 Values and the social work identity

Feather (2002) defines values as general beliefs about desirable actions and goals. Values are assumed to transcend situations and to vary in importance for each individual. They influence and justify particular types of positive or negative attitudes that an individual holds with regard to possible events and outcomes. In addition, all values are socially constructed and historically specific. And finally, professional values have been accepted by a recognized body of practitioners (Dominelli, 2002).

One of the more important functions of professional values is that they establish the identity of those who engage under a common professional identity (Sonnenberg, 2004; Banks, 1998). In fact, ethical codes describe social work aims through specific values that should be promoted by practitioners. Therefore, by focusing on social work values we build a more complete understanding of the identity and the nature of the profession as it is currently practised.

Many of the interviewed social workers identified specific values as being important components of their professional identity. These values were also often referred to throughout their descriptions of ethically difficult situations. As participants related these values to specific descriptions of their practice, I dealt with them as professional values. Nevertheless, I acknowledge that the values presented below only represent a few of those that underpin social work practice. Throughout other sections additional values are also presented as part of social workers’ ethical deliberations on cases.

5.1.1 Caring and protecting

The majority of the social workers acknowledged that their primary obligation was to help all individuals who were in need. For example, Maria⁵ made a specific reference to the ethic of care. She expressed that the ethic of care must be promoted so that its importance is recognised and reflected in the use of emotions by professionals. She emphasized that this was especially important when public services do not provide adequate treatment for clients. Specifically, Maria implied that offering services to clients also means serving with emotional involvement:

If you don't use your emotions and function coldly as a professional, and put your job security first, you will lose the game... in Greece... because you don't have the tools, I told you that before... there is no chance... the processes are so time-consuming The employees in the other departments can be insensitive to the social problem of a patient... I am speaking about patients because we are in a hospital... if you don't make efforts and if you don't try to change the attitudes of those people in the ways that they see the social problem of a patient, probably, nothing will be done for the patient's problem. (m.k, § 163)^{6,7,8}

Maria seemed to use the word “game” to express social work’s role to support clients. She also seemed to devalue emotionally detached professionals because she perceived emotional involvement in their jobs as a prerequisite of good professionalism.

For some social workers adherence to organizational rules was seen as unjustifiable practice, especially when these restricted patients’ benefits. For example, Alkistis indicated that to support an uninsured patient who had no money to pay for his medicines and medical tests, she illegally provided him with her own health insurance booklet so he could obtain free medical health care. The patient was an undocumented immigrant who was not eligible for health insurance and obligated to pay for his medical treatment irrespective of whether this was provided in a private or public hospital. Alkistis explained:

As a human being I have to see how I can help another human being... I even... do you know how many times I have written medical tests in my health insurance booklet for uninsured foreigners? But it was a matter of life or death, when a patient

⁵ All names of interviewees appear as pseudonymous.

⁶ Letters in the form of : “a.m” denote the pseudonym used for the participant, and “§ 41,57” is the reference to the paragraphing of the interviews inserted in NVivo 7 software.

⁷ All interview segments have been selected directly from the interview transcripts and appear verbatim; grammatical errors are those of the participants.

⁸ Pauses are denoted as “...”

takes anti-tuberculosis medicine and she must also take medicine to protect her liver, what can I do for this woman? I will give her my health insurance booklet. What is it? It is philanthropy. But what can I do? I will take care of the person because I can't ignore her. (a.m., § 45)

Interestingly, Alkistis engaged in an illegal action motivated by her perceived ethical obligation to help a patient. Although other factors may have affected Alkistis's decision to violate law, it was evident that she did not perceive laws as an indicator for ethical practice. In fact, most of the social workers indicated that they often used various informal resources to help their clients, even when there was no official route or requirement to do so. Similar to the feminist ethic of care, the social workers appeared to value care and seemed emotionally committed to their clients even at the cost of their commitment to employers or the state. (Meagher and Parton, 2004; Koehn, 1998).

At this point it is vitally important to highlight local differences in management, policies, laws, and so forth. In particular and from the above findings, it is possible that social workers in Greek hospitals were not suppressed by strict organisational rules and statutory laws, or they perceived ethics and their consequent ethical obligation as to care despite these laws. This is in contrast to Sullivan (2008) who found that social workers' perceptions of duties appeared to be originated and controlled by organisation rules and policy. Furthermore, it is well documented that strict management systems have an enormous impact on social work practice in the UK and US. In particular, social work interventions are strictly controlled by managerial policies and inflexible criteria imposed by managerial leadership (McBeth and Webb, 2002; Gibbs, 2001; Clark, 2000; Banks, 1998). However, the emergence of value-based evaluation and social work literature on ethics highlight social work practice is not necessarily determined by following laws. A knowledge of laws can only tell us what can be done, but not what ought to be done. Therefore, the social work profession is often characterised in literature as a value-based profession (Adams, 2002; Banks, 1995; CCETSW, 1976).

Nevertheless, the majority of the social workers working in medical units appeared to not recognise that a protective attitude towards vulnerable groups of people or individuals led to paternalistic behaviour, which is likely to have both negative and positive aspects (Bowles *et al.*, 2006). Although none of the participants explicitly referred to paternalism, all of them expressed their attitude towards protecting their clients in different ways.

In particular, six social workers demonstrated a positive attitude toward paternalism identifying with the ethic of care. Others, and mainly those who worked with mentally ill patients in psychiatric departments, were more negative. For example, Stiliani argued that paternalism was a part of her professional identity because her purpose was to take care of people who could not make decisions or take care of themselves. She said:

Our work is to take care of the people, right? Our purpose and our target is to care and support the people who cannot do it on their own, they cannot service themselves, they cannot think what is good for themselves, so our role is to protect them. (s.d, § 127)

Some of other the social workers demonstrated their positive attitude towards paternalism, but made no explicit reference to values. For example, Maria described a case in which she was able to provide a small amount of financial support to one of her clients. Maria decided not to give the money directly to the woman, and instead she reported that she used the money to buy food. Maria explained her reason for doing this was that the woman had a diabetic child, and would likely only spend the money on special food for her child rather than for herself. Interestingly, Maria did not allow the mother to manage the financial support by herself. This practice appeared more than protective, and possibly violated the right of the mother to define her own needs.

Hiding the truth was also seen to be justified practice when social workers felt that they were protecting their clients. These cases were mainly cancer patients where it was believed that it was better if they did not know their diagnosis. A detailed analysis of this particular issue is in section (5.5.1, pp.167). Another case that demonstrated a positive attitude towards paternalism involved an alcoholic who made a claim to an insurance company for a benefit. After a long delay, and while Elpida's client was assured by another public servant that the claim was progressing, Elpida discovered that the application had been lost. The client would have to begin the application process from the beginning. As the client was trying to manage his alcohol problem, Elpida decided to hide this from him, and urged him to start the process again. However, her client finally discovered what had happened and asked her to apologize. Elpida's response was "*I didn't want you to relapse*". What is also worth noting from this case is that both the administrative public servant and the social worker tried to manipulate the patient's behaviour by hiding the truth. However, the social worker argued that unlike the public servant she was motivated to protect of her client.

The above examples that illustrate dishonesty and deliberate concealment of information have been described in literature as the “dark sides” of the ethic of care. In particular, Meagher and Parton (2004) argued that when care was detached from political and critical theory it results in paternalism, and the rights of the care receivers ignored. Similarly, two social workers who worked in psychiatric departments argued that paternalism constrained individuals’ benefits and their right to be autonomous. In fact, Lena who practised in a psychiatric unit stated, “Protection is a hidden rejection”. She also said:

Have we understood that we should do things with the client and not on behalf of the client? These are not only nice slogans, they have real meaning and we must acknowledge them not only cognitively, but also through experience. (I.s., § 34)

Overall, social workers who worked in psychiatric departments had a totally negative stance towards paternalism. This seemed to be coupled with their adherence to the value of autonomy. Interestingly, Lena challenged that the motive for being protective was the reason for caring for the other. Instead, she argued that what motivated a person’s protective attitude was their rejection of another’s ability to protect themselves. Moreover, none of the participants expressed a belief that paternalism had both negative and positive aspects. This was important especially in consideration of Payne’s (1996) argument that values have dualities, and consequently dual obligations for social workers emerge. It is well documented in literature that a conflict in values is the point where ethical dilemmas originate. Thus, ethical deliberations are restricted by the inability of the social worker to view more than one set of values at a time.

Despite the fact that the majority of the social workers appeared to ignore the consequences of paternalism on people’s lives, their work appears to be guided by the ethic of care. In particular, social workers appear to express a strong caring behaviour especially for the vulnerable which is one of the main characteristics of the feminist ethic of care (Koehn, 1998).

5.1.2 Respect

Many of the social workers indicated that part of their role was to ensure that the patients are treated with respect. The meaning of respect often had a specific meaning through the following values: individualization, diversity, holistic approach to care, acceptance, non judgemental attitudes, protecting and not harming people’s lives.

Four social workers believed that respect was ensured when patients were dealt with in an individualized way, and by acknowledging that every person was different and had different needs to be satisfied. Two others also indicated that the hospitalization processes and the social role of the hospitalized patient flatten the personality of individuals, and this indicated a disrespect of patients as people. The depersonalization of patients also resulted from unethical practices by health professionals, specifically doctors.

For example, Lena who practised in a psychiatric unit, made a clear connection between the special role of social workers in promoting a person's worth. Lena also highlighted in her interview several other components, such as individuality, diversity and a holistic perception of the person, which were inseparable considerations that underpin and give a specific meaning to what she referred to as the uniqueness and sacredness of the person:

I believe that the way that hospitals deal with patients as people is in our hands more than other professions... we are trained in this and know all the theory, which I have used all these years and continuously update. Having to work with a person who is something very special, holy, unique, etc, namely a patient for me is never one of the 500 patients in the hospital, or at least my perception makes me not to see a patient as the thousandth that I see... this perception is not equally prominent in the other professions with which I collaborate, the nurses are more practical doing something good, doing it with sensitivity, doing it with humanity... the doctor makes important decisions, but we play a large part in this team effort... I dare to say that this is under attack, because when you hear in a unit that "I have 42 beds" which as a phrase is used for practical reasons, but which characterizes the whole way that the person is dealt with/// when the doctors and the nurses cannot individualize and take care of the personality of a patient, whilst the literature indicates that the personality suffers when a person is hospitalized/// therefore I find it very important that in our job we must continuously support the person, when they are a patient, when they are in their family. We must support everything that this person is, their personal history, as a unique personality... you can't forget anything. They should not feel destroyed by the processes which are dominated by the medical model which take away their personality when the doctors say "I have 10 gastritis, 3 spinal injuries...our profession is very lonely even if you measure it with numbers, in a population of, I don't know...700 professionals, or 380 or 400, there are 150 doctors etc and there are only 6 of us... the issue is not always important because it is the personality which counts, but I think we have a huge responsibility for what we represent. (l.s., § 445)⁹

What is also important from Lena's account is that doctors are those who make the important

⁹ /// indicates small passages of the interview have been removed as the researcher has deemed they do not add to the overall understanding of the meanings that the interviewee intended to communicate.

decisions about patients' lives. More importantly, she seemed to imply that their decision-making process was not based on the value of the worth and uniqueness of the person, at least with the meaning that Lena gave to value. And if the worthiness of a person is not considered in a decision-making process, then for whose benefit was this decision made? In fact, Lena considered this value as being "under attack" within the context of hospitals. By reflecting on theory about the affects of institutionalisation, Lena argued that hospitalised people were not dealt with as human beings, and she highlighted her belief by mentioning methods used by health professionals to refer to patients. Interestingly, Lena identified some words that reflected her belief that the value of individuals' worthiness did not underpin treatment in hospitals. She made specific reference to doctors who identified their patients by using their diagnosis, or by a bed number.

In one case, however, individualisation and equality seemed to conflict. Periklis, practising several years in Patra, made a distinct comparison between the worth of one life with equality in the sense that no one life was worth more than others. However, he also referred to a case where a 16-year-old adolescent with cancer was treated in the corridor because the unit was full. He expressed anger that doctors let a child be treated in this way and had not shown any sensitivity for his age. Periklis did not seem to realize that his words were contradictory because the values that he referred to, although important and equally welcomed, were conflicting. In fact, his description quoted below was an example of a fundamental social work ethical dilemma (Payne, 1996; Reamer, 1982), despite the social worker not seemingly recognizing the dilemma. This comment was a clear reflection of the dual responsibility of social workers to promote values that have dualities:

You have a 16-year-old boy with cancer and he is in the corridor having his therapy there... and you call yourselves doctors? If he was my child with all these people walking past him in the corridor with the child's white blood count very low, would I allow the doctor to treat the child in the corridor? I would kill him! He must do something about this... I don't know what, maybe he should return his degree, he must go to the administrator and tell him "I can't work you son of a bitch! The patients must leave, they must go somewhere else... I get crazy/// what can I say to the child's mother who tells me "but he is in the corridor", what can I say to her? That this is the way it is in the hospital? "Take the child inside the unit you idiot" ... "I don't know what you can do...put them all outside the unit but put the child inside". There are no middle solutions in life; it is not about deciding "this guy must die and the other must live", right? This notion doesn't exist. What exists is that everyone's life is the most valuable thing he has. Can you tell a gypsy that they are a second priority? Can you turn them away and put someone else in their place? This is not acceptable. (p.p, § 176)

As above, Periklis reflected on this case by placing himself into the role of the child's father. He seemed to reflect on this case not as a professional with a particular role and duties, but as a father who had a clear role to protect his child's interests. If Periklis had to make a decision on this case, he would likely be unable to see his professional responsibility to ensure an equal distribution of resources, and his duty to protect the rights of all patients - not just the rights of the child. Despite the fact that he seemed to recognize that all patients deserved equal treatment, when seeing himself in a personal relationship with the child his emotions forced a value preference.

This finding is important to the modeling of ethical decision-making processes which does not always highlight the significance of the ability of a social worker to maintain his/her professional identity. Empathy is considered as an essential part of the decision-making process to enable social workers to consider others' interest (Meagher and Parton, 2004; Maeckelberghe, 2004; Koehn, 1998; Tong, 1998). Although theoretically, the notion of empathy requires that social workers return to their own view rather than remain with those of the client. Social work literature on ethical decision-making is not particularly clear whether the decision maker must make their decision by being aware of their professional role and identity. When considering the ethical obligation of social workers to social justice, empathy alone is not sufficient for ethical decision-making. The promotion of social justice demands social workers to consider not only the interests of their immediate clients, but to compare these with the collective interest. This is merely because individuals' rights and benefits are not necessarily identical with what is perceived as socially just and/ or benefiting (Clark, 2000).

The worth and uniqueness of an individuals' personality also seemed to obtain a definite meaning through the value of the holistic approach. In this sense, viewing patients holistically was also a way of removing any stigma. This was often seen as a professional target mainly for those working with patients suffering from mental health problems. Similarly, Lena symbolized the mental health problem with a person with a deformity in the back, meaning that a person is much more than his/her ailments. She said:

The psychiatric diagnosis of a person is only his deformity, it is not the person. (I.s, § 208)

Another aspect of the worth of the person was the value of acceptance. Six social workers also identified themselves with the value of acceptance for the other person. This value was often

used to justify the provision of support to people that were seen as having done something “bad”, or who had made mistakes with negative consequences for themselves or others. This value was often connected to the non-judgmental attitude that social workers believed that they ought to show towards their clients. For example, Periklis described a case where he had to restrict the autonomy of an older woman by placing her in institutional care. He stated her family did not want to take responsibility for her. Periklis believed that the older woman had a bad attitude towards her family since she was a young woman. However, he insisted that this woman should be helped. He commented:

It was her own attitude and behaviour toward her family which shaped her current condition, but this doesn't mean that I will be the one who will condemn her behaviour. I see only a person who while she could have better living conditions, she is forced in a way to accept the solution of residential care. (p.p, § 125)

Recalling that Elpida worked in a general medicine unit in Athens, she characterized acceptance as “*passive understanding*” when she referred to her obligation to support undocumented immigrants. However, she stated she believed that they should not have illegally entered in the country in the first place. Supporting individuals, despite believing their actions were not good, was illustrated in the descriptions from six social workers. This was similar to what Banks (1995) indicated about social work identity; that social workers were often regarded as “*wimps*” (caring for those who do not deserve it).

Particularly for the social workers working in psychiatric departments, accepting the needs and the differences of others was vitally important in their role to promote self-realization for the people they were treating. Aristos who practised in a psychiatric unit said:

Spiritual development is a very difficult road. It is very important if you can accomplish helping another person to become themselves, not what you would like them to be, even when you have another personal opinion. (a.a, § 310)

Interestingly, Aristos appeared to believe that only those who were spiritually developed were able to accept others as having different personalities and needs. This argument seemed to imply that accepting others was a continual effort which eventually resulted in spiritual development and maturity.

5.1.3 Self determination

Similar to other studies, self-determination appeared to be one of the leading values of social work practice (Woodcock and Dixon 2005; Banks, 2005; Kugelman, 1992). In particular, five social workers identified self-determination as a core value of their professional practice. However, only one of them identified this value with his/her ethical responsibility to ensure that patients should make informed choices. In fact, even in cases where the patient's opinions or views were seen as being complicated by difficult emotions or defense mechanisms, social workers argued that the patient should allow them to deal with their personal issues and perceived those decisions as valid. Paradoxically, social workers often used terms familiar in psychodynamic theory, such as "*denial*" and "*defense mechanisms*" to characterize the behaviour of a patient and understand their wish to be informed even when they were deliberately misled. Not surprisingly, none of the social workers demonstrated any effort to dismiss the so-called "*defense mechanisms*" of the patients, probably because they were perceived as adaptive and protective mechanisms of the individual (Blanck and Blanck, 1974).

For example, Alkistis who was working in a cancer unit argued that when she spoke to cancer patients who were unaware of their diagnosis, she had to accept their right "*to decide whether they want to be informed about the diagnosis.*" However, she seemed to ignore the fact that the patients' right to be informed was already constrained by doctors who often decided to hide the truth from the patients. Thus, the patient could not make an informed decision to speak, or not, with Alkistis about his/her diagnosis.

In contrast, Aristos who was working with mental health patients confirmed that sometimes patients' decisions did not always reflect exactly what the patients wished for themselves. He argued that although he has no hesitation in accepting his patients' will and right to self-determination, he felt that the choices of mental health patients were often "*ambiguous*". Therefore, he often questioned whether the choices were definitely informed ones and whether they reflected exactly what the patients really wanted.

Although the value of self-determination implies the value of freedom, only one social worker made an explicit reference to the inherent right of all people to be free. In particular, Tina referred to the mentally ill children who were often being locked away and confined in a particular clinic in the hospital. She supported freedom as an inherent human right that must always be protected.

Tina shared the following:

Maybe it is something very personal, I don't know, but I believe that the freedom of one person is not something that we can give or take. Freedom is something that everyone is born with, the fact that someone may have a jail sentence and the justice system puts him inside the prison, but it does not affect me. I don't work in the justice system. As long as I work in a job where there is no law like this, I believe it all this imprisonment is a mistake. I think it is our indifference, so, as long as I can, I will break the rules to look after the children, yes. (t.m, § 127)

Tina also implied that this value was a personal belief rather than a commitment to a professional value. Nevertheless, this personal value seemed to guide her professional practice.

The involvement of personal values in professional practice has been well stated in the literature. Not surprisingly, Tina's account provided further evidence that professional identity is formed, at least partly, by the personality of the practitioner and their specific value preferences (Houston, 2003; Fritzsche, 1995; Elks and Kirkhart, 1993).

5.1.4 Summary

In the above sections three main values were discussed (i.e. caring and protecting, respect and self-determination), that appeared to be the leading values of social work practice in hospitals. This understanding was helpful to begin to consider how the social work role and ethical dilemmas of social workers in hospitals were formed.

Social work identity in hospitals appeared to be influenced by social workers adherence to individualistic values while collective values were ignored. In particular, caring for those in need was a guiding ethical obligation of the social workers and often motivated them to use informal resources to help their clients. However, some social workers also appeared to use the ethic of care to justify paternalistic practices. In contrast, the majority of the social workers working in psychiatric departments appeared to have a negative stance toward paternalism and this appeared to be related to their adherence to the value of autonomy.

Although self-determination was also one of the guiding values of the social workers, only one social worker identified his responsibility to protect the right of patients to have informed choices. In fact, many social workers appeared to impose psychodynamic explanations by using terms

such as “denial” and “defense mechanisms” to characterize the behavior of a patient, even when they were deliberately misled regarding their medical condition.

Social work practice, both in medical units and in psychiatric departments, also seemed to be underpinned by a commitment to recognize and respect the inherent worth and uniqueness of the person. In particular, respect for individuals was often correlated with a series of values including individualization, diversity, holistic approach, acceptance, non-judgmental attitude, and protecting and causing no harm their lives. Values that enhance social benefit over the benefit of individuals were evidently missing from their accounts. In fact, even working against discrimination was individualistic in character as social workers demonstrated efforts to support patients’ social rights.

5.2 The social work role in Greek public hospitals

All hospital social workers identified their role as helping individual patients meet their needs, and to help find the appropriate support for them after being discharged from hospital. Casework was the most common method of working for all of the social workers interviewed whether they worked in a medical unit or in a psychiatric department. Group work with patients and/or family was carried out only in psychiatric departments and their targets were psychotherapeutic in character. In fact, the social workers’ descriptions of the role of social work in hospitals were similar to the findings of studies that explored the nature of the social work identity in Greece. In particular, empirical studies have indicated that social workers are focused on providing for the increasing needs of individuals with social work activities that are characterized as “first-aid” (Pantazis, 2007; Georgoussi, 2003).

Many of the social workers described community work as any effort they made to find resources in the community to support their clients. Campaigns for promoting blood donation were also a common part of social work practice in medical units. In one hospital where surgery was available for tobacco addiction, a social worker joined a team of professionals to inform the community about the dangers of smoking. One social worker, however, indicated something that community work should ideally include, but has never been practised by social workers:

I believe that [social workers] could do other things. They should make their presence felt in the hospital by shouting /// they should open the doors to the people,

they should not hide from the problems and they should not be scared. They should highlight that the deficiencies in the hospital exist not because of the deficiencies of a bad social worker, rather it is the deficiencies of the whole system which has no rehabilitation programs. It doesn't have residences or it has residences which exclude people with various problems. It doesn't have rehabilitation units within the hospital, and above all they should speak out about all these things to the people, inside and outside the hospital through community work.. (s.m, 67).

The various views that social workers held in relation to community work raises Clark's (2000) argument about the ethical dimension of social work theories and techniques. He argued that ethics should not be considered as a separate issue, but rather as an issue closely related to theories, skills and techniques. The above mentioned examples demonstrated that whatever resources were available in community work, they were used to benefit individuals rather than the community. Therefore, social workers were not involved in structural considerations such as social justice, equal distribution of resources, and anti-oppressive values which have been argued as necessary for critical practice (Dominelli, 2002; Payen *et al.*, 2002). In this sense, theoretical frameworks that were supposed to promote collective values were used for the individual benefit of clients. This ambiguity seemed to indicate that a morally active practitioner must also be able to identify the underlying values of the theoretical frameworks and definitions that lead social work practice (Clark, 2000).

The range of professional obligations that social workers described reflected the expectations of patients and those of the hospital. Social workers' activities on behalf of the patients included: psychotherapeutic practice, psychosocial support and advocacy. Other activities were focused on satisfying the expectations of the hospitals. Evidence emerged that hospitals expected social workers to ensure that the medical costs for the treatment of uninsured patients would be covered so that hospitals could be cost effective. In addition, the hospital administrations expected social workers to ensure a steady and controlled environment without disruptions caused by the complaints of patients. The following sections comprise a detailed description of these social work practices.

5.2.1 Psychotherapeutic practice

Psychotherapeutic targets were cited by all the social workers in many of their case descriptions. These targets included: enabling patients to adjust to their reality, psychological support and

encouragement, and finding and empowering psychological strengths. Building a relationship with patients was often seen as an end in itself, without the social workers always being specific on how patients benefitted from this relationship. What was interesting was the way that social workers characterized this relationship. All social workers working in medical units usually referred to this relationship as a trusting relationship with a patient. In contrast, social workers working in psychiatric departments characterized this relationship as therapeutic. In fact, social workers in medical units seemed to show therapeutic targets in their work with the patients, but in a more vague or abstract way than those in psychiatric departments. The following quotes are from two social workers working in medical units and they both describe their relationship with two patients. Specifically, in the first passage it seemed that the social worker evaluated that his relationship with the client turned out “smoothly”, but he does not indicate if things actually went well for the patient.

I encouraged her that everything would be okay, besides, this is the reason I am there, to encourage her. In fact this woman trusted my words so our relationship turned out very smoothly. (g.s, § 57)

Aristos who worked in a psychiatric unit reflected specific ideas that were relevant to psychotherapy and the values that psychodynamic or systemic approaches held. In fact, the social worker in the example below referred to himself as psychotherapist:

All the work we do is psychotherapeutic in character, meaning that you try to explain to the people that things cannot always be good. Even we, as psychotherapists, are not superhuman. We also have difficulties with our families, with people, that there are ways you can deal with those difficulties without taking the knife and stabbing each other, and that there are opportunities outside home, friendships, and relationships, and interests and hobbies. And eventually there will be various things which can give you pleasure in life, not only at home. (a.a, §84).

Aristos seemed to imply that what was important for his patients was to understand that humans have not got “super powers”, meaning that mistakes and deficiencies were inherent to human nature and must be accepted as part of ourselves. In this sense, productivity and competitiveness were seen as values that obscured human happiness. In particular, Aristos argued that the psychotherapeutic intervention enabled the person to accept their imperfect human nature and enjoy human relationships without making a continuous effort to compete, but rather develop close friendships with others. He also seemed to question the role of family as the only

environment where a person could be happy.

In some cases the social workers' adherence to psychodynamic theory appeared to obscure the ethical discourse of social work practice. For example, Lena referred to a woman whose daughter had schizophrenia. She was working with the woman to change her over protective behavior towards her daughter. She also characterized the mother as "defensive" because she tended to provoke and challenge Lena's beliefs and opinions:

One of the most important interests in my work is to have a good emotional relationship with the person I have each time. Because I think that the therapeutic relationship is based on a good emotional interchange, of course I mean therapeutic relationship in its broader sense, right? We know very well that in our work we are said to be therapeutic through our attitude and our function, namely, it is not only the doctor and the nurse who do the injection /// with this particular lady, she was still testing me after quite some time, she was reluctant, she was provoking me, and probably because of all my years of experience I didn't feel very threatened ...I interpreted all this as part of my job. (I.s, §223)

What was interesting from Lena's account was the way that she interpreted her client's attitude. If the provocative attitude of clients was characterized by social workers by reflecting on psychoanalysis alone, in this case as a defense mechanism, then this challenged the competency of the professional. Lena did not express any kind of uncertainty about her own opinion. The attitude of the mother, however, could be motivated by her own opinions on the issue, and in actual fact, not challenging the professional at all. What was also important to note was that Lena thought of the daughter with schizophrenia as her client and not the mother. She seemed to see the mother as the means by which she could enhance the well-being of the daughter. This raises questions as to whether Lena's professional practice and ethical decision-making process included the mother as a stakeholder whose benefits should be considered and promoted alongside her daughter's.

5.2.2 Psychosocial support and discharge planning

An important role of social workers was to investigate and record the social history of patients needing their services. The referral source for these patients could come from nursing and other professional staff or social workers. These personal details were an important element in enabling social workers to provide appropriate information to patients about available social welfare support. Information was most commonly provided relevant to welfare benefits, community

support, insurance issues, and in some cases legal issues. In fact, all social workers indicated this as part of their role to “*connect patients with community resources*”. Informing patients about formal community resources provided by public, private or non-profit organisations was one of their primary purposes. In addition, when patients wanted to be availed of these resources, social workers were responsible for making the appropriate references and to fully support patients to follow the prescribed bureaucratic procedures where needed.

Furthermore, there appeared an agreement among all social workers that the state provided nothing, but a limited welfare support for people. Given the lack of a formal community network of social services, social workers provided patients with various types of information and they even used personal contacts to support patients. These practices appeared to be underpinned by their commitment to the ethic of care and particularly their ethical obligation to protect the most vulnerable individuals.

For all social workers finding community support for patients was a very difficult task as the effort involved the social worker trying to match the right personal contact with their client's need. In fact, the majority of the social workers seemed to use an informal social network based on their personal contacts to help support their clients. In this way, however, human suffering was doomed to be framed as a personal situation rather to be seen as conditioned to structural determinants (Rossiter, 2001). Moreover, the pressure for collective solutions probably was eliminated by the fact that social workers were able to provide some sort of solution, even if on an individual basis.

Namely you are forced to use your personal background too, in order to find solutions so that this person can have some form of tangible support. (a.a, § 96)

Ensuring family support for patients was also a primary target of social workers, especially for patients who were commonly characterized as “*loners*”. This effort involved social work corrective interventions in patients' relationships with their families. In many cases, social workers also provided financial or other types of support for family members to be close to their hospitalized relatives. However, the financial support that social workers could provide to the families usually only amounted to a small amount of money (10-100 euros). This money came from the hospital chapel poor box.

As previously mentioned, the majority of the social workers indicated the church as a support system for patients. For example, institutionalised care provided by church residences for older people who could not meet the criteria for public institutions was a primary solution for social workers. This was not a surprise given the Orthodox Church's participation in social protection schemes and its power to influence political and social affairs (Yfandopoulos, 2004; Matsaganis, 1999).

The financial support that hospital social workers could provide to the patients who required money for urgent needs was very limited because of scarce welfare benefits. Social workers found it important to be able to support, even with a small amount of money, very poor people to cover basic costs when they ended up in hospital¹⁰. For example, Maria who was working in a medical unit explained the way she could provide some financial support to her clients:

We receive this money from the poor box of the church which is in the hospital's yard, the R. hospital has a chapel inside the hospital, so that a patient or a person who has a relative in the hospital can light a candle and give one euro. We have a church but it is in the hospital grounds, not inside the hospital and now the administration will build a small chapel inside the hospital, so that every patient will be able to light a candle before an operation and pray for it to go well, to pray to God, but also we social workers will be able to receive more money, so as to help some people in emergency situations... for the urgent needs... for a ticket, to be able to buy someone slippers, or a pair of pyjamas, to give money to someone to buy food /// we demanded this money and finally we got it, even this tiny amount of money is welcomed because it was an embarrassment for social workers not to have the funds to help buy a ticket for a patient to go home . (m.k, §99)

Maria seemed to feel uneasy if she did not have the ability to financially support her clients. She seemed satisfied that she could provide her clients with a "tiny" amount of money that probably would be insufficient to cover all of her clients' needs.

This probably signalled what Rossiter (2001) argued about the ethical dimension of helping others. In particular, she suggested that helping others without thoughtful consideration of the values that are promoted by our actions may result in maintaining oppressive values and the unequal social relationships between the helper and the person being helped. Providing help to another person satisfies both the helper and the person who is helped; however, this action does

¹⁰ For the majority of the hospitals there is an annual budget of 600 euros for hospitals with 60-70 beds, to 6000 euros for hospitals with 400-500 beds. This money typically comes from the chapels of the Orthodox Church which are in the courtyard of the hospitals or even in some cases inside the hospital.

not necessarily imply that the person who is helped has the right to what is provided or if they are indeed helped. Moreover, the gratification that the helper feels when helping a person is “addictive”, and therefore, “ethically suspicious”. The helper easily forgets that a charitable gesture confirms the inequality between him/herself and the person they are helping, bypassing the fact that both share a common citizenship with equal rights and responsibilities (Rossiter, 2001). At this point, the contribution of reflective theory to social work practice is extremely important. In particular, critical reflection is not only concerned with the outcomes of professional practice, but also for the cognitive processes through which practitioners acknowledge their ethical and moral assumptions behind their practice. Critical reflection involves ethical and moral criticism and judgments of social work practice (Fook and Askeland, 2007; Bowles *et al.*, 2006).

Another aspect of social workers’ role in hospitals was their involvement in discharge planning of people whose living conditions after hospitalization were not secured. In cases where the patients could not live alone or were homeless, the social workers primary role was to find a residence in either residential care or the family environment. In either case, social workers felt obligated to delay the discharge even when the patients were medically ready. This practice involved social workers having to demonstrate to the administration or to the doctors that the patients had nowhere to go after their hospitalization, additional time would permit the social worker to locate appropriate living arrangements.

5.2.3 Advocacy

Three social workers highlighted the importance of being an advocate for the patient mainly when their rights were undermined by the apparent malpractice of other professionals, or when bureaucratic procedures delayed patients receiving their welfare benefits.

You must have courage to speak to the doctor. You should not go in feeling inferior. You must speak, you are representing a person who is oppressed and driven by social circumstances cannot express himself. Someone must represent this person. He probably cannot speak for himself, shouldn't we go there and say something? If we don't trust ourselves and if we have complexities of our own we will probably say, “so, what?” (s.m, §292)

In the above quote, the social worker referred to the case of a patient who was in a poor social condition with multiple problems including homelessness and hunger, but with no serious health

problems. The patient was to be discharged from hospital by a doctor stating that the patient had “no physical health problems”. The social worker intervened by speaking to the doctor and trying to convince him to consider that these social problems also put the patient’s life in a danger. However, representing patients’ rights appeared to depend on each individual’s character. None of the social workers referred to initiatives to develop collective ways of promoting patients’ rights. In fact, some social workers expressed that they felt restricted by the organisation to develop a system to enable patients to fight for their rights:

//namely you get crazy. People don’t listen. People don’t want to recognise reality. Namely, if we go out and tell them “you have the right to request, to demand, it is your right, you have an old man in your house and he wears you out, and there is no organisation in the borough, a day care institution for elderly to take him for 5-6 hours a day so as you can have a rest. Where is the Borough’s obligation?”. I do this, I tell this to anyone I see, but as you can understand I cannot go out and say these things as a social worker because... because in order to go out officially and say all these things I must have permission to speak. Maybe they will not harm me if they hear that what I say flatters them, but if I criticise them then I will have problems the next day. (p.p, §137)

In the above example, Periklis indicated that he tried to emancipate and empower people by urging them to fight for their rights. However, he obviously did not include these efforts as part of his job as he purposefully did not use his professional identity. This may suggest that these types of agendas were not dealt with in a systematic, professional manner; rather it was part of social work initiatives driven by their personal values. If these types of practiced were seen as out of the range of their profession, they were likely was unable to defend their actions. What is also important from Periklis’ account was that he was probably afraid to speak up about patients’ rights. Particularly, he seemed to believe that the administrators of the hospital would discipline him if his words were not flattering towards the hospital. Therefore, speaking up about patients’ rights remained an unofficial effort that raises questions about the democratic function of the public health sector. At this point the contribution of critical theory is highly important. Critical social work practice frames social activism within the core of professionalism. In this way social workers are empowered to use their expertise to bring structural change from within practice environments (Adams *et al.*, 2002; Rossiter, 2001).

Interestingly Efi, who was also the representative of the Hellenic Association of Social Workers, argued that the main fault with social workers was the fact that they did not campaign for the rights of their patients. She believed that there were two main reasons that explain this failing.

The first was that social workers did not want conflict with people in authority such as doctors and administrators. Nevertheless, she justified the value of having good relationships with people who were important to their practice. However, she also argued that social workers should not be compromised by the fear of losing these relationships. The second reason was that she believed that social workers did not know the appropriate ways to campaign for human rights or patients' rights. She claimed that they did not know the laws and legal processes to use to protect rights. Interestingly, in her practice descriptions Efi referred to patients as "citizens":

When the profession is in a conflict with the fiscal policy of the hospitals, namely when a bed must be released because a new patient must be admitted into hospital, or because a doctor wants to do research, or because a nurse got tired so the patients must be changed, this is fact, you must remember that. However, you should not let them exceed the limits of a good relationship which you have had with this practice. You cannot have a good relationship with other professionals if their practice does not really help the citizen. You must be unwavering and resolute. I believe that social workers do not do that because this kind of behavior needs guts and knowledge. (e.x, § 18)

She also indicated that it was not easy for social workers to play such a role when they themselves confirm their position on the bottom ring of the hierarchical ladder. She implied that by her changing job to become part of a supervisory team for public hospitals in the Ministry of Health Care, she would be in a better position to bring about system change. She commented:

When the ethical pressure or the emotional pressure does not have any outcome, then you must use the threat of calling the district attorney, and one reason that I chose to become a supervisor was because I wanted to have an executive role in relation to all this in order to be able to speak from an equal position and tell them that "you are not doing your job well". (e.x, § 34)

Examples that she used to illustrate the ineffectiveness of social workers involved nurses showing no respect for the dignity or anonymity of patients. These transgressions included the treatment of patients without the use of screens and loudly addressing them in public by their surnames. She indicated that one of the responsibilities of social workers should be to speak, convince, and if necessary, force nurses to respect the rights of the patients. She argued that social workers do not protect these rights because social workers "do not fully recognize their role". Efi possibly meant that social workers do not recognize that protecting individuals' dignity is within the scope of their professional duties. She implied that this was because the role of social workers was limited to activities other than advocating for human rights.

In fact, Efi argued that social workers were not aware that it was their ethical obligation to protect patients from the practices referred to above. Lack of education and the tight workload of nurses were perceived by Efi as the main factors that resulted in unethical behaviour. Unfortunately, the literature indicates that social work education in Greece lacks postgraduate programs and has limited opportunities for ongoing professional development. International exchanges of knowledge is also not well developed (Dedoussi *et al.*, 2004; Pediaditaki, 2003; Georgoussi, 2003). All of these factors possibly influence social workers' perception of their full role.

5.2.4 Social control

Five of the social workers indicated that part of their role was to try to control their cases “*not to become big issues*” for the hospitals. For example, a number of patients with kidney disease started to demand better facilities and services in a blood dialysis unit. Although the social worker initially supported their demands by helping them with practical issues, her efforts were finally used to control a patient who was characterized as “*more aggressive than others*” or “*psychiatric case*”. In this case the social worker tried and succeeded to persuade the patient to leave the hospital and go to a private unit for kidney dialysis. At the same time, she also consulted with administrators on effective ways to control the patient's anger. Eleftheria who had worked in the hospital for six years described the situation:

I was consulting with them on how to control him. I was telling them that since he is so angry at this point that they should not be contentious with him, after all he had already decided to leave... it was something that I had discussed with him and I told him that since you are not happy here why don't you go to a private unit. Since you are so angry and you see that nothing is changing here... there is this aspect too, instead of going to extremes... eventually he went to a private unit and I believe that in this particular case it was the best solution since things went too far.. for that particular patient. (v.p, § 44)

Interestingly, Eleftheria stated that to solve this situation she also consulted her manager who had training in psychotherapy and fifteen years experience in a psychiatric department. This was possibly connected to an individualistic approach and the patient's claim was eventually dealt with by two social workers. Although Eleftheria acknowledged that the claims of all patients were just, she decided to characterize the difficult patient's attitude as problematic for both the system and the patient himself. It could have been viewed as an opportunity to allow his experience to form a patient group to work with the administrators to bring up improved patient services. Apart from some initial help, Eleftheria did not demonstrate any effort to support the patient's demands. In

fact, social workers seemed to believe that hospitals did not expect them to support the collective or individual efforts of patients to make complaints or demand better services. On the contrary, as twelve of the social workers acknowledged, administration expected social workers to control and eliminate such incidents. For example:

And they send us all the cases who complain and say that they will protest to the administration, or they send us the poor people who wander around the hospital. All these cases come immediately to us /// namely any complain that anyone has and wants to go to the administrator or when a patient has no money... various complaints that one may have, they send everyone to us, to the social workers, whether they are Greeks or foreigners. (r.x, § 131).

Another social worker described how they used to deal with cases of unmarried women who had no means of financial or emotional support. Doctors would arrange for illegal adoptions. Social control by the social workers was more evident in these cases, especially for those women who lived in remote areas and where immediate communication between the social workers and the women was impossible. If social workers were suspicious that an illegal adoption might be involved, they would arrange for the local police to make regular visits to ensure that the baby still lived with its mother.

Many times, doctors... I don't remember their methods anymore, they said to the girl: "ok you will be discharged in a couple of days"/// the negotiation was done out of the hospital... they were telling her to leave the hospital and that they would speak later... it was not just gossip, in many cases there was straightforward collaboration with the mother, but because we were worried and we were suspicious that something would happen, we told the mother that "you know it is your obligation.. Where will you live? It is our responsibility to follow up what happens to the baby, that you are capable of taking care of it as you should... that is why we need to know your address", if the girl lived in an area out of our range, then we would send a report to the police in her village that she had a baby on this date, that she went to live with her parents or alone in her home with her baby girl or boy... and the police were responsible for sending us a report for a period of time. (l.s, § 377)

Lena described her efforts to control and eliminate illegal adoptions in hospitals. Although doctors were believed to be involved in these cases, Lena made no reference to any effort to controlling their unethical practices. On the contrary, unmarried mothers were the only people whose actions were investigated. Overall social workers appeared to be practicing the value of care, although issues of power and authority distracted from their practice and their perception of the issues. Once again, paternalistic practices seemed to result from the adherence to the ethic of

care by social workers who ignored the political dimension of their practice (Meagher and Parton, 2004). Although this description referred to practice a decade earlier, Lena commented that nothing had changed. None of the other participants described similar cases.

The practice of social control was also evidenced in cases where patients had infectious diseases, and refused medical care or hospitalization. In these cases social workers were expected to intervene to convince the patient to remain in hospital or follow medical advice for public health reasons:

Someone may say that he doesn't want to be hospitalized, he doesn't want to stay and wants to leave. With this patient you can do nothing. You have to deal with the patient who doesn't want help, and since he doesn't want help there is nothing you can do except when he has an infectious disease. In this case he will stay no matter what.. You don't have someone to tie him to the bed but you explain to him that he may infect other people and then... you convince him. (s.d, §167)

Self-determination was evidently one of the prominent values for social workers (see also 5.1.3, pp.124). However, as indicated in the above statement, when individual benefit or independence affected the life or rights of others, social workers supported the collective right. For example, this social worker expressed her decision to protect public health over the right of patients. Nevertheless, the social worker also seemed to imply that even when public health was at risk, individuals should be treated with respect. Therefore, any method used to restrict patient autonomy or self-determination had an ethical dimension needing consideration.

This example seems to suggest that implementing ethics is not a straightforward process ending when an ethical decision is made. Rather, it is an ongoing process which goes beyond efforts to make an ethically thoughtful decision. The process in which the decision is initiated is also important as ethics take precedence over reality. Bowles *et al.* (2006) argue that even when something is perceived as right or wrong, the decision of how to act is ethically important. More specifically, they advocate that ethical decision-making should not be considered as a linear process having ends, but rather a circular and ongoing process that enhances the complexity of ethical practice. These findings also support McAuliffe (2005) who found that social workers experience complicated ethical dilemmas and these are frustrating situations that can lead practitioners to several difficult and unpleasant emotional and physical conditions.

5.2.5 Financial assistance

Social workers working in medical units commonly dealt with patients who were not eligible for health insurance and experiencing financial hardship to cover the expenses of their care. Typically these people were immigrants who are employed, but their employers had not registered them with public or private insurance agencies. Some had entered Greece illegally and were not eligible for health insurance. Helping uninsured patients to cover the cost of their medical treatment was seen by the social workers as a dual responsibility to both the patient and to the hospital. In order to find funds social workers often approached “*socially sensitive people*”, pharmacy companies or by challenging employers who employed uninsured patients. For example, Maria who had practiced in Patra for several years, illustrated her effort to find funds for her client’s treatment:

I pushed someone who is not very close to me. That’s why I am telling you that social work is an alchemy. But in order to bring money to the hospital and not let the hospital look like it that has so many expenses that it cannot cover them, I was impelled to force his employer and he brought 5,000 euros to the hospital, a lot of money, he brought the money to the hospital... I have talked about this Romanian with the manager of the Traffic Police in order to see what is happening with the investigation of this case, if they have found the person that hit him so as to pay his bill in the hospital... (m.k, §87)

It is also important to note that Maria implied that personal contacts were important factors that made it easier to help her clients cover the cost of their medical treatment. For example, Maria highlighted the importance of personal contacts in her effort to support a patient. She had to ask for support from a person who was “*not very close*” to her. Not surprisingly, approaching people that were not perceived as a personal contact was considered a last resort, even when these people were partly responsible. However, Maria seemed to be committed to “*bringing money to the hospital*” even when this included her having to exert pressure on individuals. The fact that Maria declared she pressurized a patient’s employer may also indicate that she believed that the employer ought to pay for medical expenses.

Interestingly, all the participants who worked with undocumented immigrants believed that the right to health should be not obscured for people due to legal issues. Moreover, it was the absence of policy measurements that appeared to be the crucial determinant of immigrants’ health. Social workers, however, dealt with this reality on an individualized basis. Social workers appeared to be able to articulate the right of health on ethical grounds. Nevertheless, the absence

of critical practice framed the ineffectiveness of social work interventions at least in relation to the structural purposes of the profession (Banks, 2008).

5.2.6 Summary

Social workers focused on micro-level interventions and mainly those used to support individuals and their families. Although all social workers expressed their concern about social policy and the absence of welfare and health care support, none of them showed any desire to develop structural social work interventions. Specifically, social workers' aims appeared to be psychotherapeutic in character. This was particularly evident in psychiatric departments where social workers even identified themselves as therapists. Social workers in medical units tended to develop family or community support for the patients.

Importantly, social workers argued that their professional identity was defined within the limitations of the welfare state and the lack of programs designed to eliminate social problems. Social workers seemed to take on the responsibility of dealing with people and problems where there was not insufficient provision by the state, and having to find informal solutions themselves. Not surprisingly, personal accounts of social workers about the welfare state and health care in Greece coincided with relevant studies indicating that social protection in Greece is insufficient and ineffective, at least in contrast with other European countries (Yfantopoulos, 2004; Guillen and Palier, 2004; Sotiropoulos, 2003).

5.3 The meaning of ethical principles in practice

The word "ethics" is rooted in the Greek language and has a specific reference to the Greek word "*etheke*" which means the total set of values and principles that a person holds to guide his/her personal behavior. However, "*etheke*" or ethics in the Greek language makes no reference to professional ethics or values, and provides a rather broad and more abstract reference to what is "*good*" or "*bad*". In addition, "*ethics*", or for Greeks "*etheke*", does not imply a single unchanging determination or philosophical approach to what is good or bad.

To briefly re-introduce, "*deontology*", is specifically related to the Kantian philosophical approach that indicates a specific way of thinking that differentiates the "*good*" from the "*bad*". In Greece

“deontology” is used to make reference to the professional conduct or/and set of values and principles. In this study I used the word “*deontology*” and “*deontological code*” to not mislead the participants and allow them to speak about professional codes and values rather than broadly speak about their personal value system. In some cases this may have an opposite result as in some of my questions the word “*deontology*” was unavoidably included and guided the social workers to use the same word. However, they often seemed to make reference to personal values. In this sense, I believe that personal values were often hidden within the word “*deontology*” without it being their intension. In fact, many theories support that personal values are intertwined in professional practice and knowledge (Goldenbergh, 2005; Houston, 2003; Fritzsche, 1995; Elks and Kirkhart, 1993).

However, some of the social workers reflected on the distance between personal and professional values and ethics by placing the personal value system above fixed professional codes of practice. Commonly, those social workers believed that what determined the “*ethicality of the action*” was not absolutely in line with one’s professional ethical code. No one seemed to consciously reject the ethical code for social workers or place themselves in opposition it appeared to be an unconscious rejection of the “*written*” and “*coded*” determination of the “*what is ethical?*” question. Yet, many of the social workers’ moral justifications were grounded in the core ethics of the profession.

Yet others expressed their belief that personal and professional values were an inseparable part of oneself. These social workers also expressed their belief that the professional identity was something that they must carry with them at all times. In this sense, professional values and ethics should not only guide them at work, but also their personal life style. For instance, Maria indicated that she “*was always acting as a social worker*”, because she always was available to provide help to those in need.

The meaning of deontology was for some social workers explicitly connected with one’s conscience. For example, Periklis indicated that ethically informed actions protected a clear conscience. Otherwise, unethical practice would “*choke*” one’s conscience. Periklis suggested the following:

Deontology is what must be done. It is the soul...it is being able to drink a glass of water and the water flows down your throat. What is deontology? When you follow deontology, then, the water flows down your throat; otherwise it chokes you. (p.p, § 176)

Other social workers made a reference to specific ethical principles when they described the notion of deontology. In particular, respect of the person, confidentiality and acceptance of diversity were identified as the objective of deontology. These answers typically isolated specific principles and did not reflect a belief that deontology was a set of rules and values. However, answers such as “*deontology is about confidentiality*” may have reflected the social workers’ belief that the professional ethical code was something that specified rules rather than provide a more pluralistic perception of ethical principles, and a chance for multiple interpretations or correlation among various ethical obligations. Importantly, all of these descriptions, reflected a variety of social work’s ethical principles. Nevertheless, none of the social workers referred to having or following a specific written ethical document. For example, Lena referred to an ethical code; however she spoke about a personal or “*internal*” ethical code. She said:

I see deontology as a system of rules that always facilitates my practice /// namely it provides a guidance of how one must stand... although I believe that... for example I don't have a written code, it is internal talk about a personal interpretation of the code. (I.s, § 482).

As indicated previously, personal values are always intertwined in professional practice. However, what constitutes the ethically aware practitioner (Bowles *et al.*, 2006; Speicher, 1998), among other things, is the practitioner’s awareness of the ways that their personal values intervene in professional practice, and in the ways that they perceive the elements of their practice. Interestingly, Lena argued that what guided her practice was a personal interpretation of the ethical code, although she was unaware of a social work ethical document.

Theories on social work’s ethical dilemmas define these as “*a choice between two equally unwelcome alternatives relating to human welfare*”. More specifically, the ethical dilemma forced a social worker to make a decision between two “*unwelcome alternatives*” that may involve a conflict of moral principles, and the final choice will violate one of these to some degree (Adams *et al.* 2002; Clark, 2000; Banks, 1995). When social workers were asked to provide their understanding of an “*ethical dilemma*”, the majority described it as a situation that clearly constrained their ability to promote the best interest of the client due to various reasons. These social workers gave definitions that did not reflect an uncertainty, but a conflict of values. This

compared more closely with what Banks (2001) defined as an “*ethical problem*”. This is a situation where the social worker clearly knows what ought to be done, but they have difficulties to implement it. For example, Chara said:

Ethical dilemma is when social work’s deontology says that, as a social worker, I am obligated to act in a specific way and I have the dilemma when I want to act differently. (c.v, § 265)

I have an ethical dilemma when I know what I ought to do and I cannot do it because there are no facilities. (c.v, § 269)

In the first quote, Chara defined an ethical dilemma as a situation formed by ethical barriers or ethical rules that were opposed to what the social worker personally thinks they should do. She implied that ethical social work practice was not definitely prescribed by social work’s values and ethics. Possibly, she referred to a personal system of values and ethics intertwined in the ethical justification of an action. Furthermore, Chara’s definition of ethical dilemmas contained an uncertainty of what the social worker would eventually decide to do. However, she appeared certain of what she perceived as the right or wrong course of practice, and therefore, her dilemma was not one of questioning the appropriate ethical action. Interestingly, in this definition the barriers to the social worker acting ethically were the social work ethical principles. In the second quote of Chara’s interview, she identified a specific problem with the notion of “*ethical dilemma*”, possibly suggesting the intensity of the problem and the frequency of it occurring in her practice. Indeed, this answer clearly reflected the problem as the shortage of welfare support that was so vigorously highlighted by all of the social workers as one of their major ethical problems. Eleni who was a manager of a SSD in Athens identified the notion of “*ethical dilemma*” with yet another problem, also familiar with the other practitioners:

For me, in reference to my job, ethical dilemma is everything that has to do with whether they allow me to do my duties and be accountable... it is the system that does not allow you to do your duties. As I explained to you before, the relationships must be good, you have to plead, to explain the self-evident, all these things tire you, right? It is tiring, namely, I get tired when I have to call the manager of the technical department to explain why we want 3 air-conditioners... (e.e, § 94)

Eleni’s interview reflected on the issue of the administrative authority of public servants and suggested that “*good*” and personal relationships between social workers and other public servants were important. This was because organisational rules were insufficient or powerless to

control and lead professional conduct. Therefore, the will of an employee had to be strong enough to control whether their needs would be met or not. She referred to the informal and abusive manner of administrative public servants that held up social workers' efforts to provide the appropriate help for people. In fact, she referred to her effort to develop "good" relationships with colleagues not because this would be the "ethical thing", but rather it demonstrated her effort to manipulate the administrative authority of public servants.

The most common expression that social workers used when referring to an ethical dilemma was "what am I supposed to do now?" and this reflected a feeling of being at a "dead-end" rather than an uncertainty of conflicting values or ethics. In addition, social workers defined ethical dilemmas through specific reference to external factors that create them. For instance, Lena defined an ethical dilemma without referring to it as being an uncertain situation, and she included both external and internal factors in its formation. In contrast to others who identified only external factors, she explicitly detected personality as a factor that constrained social workers to act according to their deontology. Interestingly, Lena had long experience working in the psychiatric department and had an educational background in general psychotherapy. This possibly indicated the use of values such as self-awareness that is familiar in psychotherapy. This was how Lena defined the notion of an ethical dilemma:

An ethical dilemma is when you know how to function or you know how you ought to act according to your theoretical knowledge or formulation, but you can't due to various reasons... the various reasons can be the legislation, the hierarchy of your organization, could also be our own inabilities... "I know, but I don't want to, I can't for various reasons"... namely personal restrictions. (I.s, § 307)

Elpida, a social worker who worked in a medical unit introduced another dimension to an ethical dilemma when she suggested that it was created by the multiple obligations for the social worker. Here she referred to the dual loyalties of social workers to the hospital and to their patients. Indeed, social work literature indicates a range of ethical dilemmas all derived from the characteristic nature of social work to be in the middle of conflicting interests, and ethically engaged to promote the best interest of conflicting stakeholders (IFSW, 2005; Clark, 2000; Banks, 1995). Nevertheless, Elpida seemed to conclude that eventually she was ethically obligated to remain a supporter of the patients' best interests. She said:

Ethical dilemma is about the question "should I fall in with my client's best interests or with the organizations' interests, or with the States' or with the hospital's?" In which, the

state, we think of it as citizens who pay taxes, has taken the burden of all these foreigners, and this is something that I am thinking about myself and I cannot tell lies about it, it is a real problem. However, I am not here for this purpose. I am here to help the patients, and it is not my job to help the hospital not to go bankrupt. If the hospital breaks down I will break down too, but when it is about a human life there is no option, when we speak about a young man whose life, in a way, is in our hands... and we suffer from self-denial and all this rubbish which does not absolutely agree with the logic .
(e.m, § 149)

Like others, Elpida also identified the notion of an ethical dilemma with a specific problem that she had to confront in her practice. When she mentioned “*foreigners*” she made a clear reference to the undocumented immigrants who entered Greece, and as they were employed illegally they were not eligible for health insurance. In cases where these patients were unable to be self funded, their health care expenditures were covered by the hospital’s budget. However, she also made a clear differentiation between citizen and social work ethical thinking. She indicated that as a citizen the financial burden should be carried by the State. On the other hand, “*helping the patients*” was evidently her primary ethical obligation when she referred to her role in the hospital. What seemed to determine her decision was her professional adherence to the values of “*helping the patients*” and “*self-denial*”. Her ethical issue was related to the fundamental right of all people to have access to high quality health care which also implies that health care should be provided on the basis of need rather than on the ability to pay (Pennings, 2007).

Periklis was clearly opposed to the notion of ethical dilemmas as he was confident that he had a clear and absolute intrinsic ethical guidance of what is “*good*” and what ought to be done. In fact, he made a clear reference to a Kantian ethical principle of moral justification. Although he made a clear reference to his role as a hospital social worker, he implied employing personal rather than professional ethical guidance. Dilemmas turned out to be “*personal*” when his moral judgment placed personal relationships from the private domain at the centre of his ethical decision-making process. Interestingly, Periklis’s professional values and ethics did not appear to be involved in the ethical deliberation of his cases. However, a different interpretation may be suggested. Starting with emotional involvement and the effort of the social worker to think “*if this person were my son*”, empathy is reached. Thus the social worker deals with the dilemmas as a person and not as a professional. This argument rests on the feminist ethic of care, which places empathy at the core of the decision-making process (Koehn, 1998). In the following passage, Periklis illustrated the notion of ethical dilemmas:

I don't know about theoretically... personally I think that my own dilemma is not deontological or professional, right? My dilemma is posed in contrast with myself and with my own family, namely I say that this person, this young man if he was my son what should be done? Namely it is not posed in reference to me being a professional who... here you experienced terrible things, someone is about to die, he is 25 years old and he is in a terminal stage, what can you say? What deontology and all this rubbish? I cannot hear such things! In such a case I say... there are no dilemmas, I am ready to kill anyone if he doesn't act as a human, I don't hear anyone, this is my deontology, I will kill any doctor or God if he doesn't do a good job, this is my deontology. (p.p, § 168)

Aristos, who also denied ever having an ethical dilemma, made a reference to the same Kantian ethical principle. He said:

I rarely have a dilemma about something, I hardly ever... namely, I have a client, I try to understand him as well as I can. I also meet 3-4 members of his family who are his supportive environment and thereafter ... namely I have never faced a dilemma //maybe as a character I have a clearer outlook. Namely, I have made clear some issues. Namely, ethically, the basic thing is that I try to treat my clients as I would like to be treated, even when a client was aggressive or hard or whatever I have never treated him with aggression or without being polite or without respect or without interest. Even when some aggressive people came to my door and threw me up in the air, I spoke to them and things calmed down.... (a.a, § 15-19)

The definitions that the two male social workers provided for the notion of “*ethical dilemma*” did not reflect any kind of ethical uncertainty based on a conflict of equal values or equally important losses. The reference to the Kantian principle of moral justification by Periklis and Aristos, and their argument that they do not have ethical dilemmas suggested that having one absolute ethical perception minimized the acknowledgment of complicated ethical dilemmas. In this sense, having a monolithic and specific ethical approach in mind made ethical decision-making a straightforward process. In contrast, when one has a pluralistic ethical view or knowledge of multiple ethical approaches this may have contributed to having difficult ethical choices or uncertainty on ethical grounds.

What became more evident was that the majority of the social workers identified that the cause of acting unethically was due to external factors such as the insufficient welfare provision, organizational restrictions, or informal authority of other public servants. All these situations were indicated by all social workers as ethically problematic and reflected an uncertainty based on the question of how to deal with these problems.

5.4 Understanding ethical problems and their impact on practice

All of the social workers, including the representative of HASW, agreed that the serious deficiencies in the welfare state undermined social justice and human rights for Greek citizens, and mainly for those who are most vulnerable (e.g. poor people, the elderly, sexually abused children, loners, homeless, immigrants, cancer patients and mentally ill patients). This is in contrast to studies in the US that showed social workers' ethical dilemmas primarily involved medical issues such as end-of-life care, and decision-making capacity of older people (Boland 2006; Proctor *et al.*,1993; Foster *et al.*,1993). The multifaceted deficiencies in the welfare state and their contribution to complex ethical problems for Greek hospital social workers are described below.

The cases that social workers defined as ethical difficult situations were separated into ethical dilemmas and ethical problems according to Bank's (1995) distinction. The following section is compiled from cases where social workers felt certain about an ethical course of action. However, various factors constrained their ability to take action. The focus on these cases was the factors that formed the ethical problems.

The main characteristic in the described cases was that the factors reflected the current political, economical and administrative context of Greece. As previously mentioned many of the social workers described such cases by arguing that they had reached a "dead-end" as they described their helplessness to act against these structures. Other social workers, have is demonstrated efforts to solve these problems by exerting pressure on the hospital administrators, or by violating legal procedures and laws. In absence of any systematic efforts to change the oppressive structures, social workers seemed to function as survivors within an unethical system.

Moreover, one social worker defined the identity of social workers as alibis within an unethical health care system that systematically abandoned humanitarian values and used social workers to cover its careless and inhuman attitude towards people. This practitioner also indicated that these characteristics were, in a way, accepted by social workers who remained only "viewers" of the situation and did nothing to preserve patients' rights. This argument also underpinned the absence of the holistic perspective and the lack of action among social workers to address patients' rights.

Values are dead... they are killed by the professionals and by the absence, because I am speaking about my country, about Greece, of organized social policy... especially in the health sector. Namely, social workers in hospitals exist not to solve problems, but rather to function as an alibi that we do solve people's problems. However, humans in this country are not dealt with as a whole but rather as an ill organ, like a liver which is in pain, and also, I return back to the problems of the health sector, it is the fakellaki¹¹, the doctor's centralism which cancels most of the humanitarian attitude towards the people and the social workers remain as observers. We don't get involved. We know the crime but we don't deal with it. (s.m, § 15)

Indeed, the fragmentation of the welfare state, the low degree of state penetration in the welfare sphere, preferential treatment and unethical practices among health professionals are well documented characteristics of the welfare state in Greece (Rovithis, 2006; Mossialos et al., 2005; Yfantopoulos, 2004; Matsaganis, 1999). According to Sotiris, who worked on medical units, the structures of the welfare state and mainly those of the health sector violate human rights and diminish humanitarian values. Nevertheless, Sotiris also blamed the unethical practices of health professionals for the inhuman character of the health sector, and although he did not imply social workers as being involved in unethical practices, he did blame them for not challenging such practices.

5.4.1 The absence of welfare support

One of the most common factors that created ethical problems was the shortage of available public residential or rehabilitation institutions for people who were unable to live alone after hospitalization (e.g. poor people, older people). Homelessness for people with a range of illnesses and other social problems was also an issue. Lack of accommodation was evident for cancer patients who lived in cities where district hospitals had no chemotherapy units and they had to travel to receive treatment in a central hospital. Because public health insurance did not cover expenses for chemotherapy sessions, patients who had no money to pay for a hotel typically lived in their cars. Tragically, these examples were a reflection of the welfare state's enormous impact on human well-being (Mossialos et al., 2005; Ballas and Tsoukas, 2004; Yfantopoulos, 2004; Liaropoulos, 1998).

¹¹ Fakellaki is a Greek expression and refers to a well-known illegal practice of doctors who are handed money by patients. "Fakellaki" means a little envelope stuffed with cash.

All social workers characterized the lack of residence for cancer patients as “*ethically problematic situations*”. In particular, what seemed to underlie these descriptions was their belief that the welfare state should ensure a decent provision of residence for people with serious health care needs. Given the scarcity of welfare provision, social workers expressed being “*unarmed*” to support their clients, but certain of what they ought to do. However, uncertainty based on what they should finally do with the claims of their clients was evident in all social workers’ descriptions.

In the following example, Periklis spoke about a cancer patient who was sleeping in his car when he came for chemotherapy because he had no money to spend on accommodation. Periklis went to the administrative manager of the hospital and made an impassioned claim to provide the patient with a hospital bed. The manager finally allowed Periklis to find an empty bed and the patient was admitted. This is how Periklis described his experience:

What can I do with those who come to the hospital to have their radiotherapy? When I am coming to my job and see a guy who came for his radiotherapy and sleeps in his car, can I just sit and work? Can I work quietly, with a clear conscience? Can I say that I work in order to pay for the bread that I eat? Can I say that I serve... /// I went to the manager and I told him, “do you want us to quit? Do you want me to resign? Do you want us to dive in the sea? Do you want us to suicide? Is it possible to have no bed for this person... in all this colossal hospital? We have done so many ridiculous things; so many frauds and we don’t have a bed for a man?” (p.p, § 149)

Periklis seemed to speak explicitly with the hospital’s manager about the unethical practices in the hospital as if these practices were a well known and accepted reality for them. Periklis used unethical practices to support his claim to break the hospital’s rules to allow his client to be admitted to hospital. Periklis also seemed to imply that the administration manager did not find his argument offensive, even when challenging the reputation of the hospital, and the manager gave his consent to change the rules for this patient.

Other participants shared similar examples confirming the social worker’s obligation to pressure administrators to bend the rules. In actual fact, however, the volume of such cases made this an impossible solution. And, in fact, the social workers declared that not all doctors or administrators were amenable to violating policy regardless of the circumstances.

“Hospitalization for social reasons” was a common phrase that depicted an acknowledged and partially accepted phenomenon to all hospitals. Normally, social workers were those who pushed doctors and/or administrators for the hospitalization of patients who had “social reasons” (i.e. no where to go). However, the absence of community support and the number of people with “social reasons” also confirmed this type of practice as unrealistic. Essentially, this would create other problems by leaving a shortage of beds for emergency cases. The social workers acknowledged that this obscured the primary role of the hospitals, however, they also argued they were obligated to use this resource on behalf of their clients¹².

Not surprisingly, an important characterization of the profession emerged when one social worker appeared to reflect on the ways that practitioners dealt with their environmental realities. Specifically, Maria characterised social work practice in hospitals as “alchemy”. Although none of the other participants used the same word, some of their descriptions of social work practice were similar. This characterisation was clearly related to scarce welfare provision, and the improvised efforts of social workers to find alternative solutions to help people. Social workers seemed to feel their identity was dependent on the welfare resources and their lack of involvement in welfare planning. Although their readiness to be involved in welfare planning was not explored further, it seemed that the deficiencies of the welfare state made them feel that they could not do their job as they should. Maria explained her characterization of social work:

For me, social work is an alchemy/// although we don't have the tools, we try to make these problems not to become big issues, and we try to find solutions from where there is nothing. That is why I am focused on this and I am saying that eventually social work is an alchemy, that without having the tools, we try, we do, we fix, we find and we search in order to help a person, without, I am telling you this again, having the tools. (m.k, § 7)

Maria referred to the word “alchemy” again when she was describing a case in which she encouraged her client to commit an illegal action. More specifically, she encouraged an illegal immigrant to use another’s passport to identify himself at a hotel. Once again she used the word “tools” to denote the welfare resources as a social work means for practice. Due to the lack of welfare resources, Maria seemed to perceive social work practice as something that was not fully defined, and probably without a promoted and commonly accepted method. Perhaps, Maria wanted to highlight the fact that social workers tried to achieve goals that would normally require

¹² The words “patient” and “client” are used interchangeably, and no distinction has been made between them.

a variety of welfare benefits and support from the state. However, she also seemed to be helping her clients without considering the possibility of multiple loyalties, that is, using legitimate practices or loyalty to her employer. She remarked:

I tried to find them a cheaper solution by practising alchemy again, as I told you before. So I told him to take his cousin's passport and tell to the hotel keeper that it was his. I suggested this to him in order to help ... this is not my role, but I did it. (m.k, § 87)

This example of social work practice was not an exception and it was evident that other social workers violated laws. These practices are further explored in section (5.4.6, pp.164). However, the above illustration indicates that “alchemy” included any effort based on informal support or alternative solutions that transcended usual professional approaches and may have involved illegal activities. Also four others indicated that social workers often improvised and used their creativity to find a solution, as there were no “easy solutions” available to social workers. For example, Aristos who worked in a psychiatric unit said:

We have to do a little searching, how can I say it... in a way... social workers must think of various types of solutions. We don't have easy solutions, we must to extemporize a little... I had a patient who had no where to go and I remembered that he had told me about a friend he had in Patra. He needed to go somewhere to live for a while, so I said “why don't you go to Thanasis for a while?”. He told me that he had not seen him a long time, so I said “why not give it a try?”. Namely solutions that are completely at a personal level. Namely it wasn't something professional to tell him to go to his friend, however, I used it in order to find something for this person. (a.a, § 96)

Overall, the attitude of the social workers towards illegal practices, the use of imagination and personal initiatives signify the importance of personal values in the formation of the identity and role of social work. If this is true then, and we accept the fact that there are limited public funds for social protection (Yfantopoulos, 2004), social workers are more than mere dispensers and distributors of welfare provision. Their involvement in helping people is not limited to a formal system of social support; they act more like individuals than professionals having a well defined role.

Finally, the above illustrations appeared to confirm that social workers were able to exemplify the inadequacy of policy to secure human rights and social justice. They all acknowledged the structures as being unjust. Nevertheless, they all appeared to frame their professional identity within these structures. Therefore, for social workers policy was an unchallengeable factor that would determine not only the quality of health services in hospitals, but also their professional identity. In this sense policy determined the way, the time and the means by which social workers would show their care for patients. Social workers typically responded to patients' needs, however, within structures that they perceived as being insufficient and ineffective. Interestingly, none of the social workers perceived this type of practice as ethically compromising (Preston-Shoot, 2003). This was probably because social workers did not recognize their role framed with the purpose of social change. Therefore, social workers by supporting individuals meant that their ethical commitment to care for those who suffered was adequately addressed.

However, according to critical social work practice, social change should be the core purpose of the social work profession. As it was illustrated in Chapter 3, this presupposes commitment to collective values and policy practice including policy analysis and action (Adams *et.al*, 2002; Rossiter, 2001; Figueira-Mc Donough, 1993). Since these social workers did not acknowledge their professional identity framed with structural purposes, they were also likely not equipped to address to what they themselves acknowledged as "*unethical structures*".

In terms of the impact of ethical problems, all of the social workers expressed experiencing a variety of difficult emotions in the face of welfare deficiencies. Overall, they all expressed being disappointed by the public sector, and all of them felt psychologically "*burning out*" from coping with these deficiencies. For example, Rena declared that what "*nobody knows*" or "*cares*" about her psychological tiredness when she was faced with the scarcity of available resources for her clients. Rena, who had been practising in the hospital for 18 years, commented:

Nobody knows and cares about my... should I say it psychological cost? It is a psychological tiredness to try to find a solution that the State should provide. It should provide solutions. There should be social organizations so as to support our work, We simply get tired and we wrestle, and we are losing conflicts with the doctors because we can't give solutions to our cases because they are not provided by the State. I am tired with this, too much, and many times I feel ineffective... that I am not doing my job, that I am not doing my job... it appears that I am not doing my job... I feel ineffective.
(*r.x*, § 259)

This example resonates with McAuliffe (2005) who empirically illustrated the emotional impacts of ethical dilemmas on social workers. What was also important to highlight from the above quote was the fact that even though Rena seemed to recognise it was the state's ineffectiveness in providing solutions for her clients, she also felt ineffective as a practitioner. This may be the emotional result of social workers blamed for difficulties within the welfare state (Banks, 1995; Clark, 2000).

5.4.2 Structured social exclusion

There was the belief among six social workers working in medical units that their role was to work with people that were shunned by other professionals when there was no obvious solution to a patient's problem. For the social workers, this avoidance was also interpreted as *"they don't care"*. Individuals with problems that were deemed unsolvable were typically in a situation where scarce welfare provision meant that an appropriate response was not possible. For example, Chara characterized social work as a *"broom"* for the people who have nowhere to go after hospitalization. She implied that these cases were typically referred to Social Services at a late stage in their treatment because social conditions had been overlooked by doctors who had focused on medical treatment. Recognition of the patient's social status came at the time of discharge when it was suddenly realized that some patients had nowhere to go after their hospitalization. Chara illustrated the way she perceived what other health professionals and the administrators thought of her role:

A social worker in the hospital functions like a broom for the cases where doctors don't know what to do with them, and in the last minute, a day before they leave... because we can not always detect if there is any problematic case. (c.v, § 431)

In this way, Chara seemed to imply that the social worker's mandate was to sweep out patients from the lower socio-economic classes who were akin to being dirt. According to Chara, it was virtually impossible to discharge some patients because of chronic social problems like poverty, unemployment and homelessness. Thus the hospital's or the doctors' narrow view of health put pressure on social workers to find solutions, at short notice, for the other problems. There was no follow-up procedure in place to ensure the well being of the patients after discharge.

The characterization of social work as a *"broom"* has important implications for critical practice given the apparent values that underpin *"discharge problems"* and an absence of a more holistic

perspective on health. It is well documented that more holistic approaches to health lead to improved outcomes and that counseling, psychological support and follow-up are equally important determinants of quality in health services (Pennings, 2007).

Chara continued to illustrate how patients who spoke languages other than Greek were managed in the hospital. She described how the medical team would refer her patients who did not speak Greek and request that she resolve the communication problem. Chara explained:

For instance when they have an African patient who only speaks his native language and they cannot communicate with him, they call me to speak with him. What do you think about that? /// the social worker knows the codes and with very simple words and without using words that the patient doesn't know, like "reference", can communicate. I manage this. (c.v, § 585)

In this example, Chara took the responsibility to speak with a foreign patient about his medical condition using "codes" or gesticulations. Other professionals, such as doctors, declined to deal with this. Interestingly, when there were communication issues with Greek patients, for example cancer patients who needed to participate in their care planning, doctors restricted their involvement. This paradox would seem to reflect an underlying discrimination against foreign nationals. And despite Chara not speaking any language other than Greek, the hospital solely relied in these measures to meet a person's right to be fully informed about his/her medical issues (Beauchamp, 2007). But even the social worker made no reference to other action in these situations, such as requesting the hospital obtain interpreters.

Many of the social workers indicated that the social exclusion of many people was due to the restrictions put in place by various organizations. For example, admission criteria for some of the residential placements for older people, people with severe disabilities, cancer, cognitive impairments, or mental health problems were excluded. In addition, some residences also excluded older people who did not sufficient income or property to support their living expenses. Aristos who was practising in a psychiatric unit illustrated what happened when he was involved with patients who needed institutional care or rehabilitation:

There are so many gaps in social policy, I don't know.. I can't do miracles when I have a person.. and really, I give up... for example, if you want to send a person for rehabilitation in an institution, all the institutions have restrictions for those who are not well. They must be able to look after themselves, must not have a mental illness, I don't have such people here. My client had a mental health problem and he could

barely wash himself, he needed help... in such cases a paradox happens here in the hospital. When the patient is discharged from one unit, for instance if he had a broken leg he will temporarily hospitalized again in another unit, for instance in the urological unit which has empty beds, without having an urological problem he will stay there until someone finds something for this person, who eventually, sometimes dies in the hospital. (a.a, § 32)

Aristos claimed that some patients had eventually died in hospitals, not from any serious illness or medical condition, but due to psychological conditions caused by unnecessary hospitalization. Similarly, Rena confirmed that older people had died in residential care from depression, and not managing to adjust to institutionalized life. Nevertheless, none of the social workers demonstrated an effort to systematically study the causes of these deaths to support their hypotheses.

Two social workers specifically challenged some of non-profit organizations for imposing strict admission criteria that resulted in social exclusion. In particular, they claimed that some of the non-profit residential institutions for older people, although partially funded by the state, had restrictions that excluded the poor and those who could not look after themselves. Periklis described an institution, a non-profit one in the city of Patra, which admitted older people only if they had a good income or property to give to the institution after their death. The institution also restricted the admission of older people with severe disabilities or cancer. Periklis characterized the function of this institution as *“unethical”*. For older people who were ineligible for admission to this institution they were sent to church institutions four hours away. Periklis indicated that uprooting people and forcing them to live somewhere they do not choose caused an ethical dilemma for him.

5.4.3 Bureaucracy and public hospitals

The bureaucratic function of public services was seen by all of the social workers as one of the main factors leading to the violation of human rights and the reduction in help that could be provided to clients. Many of the social workers characterized the public sector as an *“iniquitous machine”* that continuously reproduced unethical practices such as inhuman behavior and corruption. For example, a social worker described the situation of the ambulance bringing in a person taken ill on the street. Administrative clerks and the doctors would refuse hospitalization for those without their health booklet. The social worker stated she would be contacted to defend the *“self-evident”*, and that *“if a doctor was found in the streets he himself would not carry with him the health insurance booklet.”*

None of the participants believed that the bureaucratic function of public services ensured equality in the distribution of resources or preserved human rights. In fact, all social workers described dealing with the bureaucracy of public services as an exhausting process, especially when public servants refused to take responsibilities for their actions. Alkistis argued that “*the fear of bureaucracy*” was a common among everyone including general citizens, social workers and administrative staff and health professionals. Alkistis argued:

It is rather a general fear of the state's machine, everyone is scared of the papers...it is the pen pushers' fear not to be exposed, if by chance they make the wrong decision, or by chance is deceived by someone, or if something go wrong etc and as a consequence someone blames them... so it is the pen pushers who are scared to take responsibility. It is the fear of the media who lie in wait to break the news and things like this, it is we, the social workers who don't take the responsibility to do something. It is because things are like this in society, namely the society and the state machine are structured in a way that everything from its beginning is iniquitous (a.m, § 57).

Herzfeld (1993) in his ethnographic study of Greece found that the stereotypical “*fear of responsibility*” expressed the reluctance of Greek bureaucrats to accept responsibility for offending the powerful. In particular, he argued that the “*fear of responsibility*” served to protect individual functionaries from the consequences of illegal decisions by highly political key actors. For Herzfeld (1993) it was typical that while clients blamed bureaucrats for being indifferent to human needs and sufferings, bureaucrats blamed “*the system*”, excessively complicated laws, and their immediate or more distant superiors such as the government of the state.

In the above example, Alkistis did not identify social workers as being bureaucrats. However, she later said that social workers were also afraid of responsibility. In fact, she seemed to imply that the fear of responsibility is general characteristic of Greek society. So while, she differentiated social workers from bureaucrats, they were the same in terms of their neglect of responsibility. Alkistis likely made this differentiation because social workers were stereotypically caring professionals and bureaucrats assumed to be indifferent about human suffering.

Fighting with bureaucracy was also seen as emotionally tiring even in cases where there was a successful outcome for the clients. The repetitiveness of bureaucratic dysfunction and the sense that “*things cannot change*” made most of the social workers feel exhausted. Interestingly, Alkistis characterized her role when dealing with bureaucratic procedures as “*catalysts*” which made it

possible for the “bureaucratic machine to work”. However, she also indicated this role as an exhausting part of her practice:

For how long do you think that I can feel the same passion for doing these things? Right? For how long one can have this passion? At some point you will get tired, you will want to retire, you will say “everything is the same”, at some time you get tired.. for example, I see some of my colleagues that are 20, 25, or 30 years in this work, and they say “I am tired of doing the same thing all the time, the state machine should be up and running by now. I get tired of always being the catalyst that makes things work. (a.b, § 97)

Alkistis appeared to relate “passion” to continuous effort to make the bureaucracy of hospital administration facilitate the provision of health care services to patients. Although her “passion” appeared to be transformed to exhaustion after endless attempts to promote the needs of patients. And once again, there was no reference to a collective and systematic effort aimed at changing hospital policy. As indicated in section (5.2, pp.126), social work practice in hospitals was primarily individualistic, and the likelihood of collective approached to challenge the “machine” very slim indeed.

5.4.4 The under-funding of public health

Five social workers referred to the fiscal policies of public hospitals and other public or non-profit making organisations as a factor that created difficult ethical situations. These social workers expressed their concern that patients’ needs should be covered irrespective of cost, particularly as these organisations were classified as public. Periklis elaborated on this:

Every public institution practices economic policy, and I get crazy! Every detail is financial! You speak about health care, about aging, about disabilities or you speak about the homeless. They speak to you about expenditure, “how much will it cost, what’s the cost. Where I will put him, I have nowhere to put him, will I have a profit, I don’t have a profit”. This is absurd! Some institutions end up having balance sheets and they have money in their bank accounts. For instance, I am saying this speculatively, if I see the balance sheet and the bank account of “K”¹³, I may find a bank account with millions of euro and I will get crazy! And this is what I want to say sometimes to the experts “go and see how much money “K” has in it’s bank account. (p.p, § 129)

Periklis made reference to a non-profit residential institution that was seen by social workers in Patra to be systematically excluding poor older people because a suspected hidden profit motive.

¹³ “K” is a non-profit residential institution.

However, he also referred to all public services and their newer cost containment measures that seemingly inhibited humanitarian behaviour.

Four other social workers made a specific reference to hospital administration and claimed that the only thing they cared about was hospital budgets irrespective to patient need. All of the social workers who referred to this issue argued that they were powerless to intervene even for the individual benefit of specific patients. Therefore, cases which fall foul of the hospital's budget priorities were usually rejected and described as being treated unfairly.

Staff shortages and poor facilities were highlighted as a determinant of low quality health care almost all of those interviewed. In reference to hospital staff, a nursing shortage appeared to be a significant problem. Some social workers verified that patient relatives were often substitute nurses. In fact, Giannis argued that in many cases "*relatives become nurses by experience*". A lack of other professionals such as social workers, psychologists and physiotherapists was also reported. That was evidently true for the social work profession as in all of the hospitals I visited, the organisation's legal chart required more social workers than the number employed. Polyzos and Yfantopoulos (2000) found that public hospitals in Greece were characterised by an oversupply of physicians, and a lack of trained nurses and other specialized health professionals.

Social workers indicated that a lack of appropriate hospital facilities meant that patients were not treated with respect and understanding of their medical conditions ignored. The phenomenon of "*camp-beds*" in the hospitals' corridors was perceived by the social workers as disrespectful for the patients. In some cases, units in the hospitals were too small in proportion to the patients served. For example, Giannis argued that one of his ethical issues was that every day he had to meet with cancer patients in the chemotherapy unit who were having therapy sitting in a chair because there were no available beds. He said:

The chemotherapy unit has five rooms which have 2 or 3 beds each, the problem is that the rooms should be bigger and the patients complain. This is what they keep telling me every day, "I am coming for chemotherapy, but how can I sit 3 or 4 hours in a chair with an outstretched hand?". This is very difficult for me too. (g.s, § 37)

As Giannis indicated, watching patients suffering with illnesses such as cancer, being treated in camp-beds or sitting in chairs was not only ethically problematic, but also difficult to handle

emotionally. Sadness for those who suffered, anger at the state for its deficiencies, and feelings of powerlessness were common to all social workers.

In addition, three social workers indicated the absence of offices for social workers in which to have private interviews with their clients. These social workers typically shared offices with other hospital employees who would invariably over hear confidential information. Elpida appeared to show off her ability to manipulate patients to stop them from suing the hospital for breaching confidentiality. She seemed to be proud of her ability not because she was ensuring or promoting patients' rights, but because she was able to control patients from making demands on the hospital.

I submitted requests, papers, I was asking for hearings with the manager and the general manager of the hospital. They all agreed with my claim but they were asking me to give them some time, so as to fix it, they wanted some time. So I had to show some understanding, but I told them that the fact that no one had made claims against us is not a coincidence. It needs a lot of skill to do this, but the clerk I share an office with must show tolerance because she is not trained to hear these things. In fact, I remember her saying to me "I can't stand this, turn them away, there are so many, and why are you doing this? How can you stay calm and not get ruffled?" I told her I am sorry I am putting you through this, but I believe there is no other way. (e.m, §222, 226)

Elpida seemed to take control of her colleague's complaint and frustration by presenting the situation as having no alternatives. Although she acknowledged that the absence of a suitable location for confidential interviews was an ethically problematic situation, she seemed to make efforts to control this problem without permitting the involvement of others (e.g. colleague, patient) to resolve this issue. This situation is similar to that noted in section (5.2.4, pp.135) where the social control practices of social workers were focused on preventing problems from becoming "big issues". However, none of the social workers appeared to acknowledge that such practices likely did not promote patients' rights. Moreover, Elpida appeared to violate the right of her clients to be self-determinant given they were not aware of their right to not to disclose information when confidentiality was not ensured (Reamer, 1982).

5.4.5 Health professionals and unethical practice

As briefly introduced in sections 5.1.2 (pp.119) and 5.2.4 (pp.135), the practice of other health or administrative staff resulted in complicated ethical problems for social workers. These findings provide further evidence to support what other studies have demonstrated about the

consequences of unethical practices in public hospitals. In particular, informal payments affect access and utilization of health services as patients who cannot afford to pay cannot access the same level of services or have to wait longer for care. Moreover, informal payments appear to increase the rate of unnecessary medical treatments (such as the rate of caesarian section deliveries) which is unlikely to reflect need (Mossialos *et al.*, 2005; Ballas and Tsoukas, 2004; Liaropoulos, 1998).

All social workers argued that one of their major ethical problems was the unethical behaviour of others, including doctors, nurses, and social workers, and internal and external staff. In particular, abuse of authority was seen as a major ethical issue that resulted in a systematic restriction and violation of human rights, and degraded health services. In all cases, the attitude of administrators toward this issue appeared remarkably indifferent, and in some instance administration was viewed as the system that consciously covers unethical practices. All social workers expressed being certain that politicians and hospital administrators were aware of the situation, but took no action to stop it.

Social workers described various cases which involved the unethical practice of doctors. The main aspects of doctors' unethical practice appeared to involve:

- a) "*Fakelaki*";
- b) The private practice within the public hospitals;
- c) Illegal adoptions;
- d) Discrimination;
- e) Neglect of duty; and
- f) Depersonalisation of the patient/ usage of formal language/ detached behaviour.

Various empirical studies have described physician involvement in taking bribes and other unethical practices (Rovithis, 2006; Mossialos *et al.*, 2005; Ballas and Tsoukas, 2004; Liaropoulos, 1998). Although all social workers acknowledged that doctors were taking bribes, they pointed out that in many cases it was patients who were offering bribes to the doctor. The social workers indicated that surgeons and unit managers were bribed most often. The reasons that these two groups were targeted were the surgeon would provide better treatment, while unit managers could arrange for an extended hospital stay.

All of the social workers indicated that unethical practice of doctors was something that “characterises the system”; however, they did not have evidence to prove this. They also claimed that as patients were involved in this informal arrangement with their doctors, there were no charges laid against the doctors. Sotiris, who was a social worker working in general surgery and in intensive care, claimed that social workers could do nothing about this as they are not allowed to be involved in the medical issues of a patient. He said:

The public health system profiteers// I don't have something specific, for example for the issue of “fakelakia”. The bribes of doctors is not something that has to do with names. Neither do patients accuse doctors. It is something that exists, you know it, the political leadership knows it, the health professionals also know it. It is something that characterizes the whole system, but when someone comes to me and asks me to name a case, I am not ready to say something because I can't be sure of a name. It is just a rumour. You can only assume from some specific circumstances. What are these circumstances? For example, if a patient waits for some time to be operated, it is not a coincidence that he is very poor and another patient who is wealthier comes and is operated on immediately. Then this is an example without naming someone, ok? Especially in the surgery units, in units that I work, it also exists. (s.m, § 31)

Sotiris seemed to be certain that doctors took bribes for their medical services in hospitals. He also implied that taking bribes was most common in surgical units, probably because in these units patients and their families are more vulnerable as “life and death” issues were sometimes involved. Sotiris also argued that the political leadership was aware of these practices, but did not make any effort to control and eliminate them. Interestingly, there is a bulk of literature indicating that ethical issues related to “life and death” are common amongst health care professionals (Boland, 2006; Manetta and Wells , 2001; Csikai, 2000; Foster et al., 1993; Proctor et al.; 1993). The ethical issues that social workers identified in these studies usually involved questions about competency, patient confidentiality, truth-telling, decisions of physicians, assisted suicide, and dilemmas on self-determination versus the best interest of the patient. In contrast, Greek hospital social workers indicated that the major ethical issue was the involvement of the doctors’ unethical quest for bribes even when patients’ lives were at risk.

Elpida, who was a manager of a SSD in Athens, also claimed that she was unable to take an action against the unethical practice of doctors since it was the patients’ choice to bribe doctors. She specifically referred to cases where doctors, although prohibited by law to work privately, see private patients in their offices during their working hours. Elpida explained:

Managers often have two offices and see their patients privately in one of these, while the public sector pays them; and there are other public servants who work and support the public sector and they don't even have an office of their own; we are talking about an illegal practice, of course, it is illegal. So, what? It is indeed true! We all know it and nobody does to anything about it, so we remain silent. But silence is complicity. Do you think that I am not an accomplice? I know very well that indeed I am, but what can I do? ... first of all, the client himself must help. He must make a accusation against the doctor. Namely, it is a dance that doctors and patients dance together and it is a mating dance. Since they dance together, both parts consent, so, what can I do about this? Can I put a camera inside doctor's office at that time?.. truly, I don't see how I can help in this. (e.m, § 230)

Interestingly, Elpida referred to the unethical practice of unit managers who are also doctors and have an administrative role in the hospital. Nevertheless, Elpida did not suggest that getting involved with an authority as the main difficulty, instead she pointed to the fact that patients were also involved in such practices and they do not make accusations against doctors. Social workers seemed sympathetic towards the patients' need for high quality health service even if it meant they had to bribe doctors. They all acknowledged that the authority of the doctors over their patients was sufficient to ensure the continuation of unethical practices. Interestingly, the participants were able to identify the role of the power relationship between doctors and patients and its determinant role for the exploitation of the latter. However, all participants appeared to remain just sympathetic to the exploited patients rather to move towards an emancipatory practice. Once again, the inability of the social workers to work towards the development of a more structured partnership promoting broader collaboration and intervention for structural changes emerged. In this sense, the absence of a critical approach determined the inability of social workers to frame emancipatory practice within their professional identity (Dominelli, 2002).

All social workers appeared to feel unable to intervene in cases when doctors neglected their duties. They claimed that as they were prohibited from intervening in the medical issues of patients, they had no right to point the doctors' deficiencies. In fact, this was not a surprise given the obvious superiority of doctors over other NHS professionals in Greece (Dedoussi *et al.*, 2004; Georgoussi, 2003). In this respect, social workers fear of responsibility was once again obvious and reflected in Herzfeld's (1993) account about the reluctance of Greek bureaucrats to accept responsibility for offending the powerful. For example, Rena who worked for several years in medical units described a case where an older man was hospitalized with pains in his abdomen. For over a week, doctors had not examined the old man and decided to discharge him from hospital even though he still complained of pain. Rena worked with the older man during this time

trying to comfort him, however, she felt unable to intervene to ensure treatment. In the following quote, Rena described this case as an ethically problematic situation:

Ethical problematic is our relationships with doctors... namely, we have many patients who are not treated as they should by the doctors and we can't intervene. I had an old man in 719 room. I even remember his room because I was going down to my office crying because I felt that I did nothing for this man/// the day that the old man was leaving the hospital, doctors hadn't examined him yet, and the old man was complaining that he is in pain// I helped him to get dressed and he left without being medically tested, he left in pain, and while I was going down the stairs I was crying because I felt that in reality I did nothing for the old man. (r.x, § 43).

The overbearing attitude of administrative staff, mostly those employed purely as administrators, was one of the main problems for social workers. All agreed that by maintaining a good personal relationship with these public servants was one effective way to deal with their capricious behaviour. For example, Alkistis illustrated how this behaviour could affect the clients' interests; however, she perceived that such practices could not be challenged:

Unfortunately, it is in each public servant's hands because every public servant has a duty, right? Of course if you try very hard when the patient has a legal right... Because many times we try to push them to bypass some things, and some other times too, we push for things that the patients are eligible to take, right? Every public servant has a particular duty. If they don't want to be conscientious, even when the patient is eligible to take something, the public servant will not do it. // of course I could decide to pit myself against them, but I say "if I will need him tomorrow and he doesn't serve me again? What I will do?". (a.m, § 82, 85)

Alkistis made a conscious decision not to challenge public servants whose behaviour violated patients' rights. She justified her decision with the belief that the very same authority was occasionally necessary for promoting her clients interests when unjust policies or laws restricted them. Inevitably, neglect of duty by public servants often resulted in long delays in providing services. Some social workers declared that the preservation of human rights depended on the behaviour of these people. But all agreed that in the interests of their clients, maintaining good relationships was preferable to reporting unethical practice.

With reference to unethical practices by social workers, the majority of the participants explicitly admitted such actions. For example, dishonesty was not perceived by all social workers as

unethical and rather it was an accepted practice especially if it benefited their clients. Such cases appeared to reflect the adherence of the social workers to the utilitarian approach to ethics.

For example, two social workers demonstrated their conscious decision to hide the truth from their clients. In one case, Tina said she found it important to provide some free time away from the psychiatric department for a group of children. For this reason she decided, at personal risk, to give some children a break from hospital routine, but others would have to remain there. She clearly indicated that she positively discriminated against some children. Tina explicitly stated that she was dishonest with them because she was not willing to take the same risk for them all. She often used the opinion of a doctor to justify her decision. The following excerpt is Tina's description of covering the positive discrimination and lying to the children:

I usually say [to the children] that I can't take them all, for example, that I can take only some of them today, "another day I will take you". You hope that the day will never come or that the child will have leave the Care Unit before then. Or other times I tell them that I will ask their doctor, who obviously refuses, and then I am covered for not including the child, who I didn't want to take anyway, but I am not telling the truth, because in other cases I have to fight with the doctor to take children out/// this is how I deal with this. (t.m, § 119)

However, another social worker clearly stated that dishonesty was definitely unethical practice. He explained that he was dishonest in one case where he reassured a client, an older lady, that the care home where she was to be admitted was of a good standard and one of the best in the area. In fact, Periklis had never visited the home and was not really informed about the living conditions there. When the older woman urged him to see her as his mother, he regretted his dishonesty and assured her that he would go and visit the institution before he proceeded with her admission.

Two others argued that social workers hide, with their silence, the indifference welfare in the system in Greece. Sotiris indicated that social workers not only protect the apparent public image of hospitals, but they also cover the corruption by being simple bystanders. However, he implied that it was not their role to control and punish the unethical practices of other professionals. He said:

We consent with our silence. Nevertheless, we are not inquisitors to deal with this, because in order to deal with it, one must also be... to have evidence. This is not our mission. Our mission is to help people, but the system has so many elements of corruption that touch the social services department that we can't address these issues at all. (s.m, § 23)

Similarly, Chara argued that social workers try to defend the inhumane welfare system when they deal with people in need because there was nothing substantial to offer. She exemplified this belief with the 40 euros a month welfare benefit for single mothers, and the humiliation of experienced by women due to the bureaucratic time consuming processes required to claim such a small amount of money.

In reality we mediate. We try to justify the unjustifiable. For instance, the benefit for an unmarried woman is 40 euros, we try to say to her, ok, this is what the state gives and you should take it. We tell her to go and suffer the bureaucracy of the welfare state for five months, be humiliated by queuing continuously for 40 euros, and we say this is how it is. We try to justify the unjustifiable. (c.v., § 510)

5.4.6 Social workers and the violation of law and organizational rules

The violation of laws and legal procedures was seen by the majority of the social workers as an ethical obligation when other factors, such as the deficiencies of the welfare state or the bureaucratic function of public services, obscured the best interest of the clients or their rights. An example in section 5.1.1 (pp.116) described a social worker giving her health booklet to a patient with no insurance. Further examples emerged and these continued to demonstrate unflattering professional behaviour that was argued as ethical necessary.

Scarcity of available residences for mentally ill patients was yet another reason for social workers to engage in illegal practices. For example, Aristos described a case where a patient without family needed somewhere to live. He had a serious mental illness and was incapable of work. There were no special social programs to help provide him with financial support for independent living. Aristos had found a residence for mentally ill people who had previously been hospitalized, however, Aristos' client had never been an inpatient and was there for not eligible. Aristos arranged with a psychiatrist to provide a nominal admission to a psychiatric unit to satisfy the residence's qualifying requirements. He described being at a "dead end" with no other viable solution, and "ethically" forced to "manoeuvre" organisational restrictions:

Many times you are just forced because you have a man... and you are at a dead end because you don't know what to do with him... for example, I know that this man cannot live alone. He has no job. He has no money and he has a mental illness which is in remission. In a residence he could be functional and be able to enter again in society, and he could be with people, so he could get better. So you are forced to do this... namely you try to find a way to manoeuvre in order to help this person not to be wasted. (a.a., § 52)

Similarly, Chara arranged with a doctor for a free operation for an uninsured immigrant. Chara's involvement was to ensure that the patient would be operated on and leave the hospital without following the legal admission procedure. This way there would be no record of the provision of health care without payment. She stated that she could have said to the patient that nothing could be done without proper insurance, but her conscience would not let her. She also argued that social workers ought to do whatever they could to help their clients.

These examples of social workers justifying the violation of laws on ethical grounds provides further support to Furman et al. (2007). Although this study was conducted with students and used a case vignette, students chose to violate statutory laws when they perceived these to be against their clients' interests. Banks (1995) also argued that laws can only determine what can be done, but not what ought to be done. Moreover, the decision of the social workers to violate the laws when thought necessary may also reflect their engagement with the value of care. However, it also seemed that their decisions were a response to the immediate person in need while the collective interest for equality was ignored. As previously mentioned, this is what Meagher and Parton (2004) named as parochialism and was described as one of the "dark sides" of the ethic of care.

In contrast, the representative of the HASW expressed an absolute negative stance towards illegal practices. She made a clear distinction between being a good person and being a good professional. For example, commented on the decision of some social workers to use their personal health booklet to enable illegal immigrants to obtain free medical treatment. Recalling that Efi had several years of hospital practice, she commented:

It is not only an abuse of public money, but it is also illegal. I will tell you something.. the system is unethical. This is something that I absolutely believe. It is unethical and humiliating, and deficient and what ever you want to imagine, but this doesn't mean that we should be unethical too /// if (the immigrant) needs medicines, the system should solve this problem. I am not allowed to use my booklet like this. I will not break the law.

We are not good Christians, we are good professionals. If we have the guts we should report it to the Ministry/// what are you talking about? HASW should take a stance towards illegal practices? HASW says we shouldn't violate the laws as every normal person believes. The end doesn't justify the means when we commit a crime. I don't care, I hold very tough stand on this, I once told a hospital that I will try to help a patient not to die but if he dies this doesn't concern me. The system should be concerned and the state which has cancelled everything it had put in place itself. I have no ethical dilemmas about this. (e.x, 209, 213, 328)

Interestingly, Efi seemed to believe that a good “*Christian*”, or a good person, would be ethically permitted to violate a law to support another person. Contrarily, she believed that professionals were obligated to protect laws. Efi appeared to identify the practice of good professionalism with the role of public servants to protect the state. Paradoxically, the participating hospital social workers were also employed as public servants and they did not seem to envisage their obligation to protect state laws. This contradiction between Efi’s and the social workers’ account could be explained in different ways. On the one hand, the hospital practitioners had a special concern and a need to excuse their inability to make big differences in their clients’ lives by stressing the unethical system and the deficient welfare state. On the other hand, Efi as a member of the HASW, was especially concerned to explain her view on “*good professionalism*” even though she had practiced in these hospitals. In this sense, the perception of “*good professionalism*” by both sides was probably not different. However, due to different concerns social workers distanced themselves from the state when they challenged unethical policies. Importantly, Efi appeared to have a negative attitude towards the utilitarian approach as she explicitly disapproved unethical means be used for good purposes. She also seemed more adherent to what Banks (2007) described as “*new accountability*” which engaged the professional to work according to specific procedures, tasks, and standards, and to practice with an impersonal attitude to be able to identify different stakeholders other than the person in immediate need.

Evidently, violating the law and organizational rules were perceived by the social workers as an outlet to not compromise to unethical structures. This type of social work practice, however, should be understood by taking into account two important factors. First, given the overall absence of evaluative processes and managerial control in Greek public hospitals, the risk for social workers was relatively small (Rovithis, 2006; Mossialos *et al.* 2005; Yfantopoulos, 2004; Ballas and Tsoukas, 2004; Sotiropoulos, 2003). Second, social workers did not express any concern neither for the long term consequences nor for the overall effect of this practice for

societal well-being. Therefore, this practice appeared to be individualistic in character and they did not demonstrate any concern for the underlying social justice issues. As in critical practice, challenging the structures should be perceived as a genuine political action which should be evaluated by its underpinning values (Rothstein, 1998; Morone, 1997).

5.4.7 Summary

This section provided a detailed analysis of cases which were described as ethically problematic, but entailed an ethical certainty. In such cases various factors appeared to constrain the ability of the social workers to act according to what they perceived as their ethical obligation. In particular, five main factors appeared to create ethical problems including the absence of welfare support, policies that structure social exclusion, bureaucracy, under-funding in public health, and the unethical practice of health professionals.

Social workers, in order to not compromise, appeared to violate laws or legal procedures in their effort to overcome the structures that obscured the best interest of the clients and/or their rights. Importantly, although social workers argued that work under *“unethical structures”*, they did not recognize their role framed with the purpose of social change. Therefore, by supporting individuals, social workers adequately addressed their ethical commitment to care.

5.5 Understanding ethical dilemmas

Some of the social workers' descriptions of ethically difficult situations involved a clearer conflict with ethical principles. Therefore, these are characterized as ethical dilemmas which have been defined as (Clark, 2000; Banks, 1995). However, social workers were not always able to determine the conflicting ethical principles. In fact, in many of these descriptions social workers expressed a clear preference for one specific ethic over another. In some cases they seemed to make their decisions not on ethical grounds, but based on justifications related to organizational rules or cultural issues.

5.5.1 Truth telling

A prominent ethical dilemma identified by most of the social workers working in medical units was that of telling or hiding a cancer diagnosis from patients. In fact, all social workers had a clear

opinion on this issue and that was to hide the truth. This decision was commonly based on two main justifications. First, the social workers seemed to accept that they had no right, or even that it was unethical to intervene in the medical issues of patients. Second, they seemed to accept the paternalistic attitude of the family wanting to decide whether to inform the patient as not.

In reference to the first justification, the acceptance that “*those who diagnose death should be responsible for announcing it*” was a familiar argument. For example, when Sotiris was asked about how he managed this ethical dilemma he replied:

I don't intervene. Don't you want an honest answer? It is an issue that I don't intervene because the doctor believes that it is clearly his issue. Besides, the doctor determines and knows the therapeutic needs of a patient and there is no way for other health professionals, including nurses and social workers, to express an opinion for a medical action. (s.m, § 51)

Sotiris was one of the social workers that identified hiding the truth from patients diagnosed with cancer as ethically problematic. However, he had a clear and uniform justification to hide the truth from the patients. He supported his justification by identifying the absence of a multidisciplinary team that would enable other health professionals to be involved in decision-making. And second, as stated above, he indicated that doctors had the responsibility to reveal this information to patients. However, when he placed himself in his patient's position, he argued that he would prefer to be told the truth.

Alkistis was asked how she dealt with this kind of case. Although she characterized being involved in the doctors' role as unethical, she made no comment on whether it was ethical or not to hide the truth about a patient's health issues:

I will deal with it according to what the patient knows. Namely, in any case I will not inform the patient because I am not the responsible professional to inform him... I will see, I will find out what the patient knows. This is something that you get to know in the first interview with the client. The client will tell you. He can't keep it secret, and according to what the patient knows I will deal the case. I am not going to intervene because it is not my job and this is unethical. Namely it is a real duty violation if I inform the client. It even may be perceived as acting out of malice, I don't know what exactly, it is clearly not included in our duties. (a.b, § 283).

However, Alkistis acknowledged that a doctors' decision to hide the truth from a patient was biased by their own emotional difficulties. As such, their decision to hide the truth was possibly

not completely based on the best interest of the patient. She also seemed to believe that physicians, except psychiatrists, did not have the capability or the training to deal with a patient's response after being informed of having cancer. Alkistis finally acknowledged that getting involved in a doctor's responsibilities was unethical, however she avoided the simple issue of truth telling. Reflecting further on being with a patient who was unaware of a potentially serious diagnosis, she replied:

Look, on none of the occasions do I feel sorry for them. I always have in my mind when next to the bed of the sick, even when the logic doesn't make me think this way, but I think when next to the bed of a sick man, many sitting there are condemned too, namely ...I think that death is not the only outcome. The patient may escape from this situation and have many years to live, I don't know, namely I am thinking that I am not seeing a condemned man, I am thinking that I see a person who lives. (a.m, § 319)

Interestingly, Alkistis's explanation of how she felt about being with someone who had cancer clearly illustrated her thinking and views on this matter as she "sees a *person who lives*" and not a person who is "*condemned*" to die. From a psychodynamic approach, this answer reflected an emotional difficulty dealt with by a defence mechanism. In this instance rationalization protects the "*Ego*" of the social worker when meeting a cancer patient and her fear of death. Furthermore, she also inferred that patients could perceive her telling them the truth as an "*action out of malice*". She also explained that a perception of evil was "*bringing bad news*" or "*news about death*". This may also be interpreted with the way that cancer, at least, is culturally identified with death.

The second most common justification for avoiding the truth with patients was the acceptance of the paternalistic attitude held by family members. All social workers defended the right of the family to determine whether the patient would be informed of the truth or not. For example, Maria felt certain that patients had the right to be informed about their diagnosis. In fact, Maria was the only social worker who clearly referred to self-determination as a right that was constrained when the patient was unaware their health condition. However, she also acknowledged the right of the family to determine this decision. Interestingly, in her argument the issue of scarce supportive community organisations was intertwined. She argued that since there was no available welfare support, the family was the only supportive system for the patient. As such, this gave the family right to intervene in vital decisions about patients' lives and should be recognised more often. She said:

I believe that the patient has the right to know the truth. This not debatable for me. I am sure about this, however, I can not ignore the fact of the environment that this woman will live in, this family, eventually and in the long term, will take all the responsibility and the initiative of taking care of her...right? Besides, when we want to rehabilitate a person we will firstly count on the family, because here the family still works. The family exists in order to help a person who suffers, its a member who suffers, and the family is the first thing that we will try to motivate and use, so we don't want to spoil this relationship. (m.k, § 215)

As in the case with doctors, some social workers acknowledged that the family's tendency to hide the truth from their relative about their diagnosis of cancer was biased by family's emotional difficulty to deal with it, or by defence mechanisms such as denial. In fact, Giannis who practiced in oncology unit commented:

Relatives have much more difficulty dealing with it than the patient, because I believe that they themselves have not accepted this fact. The patient also denies the fact, but the family even more, but at the same time family wants to help, but how can you help your man if you haven't accepted that he has cancer and that you have to stand by him? (g.s, § 69).

As alluded to above, many of the social workers also referred to the ways that cancer was dealt by Greeks in general and the stereotype of the Greek "emotional" character. For example, Maria strongly believed that cancer patients should be informed of their diagnosis, however, she recognized that in Greek society cancer patients were still stigmatized:

In Greece, if you hear that your man has cancer it is ...how can I say it... in Greece, cancer is a word that we don't want to use. We call it the loathsome disease, the cursed. We have given various other words in order to say that this man has cancer /// I am telling you that in Greece we still have cancer as a social stigma. (m.k, § 183, 195)

Similarly, Sotiris justified doctors' decision to hide a diagnosis of cancer by referring to a stereotype of the Greek character. In particular, he argued that since Greeks were very emotional characters a shocking truth would be devastating for them and they probably would not handle it.

Since Greeks are Mediterranean people, we are very emotional. We can't stand reality. So, the knowledge of the truth instead of driving the person to better ways of adjustment creates worse problems. (s.m, § 102)

What is worth noting from the above illustrations was the stereotypes were a significant feature in their practice and, none of the participants referred to the responsibility of the social worker to

advocate the patients' right to be honestly informed about their personal health issues. Although, they were able to identify doctors' professional obligation to inform patients. Additionally, social workers made only few references to their own feelings despite they readily acknowledged and illustrated the ways that doctors' and family's emotions were important factors in their decisions.

The following example illustrates a case where Maria, who strongly believed that patients should be informed, accepted the doctors' and family's authority to decide what information was shared. Maria's behavior, however, was inconsistent with this. Maria decided to prompt the patient, who had breast cancer, to go the Association of Women with Breast Cancer to find support and speak with other women with similar problems. She informed the patient without mentioning anything about the diagnosis and purposefully avoided the word cancer. However, Maria recognised that once the patient decided to go to the Association the patient would realize the truth about her cancer diagnosis. When the family heard that Maria had informed the patient about the Association, they were angry and asked for an apology. Maria reassured them that she did not say anything about the diagnosis, and the family decided not to mention anything more about the Association. Maria did nothing further, and the woman left hospital without knowing the truth about her diagnosis. Maria commented on her emotions:

I feel reassured because of the fact that I gave them the information. The way that they took this information maybe is something coincidental, maybe at a second level and in time they will tell her ... maybe a second time they will think it over. What is important is that I told them.... that I have given them the information. (m.k, § 223)

Whilst this social worker seemed to defend her decision to conform and hide the truth from the patient, emotionally and ethically she was driven to act differently. It seems her conforming left her conscience restless and she needed something to feel "reassured" about. This uncomfortable emotion, although not acknowledged by Maria, drove her to provide the patient with a piece of information. Feminists theorists on ethics have argue about the emotional involvement of an individual in the ethical decision-making process. According to these theorists, emotions are embedded in what people understand as moral or ethical and derive from intimate relationships and empathy (Koehn, 1998).

All social workers who identified hiding the truth from the patients as ethically problematic seemed to deal with it as if they were in the patient's "shoes". However, they identify this ethical issue as having a specific professional role, that is, to advocate and promote one's right for the

truth. Therefore, ethical action may not only be a matter of knowing or identifying ethically problematic situations, rather it is also important to acknowledge ethical responsibilities as part of professional practice and role (Bowles *et al.* 2006). However, the ethical engagement of social work to social change is prone to remain an intellectualized purpose unless a framework for action will be also used by the professionals. In particular, the critical approach provides a comprehensive framework for action to achieve political and social changes.

Few referred to self determination as a right that had been undermined. Virtues such as honesty were missing from their ethical deliberations. According to the ethic of care, not all actions derive from a genuine desire to show our nurturing interest for the other and therefore, some actions may be incompatible with caring (Koehn, 1998).

The role of emotions in the ethical decision-making process was illustrated and this fact may constitute evidence for those who model the process of ethical decision-making. If the decision maker's emotions are able to alienate the enactment of the decision, then an ethical decision-making model should not be based on an artificial conviction that decisions are made based on values such as the best interest of the client. Instead, a model should include the thoughtful examination of the decision maker's emotions not only to predict emotional violations, but also to ensure a more conscious enactment of the decision. Additionally, in the instance of the social worker who expressed her feelings recording the cancer patient may suggest that difficult emotions and the enactment of defense mechanisms obscure one's ability to recognize the ethical dimension of a situation.

5.5.2 Autonomy versus safety

Some social workers found it ethically difficult to decide whether to ensure someone's best interest. Older people and issues of safety were a particular concern. Knowing what was safety for older people was not always a straightforward process. Therefore, for some social workers the real ethical issue was not to choose among autonomy and safety, but rather to ensure that older people would be safe in institutional care. Rena made a clear illustration of this consideration:

For me the only solution, subjectively, was to send this person to an institution, to have his food, his care, but he didn't want to go. This is the dilemma, what we believe that should be done and what the person himself believes, especially when he cannot understand the situation. Also when they have a family who cannot have them in their

home and decides to put them in an institution and in many cases they don't want to go. At this point you have to work hard... how can you take the decision that it will be the best, is it the best, when the old man goes to the institution and will be depressed and die in the institution. Because such cases are real. When you say to him that you are going to live in an institution, he sees it, he accepts it, but when they go to the institution they refuse to eat and after few days they die. (r.x, § 27).

The following example illustrates Rena's changing attitude towards self-determination as she became more sensitive to a person's own will through a shocking experience with a client. The case was a hospitalized older man in the neurosurgery unit who suffered from severe pain in his back. Doctors were postponing his surgery without informing him about the reasons of this delay. After some days, the patient warned Rena that he would commit a suicide if his surgical needs were not met. Rena ignored his warning and he committed suicide. Rena explained how this case affected her practice:

This case affected me a lot in the ways that I now deal and see all these cases /// after this case I am much more sensitive to what people want for themselves irrespective of what I believe it is the best for them. (r.x, § 6)

Many years later, Rena came across a similar case where an older man, incapable of caring for himself, threatened he would commit a suicide if she "sent" him to an institution. As he expressed an eager desire to retain his autonomy and appeared to be at risk of suicide agreed that he go home alone despite her concern that he would not manage. She stated that by sending him home "he would experience the reality of his condition" and he would finally choose institutional care. However, the man died in hospital prior to his discharged and Rena felt relieved as "God finally gave the solution".

The intense desire among some people to preserve their autonomy and their consequent suicidal behaviour pressed Rena into an emotional appraisal of autonomy and self-determination as rights that needed to be preserved. Here again, emotions seemed to play an important role in ethical deliberation.

In all of the descriptions where social workers restricted older people's autonomy by placing them in institutional care, it was clearly identified as the worst solution. However, they felt at a "dead end" due to the complete absence of home care services. In some cases social workers argued that the cognitive and physical abilities of these people were such that institutional care was not justified. Yet, the absence of home care organisations and legal advocacy for patients, and the

poor financial state of older people coupled family support meant that social workers had no choice but to send these people into residential care.

In addition, none of those interviewed felt that living in an institution would improve their quality of life. Although social workers defined such situations as ethical dilemmas, it was clear that the “*best interest*” were not being promoted. Rather, institutional care was given the absence of other alternatives.

Self-determination and autonomy were evidently prevailing values in the social workers’ thinking. This finding is consistent with those of other studies that indicated that self-determination is a leading ethical principle for social workers (Woodcock and Dixon 2005; Banks, 2005; Kugelman, 1992). For example, Elpida described a case where a diabetic older woman had gangrene in her foot. The patient did not want her foot to be amputated despite her health at great risk. Refusing to sign approval for her surgery, her surgeon postponed the surgery and prescribed strong painkillers. The woman eventually died from a perforated stomach due to the drugs. Elpida described her thoughts on the situation:

She had severe arteriosclerosis. She eventually had gangrene. It was very a difficult dilemma to convince her to let them amputate her leg. I was trying to understand her. To understand what she really wants. She didn't want this dilemma; to decide between "either I lose my leg and I save my life or I leave it as it is and I die". She refused to accept this. The doctors reacted, and they were saying that since she refuses the operation she should leave the hospital/// I could see that she wouldn't be able to stand it if they amputated her leg. The right thing was to amputate it. I was accepting what the specialists were saying, that she had a gangrene and indeed the gangrene got worse but eventually she didn't die from the gangrene. She died from a perforation of her stomach because she was taking a lot of hard painkillers/// I felt that this woman wasn't ready for such a big change in her life. (e.m, § 390, 394,585)

Elpida seemed to respect the patient’s right to decide herself even at the risk of losing her life. Interestingly, she said that her client “*didn't want this dilemma*”, suggesting that this ethical dilemma was her client’s too. This may have also indicated her adherence to the value of self-determination as she allowed her client to have control over this dilemma. However, it does not seem that her final decision was made on ethical grounds. On the contrary, it seemed that the social worker unconsciously supported the woman’s refusal that ultimately led to her death. In particular, Elpida said “*I could see that she wouldn't be able to tolerate amputation of her leg*” and “*I felt that this woman wasn't ready for such a big change in her life*”. Elpida made an assessment

of the patient's emotional ability to accept her reality, and she analyzed the case based on the patient's feelings. In fact, she made no reference to a risk assessment in consideration of death that could result from the strong painkillers and a delayed operation. What was also significant was the doctors' reactions and attitudes toward this case. Elpida referred to a detached response from the doctors as they insisted the patient should leave the hospital since she was refusing the operation. Elpida commented:

The doctor spoke to the lady but she couldn't understand because doctors usually use a formal language. He is in a hurry. He doesn't care. He says: "ok, I told her that, I don't have a problem" or "I don't care". Sometimes I cannot blame them. They want to make the patient understand, but they really don't have the time, so they say to me; "take care of her, speak to her in a way that she will understand you". But I also have to understand what the doctor says and, in order to understand him, I must study the case, to search, to have experience in his profession. I was helped in that by my previous occupation as a nurse. (e.m, § 593)

Elpida implied that doctors did not give the appropriate time and nor did they use understandable language to ensure that their patients made informed choices about their health issues. Interestingly, the social worker felt that she had the right to be involved in patient's medical issues in contrast to the social workers working with cancer patients. Her level of patient engagement likely reflected her background in nursing.

5.5.3 Patients best interests versus hospital rules

Discharge planning was one of the prominent ethical dilemmas for the social workers. Most commonly these cases involved a patient who had to be discharged from hospital but for "social reasons" the social worker believed that this was a premature decision. Typically, all descriptions involved the complete absence of community resources. In these situations conflicts between doctors, administrators and social workers were inevitable. Even though most of the social workers acknowledged that "doctors are right" when they pressure to free beds, nearly all of them explicitly took on the role of patient advocate. Even though social workers argued that they had no power to influence decision-making, in these cases they sometimes successfully influenced the discharge planning process. All of the described cases reflected the social workers' respect for a patient's right to self-determination, and adherence to the ethical principle to support the best interest of the client.

For example, Giannis described a case of a woman who was left quadriplegic after a traffic accident. She was alone with two young daughters and had little money. She needed intensive care and rehabilitation, but could not afford to pay for private health care. There were no public rehabilitation institutions where she lived. The only solution Giannis felt he had was to send her to a public rehabilitation institution in another city. However, this institution had no free beds and a long entry procedure, and Giannis wanted to postpone discharge from hospital until the rehabilitation had been available. He was also certain that the woman had not the appropriate environment and support to be cared for in her home. Giannis described the situation:

The doctors were pushing me and I was pushing her daughters to leave the hospital. There was a dilemma for me, "what am I supposed to do now? Who am I going to support? Should I support the patient or the doctors? Namely, what I should do? Of course, it is my principle always to take the part of the patient, right? For me the patient is the principle. The patient has the inalienable right to be hospitalized here, to stay here, and since I judge that this woman from a social perspective has no one to take care of her in her home, she doesn't have the appropriate environment, she should not leave the hospital. Medically she might be able to leave, but socially she couldn't. I wasn't putting my signature to let this woman leave, and eventually after my persistence and patience the woman remained for some time. I sent her papers to the institution and eventually she went to Athens for rehabilitation/// but unfortunately, the doctors are always chasing us because they need the beds. They are right. There are so many people who are hospitalized here because the hospital is regional and people come from all over the region, so they need the beds, besides, hospitals are not institutions. (g.s, § 101)

Similarly, Rena advocated for a patient to remain in hospital where the manager of the orthopedic unit was ready to discharge him without informing social services. Rena stated that the patient was a loner and could not ambulate without assistance. As a result, she was attempting to find suitable accommodation in a residence. When Rena heard that the patient was being discharged she went to the manager, and complained about this decision without her. The administrative manager called a meeting to discuss the issue. Rena illustrated the case:

I went to the Administrator and I told him "with what right he does such a thing? The hospital is not the Manager's home to do whatever he wants. He knows exactly what is happening with the patient. He knows the procedure. He could show some sensitivity at least until the patient can walk. They should take care of him better". They should give us some time, something would happen at some point, an institution would open or something /// when I met with the Manager he told me "I want you tomorrow to tell me where he will go", and I replied: "I have nothing to say, what I am telling you now is what I will tell you tomorrow and after a week, and this is something that I wrote to you with my signature. I told you what is happening with this case. He will leave once we find an institution to accept him. I have nothing more to say to you neither have I another

suggestion. (r.x, § 231,251)

In contrast, Sotiris expressed a more moderate stance in a similar situation. He described being in the middle of a conflict between the hospital's and the patient's interests. Sotiris reviewed a case where there was a young woman seriously injured and had cerebral necrosis. The hospital's Administration wanted to discharge the woman as the doctors argued that medically the hospital had nothing more to offer. The parents of the patient were requesting more time as they were preparing the appropriate conditions in their home to provide her ongoing care. The parents had also refused admission to a rehabilitation institution as they felt the quality of care was very poor. The social worker respected their request for a delayed discharge given they had already paid 5000 euros a month for exclusive nurses for their child. He also agreed that the quality of care in rehabilitation was very low. On the other hand, Sotiris also acknowledged that the hospital was responsible for keeping some beds free for people who needed urgent treatment, and that it was unethical to "*put someone's life in risk because the hospital has no free beds*". However, he expressed further suspicions:

That the doctors need the bed has a dual interpretation and meaning. Even money might be involved in this. Remember, I told you that sometimes some public units are private in reality in the sense that doctors might have a complementary income, especially from the cases that need surgery, of course from those patients that have the money to give, right? That doesn't necessarily mean that doctors ask people to give them money, but the people themselves may give them the money (s.m, § 150)

Finally, Sotiris detached himself from the decision-making process. He argued that he remained in the middle of this situation as "*the social workers are always in the middle*", and he justified his place in the decision-making process as:

I don't represent either the social services department or the hospital. There is an organised Administration who must make the decisions. They are who decide not me. There is a hierarchy. I am just a cogwheel of a machine. I am obligated to do my job by protecting the hospital and respecting the human beings by being in the middle. We are always in the middle. We are always in the middle (s.m, § 186)

This last examination of an ethical dilemma possibly provides some evidence that supports the theory that distinguishes the notions of "*ethical examination*" or "*thoughtful examination of ethical dilemmas*" with that of "*ethical action*". In theory it is suggested that ethical action is not necessarily a result of a thoughtful examination of the ethical dimension of a situation (Dodd and

Jansson, 2004; Speicher, 1998). In fact, the last social worker made an examination of the dilemma which revealed many of its complexities, and he finally decided to remain in a place of “ethical neutrality” and took no ethical action. However, from a critical perspective ethical social work practice is about acting ethically in professional contexts, and actively challenging and working to change the contexts if they do not support human wellbeing (Bowles *et al.*, 2006). Social work ethics could be used as a framework to direct action to achieve political and social changes.

5.5.4 Protecting oneself

Social workers appeared to be clearly motivated by their need to protect themselves. Although not always consciously identified, many of the social workers’ ethical decisions involved their need or even ethical obligation to protect themselves, even if this would limit the best interest of their clients. Interestingly, the ways that this motivation operated in practice varied and this may depict important features of the nature and the values of the social work profession. For example, most of the social workers indicated being engaged in illegal practices to promote their clients’ interests, yet they did not mention being afraid for themselves or even being reluctant to be involved. In fact, they exemplified cases and appeared to be indifferent about possible consequences that illegal actions may involve.

For example, Sotiris made an explicit reference to a persons’ right to limit their efforts in order to protect themselves. He also identified the compromised social worker as the one who identified with the organization’s interests, implying that those were always opposite to clients’ interests. He said:

We must always be on the side of people’s interests. If we are on the side of the organisation’s interests then we are compromised, but we have the right to be compromised, you cannot be blamed/// because you can’t play the role of Don Quixote for a whole life. You can play this role in your 20s, in your 30s, but in your 40s and in your 50s you get been tired. We also have the right to be tired, or to change the priorities in our lives. Above all we are humans. We are not just social workers, and we have a purpose in life. It doesn’t mean that as human beings our personal targets are identified with our professional targets. The human being is above his profession. (s.m, § 272, 276)

Interestingly, Sotiris drew a parallel between the role of social workers and Don Quixote, an idealistic character who was dedicated to the virtues of knights. He seemed to imply that it was

difficult and tiring for practitioners to be committed to social work's ideals, and still continue resist the structures that inhibit the benefits of clients. In addition, Sotiris made an explicit distinction between the benefits of social work's clients and those of the organisations. He seemed to challenge whether organisations actually promoted and preserved the benefits of the people they serve. The social worker's role was also characterized as exhausting by another social worker. In particular, she noted that after some years of fighting within a bureaucratic environment practitioners were exhausted and quit their efforts after losing their passion.

5.5.5 Obstacles in the resolution of ethically difficult situations

The social workers indicated some obstacles that constrain their ability to resolve the ethical problems or dilemmas they encounter in their daily practice. These obstacles also seemed to restrict social workers' involvement in ethical decision-making, and included the ineffective system of referrals to the Social Services Department, absence of multidisciplinary teams, and doctor orientated medical services.

In particular, five social workers noted that the referral system in hospitals was not working properly to inform them of patients in urgent need of social support. For example, patients in need of some form of sheltered accommodation were referred to SSD at the time of discharge rather than in advance of it. Therefore, insufficient time to find appropriate solutions and the pressure from doctors to discharge patients resulted in social workers to making quick decisions and increased the tension of the ethical problem or dilemma. For example, Sotiris commented:

Some times we fail to notice some cases because the system of referrals is not working very well and we are not able to visit the units every day to see all the patients. Something that could only be possible if we had under our personal responsibility 25 or at the most 30 patients. (s.m, § 218)

Sotiris connected the heavy workload of social workers with the ineffective system of referrals. He said that because social workers had responsibility for units with more than 30 patients, it was difficult to visit all of them daily. Thus, a system of referrals would help social workers prioritize what patients were seeking and how quickly they were assessed.

Additionally, the majority of the social workers working in medical units argued that the absence of multidisciplinary teams created or complicated ethically problematic situations. This was often

related to the doctor orientation of public hospitals. For example, Maria indicated that doctors usually ignored the social status of patients, and medical decisions were made independent of this. Maria suggested that if health professionals worked in multidisciplinary teams, patients would be provided with better health services. She said:

Every time doctors forget things, “what is the social profile of this patient”. Often this is our mistake because we haven’t given the doctor the appropriate information. We need what we call ‘team work’ so we can collaborate with the team to decide what would be the best provision of services for this patient with a precise profile. (m.k, § 47)

In some cases where multidisciplinary meetings were the norm, the authority of managers prevented the equal participation of professionals. For example, Lena who was currently working in a psychiatric department of a hospital suggested that one of the prominent ethical problems she had was the authoritarian practice of her manager. She argued that although the department was supposed to work together as a team, her manager often ignored team decisions and even cancelled treatment plans at his own decision. Lena described cases where the team had decided the discharge arrangements and her manager postponed discharge after contact with family. Lena felt this practice gave inconsistent messages to families and ignored the interests of patients to be released as soon as possible. Lena commented on her manager’s attitude in the multidisciplinary meetings:

The notion of good collaboration is something that we all should serve and protect. I can always explain why I want to do some things but there is always an obstructive stance which says “yes, but you are not going to do this”, or “you are going to do this but another way” ...it is an instruction, and many times this instruction is not compatible with our approach./// so, I cannot collaborate, and in order not to be rejected in my role and as a person I prefer not to participate in the meetings or in practices which don’t convince me that what they say is what they mean. (l.s. § 381,397)

Lena confirmed being rejected, as a person and professional, by the authoritarian practice of her manager. She demonstrated that she periodically decided to boycott multidisciplinary meetings to express her opposition to such practices. It was important to note that Lena’s manager was a psychiatrist, and issues of authority and status among doctors in hospital settings also seemed to be a key factor for ineffective multidisciplinary approaches to patient care.

All social workers declared that the absence of multidisciplinary teams limited their ability to be involved in the ethical decision-making and in the design of treatment plan for patients. For

example, Eleftheria and Alkistis suggested that the decision of whether the patient was informed about the diagnosis of cancer should be made by a team of professionals and with the participation of patient's family. However, they all declared that they were unable to force other professionals to work as a team.

Ten out of fourteen social workers identified that the doctor orientation in public hospitals was one of the prominent reasons that they felt excluded from the decision-making process. In fact, doctors were higher in the hierarchy, often managers of the units, and in administrative positions in the hospitals. The scientific boards of hospitals usually had seven positions for doctors, one for nurses, and one for the "other health professionals". In this study, in four out of six hospitals the manager of the SSD held this place. Giannis who worked in a medical unit in Patra expressed his opinion about the central role of doctors in hospitals:

The hospital is doctor orientated. The doctor has the first and foremost word, no one else, and this is something that I can see also with the patients. When the doctor speaks there is a silence, "he is the doctor", you can't complain, you can't say anything, there are other professionals are behind the doctor, do you understand? Namely, the doctor has the last word, the doctor said that the patient will be admitted, then this is final. (g.s, § 133)

Similarly, Lena who worked in a psychiatric unit in Patra expressed her belief about the doctor orientated function of hospitals:

The model in hospitals, in the places where medicine is practiced with other specializations, are doctor centralised and I accepted this reality. The image of the doctor is very important, and it has always been the same in all the years that I have worked in hospitals, but the same is not true for the other professionals. (l.s, § 445)

Both social workers in the previous excerpts characterized the function of their hospitals as doctor orientated, believing that their authority was unchallengeable because everyone including patients and social workers accepted their superiority. Giannis described the authority of doctors in a way that implied undemocratic and non-participative processes or decisions. Lena implied that the expertise other professions was not acknowledged or accepted, at least at the same level as that of doctors. These findings support what other empirical studies have already shown. In particular, the doctor orientated medical services and the absence of multidiscipline work in NHS was evident by Georgoussi (2003) and Dedoussi *et al.* (2004).

5.5.6 Summary

Personal values appeared to determine social work practice. In fact, the majority of the social workers saw their personal values as an indicator of ethical social work practice. The social workers expressed their belief that personal and professional values were both inherent to each individual, although none of the participants referred to being aware of the social work ethical code. Moreover, some social workers expressed having a clear and absolute intrinsic guidance of what is ethical.

The majority of cases that the social workers described as ethical dilemmas did not reflect any kind of value conflict. Rather, they more clearly represented social workers' perceptions of being restricted and not being able to promote the best interests of their clients. The multifaceted deficiencies of health and social welfare, the structured social exclusion due to organizational restrictions, the bureaucratic function of public services and the unethical practice of other professionals were indicated as the major factors resulting in ethical problems. Commonly, social workers who had to work with cases in which one or more of the above factors were involved, often expressed that they were at a "dead-end". In particular, they claimed that due to these factors their ethical obligations or duties to the people they were serving were impossible to fulfil. Overall, social workers appeared to function as survivors of what they perceived as unethical political, social and organisational structures. Any concrete social work action to address these structures and their impact on patient care were not noted.

Some social workers described cases that involved a conflict between two individualistic values or an explicit and clear preference for one value over the other. These cases often involved:

- 1) The dual responsibility of the social workers to promote and preserve the safety and autonomy of mainly older people ;
- 2) The dual responsibility to ensure equal distribution of resources and individual rights; and
- 3) The dual responsibility to protect oneself and protect the best interest of the client.

All of the social workers were ethically engaged to promote the best interest of those patients with whom they had a direct relationship. In addition, social workers believed that engaging in the organisation's interests was clearly compromised practice. Nevertheless, social workers seemed to not acknowledge that organizational rules or functions were designed to ensure equal

distribution of resources. Consequently, violating the laws or legal procedures often took on an ethical dimension. This was especially so when social workers perceived them to be obstructing their role to protect patients' rights or as the only way to bypass the factors that were seen as developing ethical problems (e.g. bureaucracy, cost effectiveness policy). Their practice appeared to be underpinned by the ethic of care, however, they tended to ignore community justice and their ethical obligations to others, except the present person in need (Meagher and Parton, 2004; Koehn, 1998). Moreover, their engagement with the ethic of care often led them to paternalistic practices by deliberate concealment of information or dishonest behavior. Although such practices are theoretically incompatible with the ethic of care (Fraser and Strang, 2004; Koehn, 1998), social workers perceived that they were justified when one cares for another person.

5.6 Evaluating hospital social work practice

Both the welfare state and the National Health System in Greece are characterized by a lack of evaluative processes which would enable the efficiency and effectiveness of newly implemented measures and professional practices to be determined (Rovithis, 2006; Mossialos *et al.* 2005; Sotiropoulos, 2003; Yfantopoulos, 2004; Ballas and Tsoukas, 2004). Specifically Liaropoulos (1998) indicated that public hospitals "*are still run by untrained career civil servants, and members of the boards of directors, each headed by a doctor, who are political appointees with no interest in efficient operation*" (pp.166).

Not surprisingly, all of the participants argued that the formal evaluative process in Social Services Department was not an essential part of their practice. In fact, they seemed to believe that their personal ethical engagements and their perception of what constitutes good social work practice were the only evaluative criteria necessary for their practice.

The manager of the SSD, in collaboration with the general administrative manager, formally has the responsibility to evaluate all social workers. With a recent legislation, all SSD will progressively become part of the medical department, and therefore the general manager of the medical department will soon be collaborating with the manager of the SSD to evaluate all social workers. The general manager of the medical department, typically a doctor, will also evaluate the manager of SSD.

The evaluation process in public organizations has no effect on either staff promotions or downgrading. The promotions of public servants are based on years of experience and education. In addition, as the law protects the security of employment in public organizations, staff downgrading and dismissals are not possible through the typical evaluation processes (Liaropoulos, 1998).

As in the case of all public servants, managers have the responsibility to fill out a standard evaluation form for all the employees of the department. For the evaluation of the manager of SSD the other manager fills out the same form. The form has questions pertaining to the employee's timekeeping, and questions that refer to the extent that the manager is satisfied about the quantity and the quality of the employee's work. All the employees are graded in a numerical scale of 1 to 10. The manager of the SSD proposes the grades for the social workers and the administrative manager typically signs their approval. Only in cases with an exceptional grade (10) or low grade (5 and lower), is the manager obliged to comment to justify their decision. Social workers are not provided with the forms unless they make a written request to the administrative board of the hospital. However, they are informed of their grades by their manager, but in some cases only if they ask. Not surprisingly, almost all of the social workers declared that in reality no one evaluates their job. For example, Maria said:

Here... not only in our hospital, but in the rest of hospitals too, if you want to work you will work. There is no one who will ask how much you work, neither will they criticize how you did this, as long as you can reach the outcome that you like. (m.k, § 27)

Maria explicitly stated that the evaluative process in public hospitals could not ensure the effectiveness and the quality of services provided. In fact, she argued that social workers were evaluated neither on the quantity nor on the quality of their work. Therefore, social workers' accountability depended on their personal perception of what constituted good social work practice and their work ethic.

Rena raised the issue of record keeping in social work practice. She argued that social workers did not record their work with patients, except for a patient social history, personal details or documents to prove their efforts to find residence or rehabilitation units for patients. Moreover, she argued that no one asked social workers to keep a record for their work. Interestingly, Rena appeared to be dissatisfied with the fact that no one really cared about the services she provided,

and as there was not record of her work she seemed disappointed that it could not be acknowledged. Like other social workers, Rena also believed that the only thing that administrators expected from them was to facilitate the quick discharge the patients.

Similarly, all of the social workers demonstrated the absence of social work supervision. The absence of supervision and record keeping in SSD was also identified by Georgoussi (2003) who explored the daily activities of social workers in public services in Greece. Not surprisingly, all of the social workers expressed trust in their personal evaluative criteria. In particular, personal values were determining criteria for the evaluative process. Aristos illustrated how he perceived his assessment grade:

I took a good grade... but ok, it is just a good grade. It doesn't mean that this can change anything. Namely I personally don't care about the grade that he will give me. If I feel ok myself with what I have done, it is my own self that will grade me more than my manager. What I care is to know that I haven't fooled anyone or that I didn't do the best I could. I see myself more on a moral base rather the grade that my manager will give me in his evaluation. It is important for me to feel that I did the best I could. I grade myself. This is more troubling for me than the grade from the manager who may not have seen or be aware of some things. (a.a, § 258)

The role of the helper and the consequent pleasure for him or her was indicated by Lena as an important element of her evaluative practice irrespective of the outcome of the action. She argued:

I believe very much in the feedback of emotions that the social worker will feel on giving. Namely he says, "I did today this and this, I didn't bridge over, but ok, I am feeling good, and this is very good, independent of whether I provided a solution or not. The solution doesn't always reflect if you did your job or not, right? (l.s, § 242)

Lena said that she felt pleased by helping others, and it was this feeling that signaled to Lena her effectiveness. Interestingly, with this evaluative process Lena did not consider whether her clients were actually satisfied or whether their needs were adequately met. Lena's account rests on what Rossiter (2001) characterized as "addictive gratification". Rossiter referred to the ethically "suspicious" moment of a social worker who is motivated by his/her feelings of gratification when helping someone in need. In this instance, the social worker has forgotten about the client's right, as a citizen, to be offered assistance. According to Rossiter (2001), the perception of a "charitable gesture" has confirmed the unequal social roles between social workers and those they help.

None of the participants demonstrated following a specific or systematic method of evaluation. In addition, no one referred to evaluation as a process that was comprised of specific techniques or methods. This finding supports the study of Elks and Kirkhart (1993) who found that private social workers do not use any kind of evaluative instrument. Although, the social workers indicated that they perceived the evaluative process as something that should be conducted by evaluators and researchers, and not by practitioners.

It was important to note that none of the social workers referred to professional skills and knowledge as being part of their evaluative process. The separation of ethical principles or ethical consciousness from knowledge and professional skill raised questions about whether social work was perceived as scientific with related systematic action based on specific professional purposes and identifiable outcomes. Even if social workers seemed to involve ethical considerations in their evaluation process, the absence of standards of technical knowledge and skill signifies unethical practice (Clark, 2000).

5.6.1 Characteristics of the “good” social worker

The following sections define and examine the meaning of good social work practice according to the participants. This knowledge sheds more light on the examination of the evaluative process and the evaluative criteria used by the social workers. Specifically, the standards or criteria by which social work practitioners implicitly or explicitly compare “good” with “bad” practice was examined. In this sense, by taking into account what social workers perceived as “good” social work practice, we obtain a deeper understanding of their evaluative process and ultimately what counts as effective from a practitioner’s perspective.

5.6.2 Personal values as the moral base for “good” social work

Some social workers demonstrated that personal values and “*personal philosophy*” played an important role in the way that they practiced their profession. For example, Sotiris highlighted the role of personal values in the ways that professionals see their practice. In fact, he seemed to imply that the values and principles which a professional holds were determined not by their profession, but by the values held as a person. Sotiris commented:

I believe that the values and the principles have to do with a very personal element, they have to do with who you are and not with your profession. (s.m, § 11)

Overall, personal values appeared to be more than just intertwined in practice. In particular, social workers perceived that their personal values were appropriate guidance for their practice, and a decisive element in their moral justifications. Moreover, ethical practice was often appraised as being identical to the practice of a social worker who was guided by personal values (section 5.3, pp.139). Not surprisingly then, the concept of “good” social work practice appeared to be defined according to the personal values of the social workers. However, the social workers expressed no concern that personal values may be opposite to those of the profession. It was rather an unquestioned acceptance of the goodness of humanitarian values and a perception that such values could not conflict with one another.

In addition, character traits and the spiritual efforts of the social workers to explore the real meaning of life, as well as philosophical thinking, were believed as a very important aspect of the good professional. Importantly, these findings may also indicate the social workers’ adherence to the virtue approach of social work ethics which emphasized the personality of the practitioner rather than the specific rules or outcomes of practice (Mc Beath and Webb, 2002; Banks, 1995). Cultural influences further this understanding given virtue ethics originated in Greek philosophy and have deeply characterized the Greek culture. Perhaps not surprisingly, participants reflected on the “*virtuous*” human being as they are culturally presented in Greek philosophy.

The “good” social worker was perceived as the one who has a fighting, imaginative and flexible personality. Evidently, the majority of the social workers related these character traits with having to work in the context of health and social welfare in Greece. Overall, social workers indicated that it was difficult for them to be effective, however, the personality of a practitioner appeared to enhance the potential for practice with good outcomes. For example, Maria said:

I would be a very happy mother if my children became social workers because social workers learn to think, “while I have nothing how can I find something?” (m.k, § 7)

Maria highlighted the ability of social workers to practice their creativity in daily practice. Searching for resources, including informal ones, to support people’s claims was perceived as a useful endeavour that resulted in a valued life long skill. In addition, flexibility also correlated with the effective ways the social worker could communicate with people, including those in authority.

For example, Elpida suggested that the social worker should “*know the art of flexibility*” meaning that they must appreciate the appropriate moment and the way to communicate with doctors. She argued:

You must behave with flexibility. You need to be flexible, very much flexible, especially at the level of relationships with colleagues, because there are times when you must conflict head to head with doctors but there are some other times that you must let the doctors speak, speak, speak.. and then you will do it in your own way. (e.m., § 35)

By taking into account the difficulties that the participants declared having in their practice, they expressed their belief that the “*good*” social worker should have the strength to continuously fight to promote the best interest of their clients. In the following quote Chara implied that neither hospitals nor the Greek state work for the benefit of people. Therefore, she claimed that the social worker should take a clear positive stand on clients’ interests. This is how Chara characterized the good social worker:

A social worker who is a fighter, who doesn’t quit no matter the disappointments, they continue to try for the person, not for the organizations or the state, they don’t fight in order to cover... because in reality we are mediating by trying to justify the unjustifiable. (c.v, § 510)

Another character trait suggested by two other social workers was courage. They indicated that since social workers must be prepared to fight to do their job, they must have courageous personalities to keep fighting without being frightened of other professionals who have greater authority. Once again, social workers demonstrated their lower status among other health professionals. Moreover, they also implied that their professional roles were in opposition to those of the hospital or to those of professionals with greater authority. McBeath and Webb (2002) who have argued that social work practice should be based on the virtues of Aristotle’s ethical theory, perceive courage as one of the basic characteristics of the virtuous social worker.

5.6.3 Psychotherapy and the “*good*” social worker

Many social workers indicated sets of abilities that they perceived were needed by a good social worker. These were commonly characterized as the core aims of psychotherapy. In fact, four of the participants had psychotherapy experience and three others had an interest in gaining this experience. Self awareness was one of the prominent qualities of the good social worker. In fact,

Lena who had 15 years of psychotherapy experience stated she wanted to start psychotherapy again to “*redefine*” herself given her life had changed a lot. She argued:

I need to redefine myself and to see myself through my new reality. When you have to deal with people who need to redefine themselves through difficult conditions at least you must have a clue of where you stand and who you are, at least a clue. I am not saying that I learned everything about myself or I accomplished everything. (l.s, § 275)

Lena implied that what she did with her clients was to help them define or redefine themselves through a psychotherapeutic relationship. She demonstrated that in order to have a good relationship with her client, she must have experienced psychotherapy. As previously indicated, two social workers, including Aristos, referred to themselves as being therapists. Psychotherapeutic practice was one of the main characteristics of social work practice in public hospitals (section: 5.2.1, pp.127). Not surprisingly, psychotherapy experience was perceived as a prerequisite qualification for the social worker. In fact, Aristos said, “*A good therapist is the one who has tried to treat himself*”.

Elpida argued that psychotherapy was a quick way to remove stereotyping from social work assessments and eliminating possible discrimination:

First of all, those who do psychotherapy will become better persons, but also as professionals I believe that they will be better able to understand people’s motives. They will know their behavior better, where these motives come from, and they will see less of them as stereotypes, which of course one can get over them through experience but I believe that a quicker path is psychotherapy. Namely it is not needed to pass all this experience... I have much experience at all these levels (e.m., § 78)

Elpida believed that discriminating against clients was malpractice. Although she indicated psychotherapy as a means by which this could be achieved, there was no reference to how education and training for social workers could be implemented. Interestingly, Elpida’s account of discrimination also reflected the individualist nature of social work practice in Greece. Another characteristic of the good social worker was also seen as an outcome of psychotherapy. In particular, Lena implied that psychotherapy experience protects the social worker from burn out:

If the professional has worked with himself, then he has the ability, in any new responsibility he takes, to approach it fresh from the beginning. Namely, he doesn’t have the perception or the attitude “ah, this is another case” ... the fact that this person is

fresh means that he is responsible. He enjoys and refers to his working experience, but he doesn't see his experience as something absolute, he doesn't say "I am certain what I have to do with it", and he is able to rebuild himself from the beginning. He has found the ways to preserve. This is also a result of freshness, his sensitivities. (l.s., § 470)

Lena implied that every client should be seen as different with a unique personality and individualized needs. The underlying value was the belief of the inherent worth and uniqueness of every person (discussed in section 5.1.2, pp.119). Lena identified burn out as a condition that violated this value and signalled bad social work practice. The consequence of burn out was a condition that drove practitioners to think that all clients were the same. "Fresh" was indicated by Lena as the opposite condition to burn out. Specifically, she referred to being fresh as an ability that you acquired through psychotherapy and this enabled social workers to develop as professionals through their new experiences with clients.

What was also worth noting was that none of the social workers appeared to make any reference to qualifications for social workers' roles as social reformists or policy activists. The fact that social workers appeared to highlight psychotherapy as a qualification of a good social worker indicated that social workers did not perceive social change as a professional purpose. Interestingly, these findings denote a complete absence of the critical approach of social work practice. These findings were consistent with the literature which indicates that social work is dominated by approaches that do not respond to the structural purposes of the profession (Dudziak, 2002; Gibelman, 1999; Payne, 1999; Beck, 1959).

5.6.4 Summary

Evaluation of social work practice appeared to be a formal process, no different from all public servants, but included nothing more than a grade proposed by the manager of the Social Services Department and approved by the general administrative manager of the hospital. Although these grades were recorded, social workers were only informed by making a formal request to the hospital administration. Social workers appeared indifferent to the process. Therefore, the notion of "good" social work practice was based on the personal and professional criteria of social workers as there were no stipulated standards of good practice in hospitals.

The majority of the social workers highlighted the importance of the personal values and the character traits of a practitioner as indicators of "good" social work practice. An individual's

conscientiousness and feelings of personal gratification for having helped appeared to be two of the prominent indicators of what social workers perceived as good practice.

Many social workers also identified specific character traits of one's personality to highlight the meaning of good practice. Interestingly, some of these characteristics appeared to be influenced by where they practiced within the limited welfare state in Greece. In particular, many social workers working in medical units stated that the good social worker should be a fighter and imaginative. However, the lack of resources provided by the state to help their clients led them to unauthorized actions. In contrast, social workers working in psychiatric departments appeared to highlight the importance of the relationship between social worker and client.

Another important indicator of good social work practice appeared to be closely related to psychotherapy. In fact, the majority of the social workers believed that psychotherapy enabled social workers to be self aware, to be able to control their emotions, and to protect themselves from burn-out. These were also perceived as important professional abilities that indicated good practice.

Conclusion

Social work in Greece is practised within a context where social protection ranks very low, at least in comparison to other European countries (Yfantopoulos, 2004). While social exclusion, poverty and inequality are intense social problems, the welfare state and health care sector are characterized by multifaceted deficiencies including fragmentation, preferential treatment, absence of accounting systems and management control, and unethical practice of health and administrative professionals (Rovithis, 2006; Mossialos *et al.*, 2005; Ballas and Tsoukas, 2004; Matsaganis, 1999; Liaropoulos, 1998). At the same time Greece appears to be effected by neoliberalism and globalization that enforced the privatization processes in various sectors including the health sector in Greece (Zambeta, 2000). These realities were extensively reflected in the descriptions of the hospital social workers. In fact, the majority of the cases that hospital social workers characterized as ethically problematic involved a complex interrelationship of structural factors which originated in the multifaceted deficiencies of the welfare system and by the effect of globalization including privatization and mass immigration.

While all hospital social workers acknowledged the structural roots of their ethical dilemmas and problems, paradoxically, they all appeared to be engaged in individualistic values such as the value of care and self-determination. Not surprisingly their professional roles and interventions were individualistic in character, and macro-level interventions along with collective values such as social justice were completely absent from their accounts. In fact, even anti-discriminatory practice was individualistic as social workers demonstrated efforts to support patients' social and citizenship rights individually. Overall, social workers appeared to have a clear preference to individualistic values over collective ones.

Moreover, social workers reflected, with certainty, what they perceived as their ethical obligations. Even when participants referred to cases that required a dual responsibility to two different but equal values, they expressed a clear preference on particular ones. What appeared to effect this reality was that personal values played an essential role in the way that social workers practised. Their ethical social work practice was often appraised as being identical with a practitioner guided by his/her personal values. Not surprisingly, the concept of "*good*" social work practice also appeared to be defined according to the personal values of the social workers. Therefore, what appeared to be a determining factor in the ethical decision-making process of these hospital social workers were their personal values, sometimes expressed as "*internalized social work values*".

Importantly, social workers often appeared to make a decision by "*putting themselves into their client's shoes*". The individualistic character of social work practice and the absolute ethical commitment of practitioners to act for the benefit of their clients particularly affected this decision. The underlying value of this behaviour appeared to be the ethic of care. However, if social workers were determined to take the place of their clients, they possibly ignored their multiple loyalties. This is what Meagher and Parton (2004) described as the "*dark side*" of care as practice is detached from policy theory and a communal concern for equality and justice in terms of power and resources in society.

For example, violating laws or legal procedures was a reality for hospital social work practice that appeared to be constructed by a complex interrelationship of factors. All of the participants who demonstrated violating laws or organizational and statutory procedures argued that this was a defensive action against the abusive structures that systematically ignored patients' rights. Bureaucracy, the absence of protective laws for citizen rights and the unethical practice of other

professionals with authority were some of the major abusive structures demonstrated by the participants. However, the individualistic character of social work practice along with the consequent absolute commitment to the promotion of individual benefit also appeared to be factors that strengthened their perception that violating laws or legal procedures was actually part of ethical social work practice.

Importantly, the above findings led to a fairly consistent response to ethical problems that produced ethical decisions with similar characteristics. Evidently, social workers' moral judgments reflected their adherence to individualistic values and their perception that personal values could appropriately guide their professional roles. In this sense, social workers responded poorly to the core role of the social work profession which is social change underpinned by the value of social justice. Nevertheless, all social workers were able to acknowledge and exemplify how structural oppression violated human rights and reproduced human suffering. As a starting point this was particularly important for the development of a critical approach in social work practice. However, social workers must be educated and emancipated so as to be able to use their power and their knowledge to effectively address what they defined as unethical structures.

Chapter 6

Ethics and Ethical Dilemmas and the Broader Social Work Context: Social work Education and the Hellenic Association of Social Workers

Introduction

The role of social work education in preparing future practitioners to deal with ethically difficult situations was raised as an issue for all hospital social workers. Therefore, understanding ethics within a broader social work context was appropriate. Specifically, the ways that social work academics perceived the role of social work values and ethics in practice emerged as an important issue of this thesis. In addition, as Payne (1997) argues, social work education is one of the main formational factors for the profession's identity. The group interview with social work academics was held to further my understanding of the meaning that social workers give to the ethical dilemmas.

In addition, HASW's contribution to the promotion of social work ethics was also explored through an interview with an executive member of the Association¹⁴, and through a thematic analysis of its journal. As it is a member of the International Federation of Social Workers, HASW was considered as officially responsible for the promotion of social work ethics.

The following sections begin with the analysis of the group interview. The presentation of this analysis starts with the cases where academics characterized ethical dilemmas. From these descriptions two issues emerged: the unethical practice of academics working in social work schools and the option of whistle blowing. The analysis of the personal accounts of academics on these issues complements the analysis of similar cases encountered by hospital social workers. The issue of the absence of evaluative processes in social work as a factor that contributed to the neglect of duties also emerged. Finally, the academics provided detailed comments on the distance between social work education and practice which was also raised by many of hospital social workers.

¹⁴ The expressed opinions of the executive member of the HASW that was interviewed may be hers alone rather than representing all members.

Following is further analysis of the role of HASW in addressing social work ethics. These findings indicate how the representative of HASW described the role of the association for the promotion of social work ethics. She also reflects on her social work experience in a public hospital and responds to some issues raised by the other participants who had no executive role in HASW. The place of social work ethics in literature is also explored through sixty seven publications of the journal "*Social Work*" of HASW.

6.1 Ethics and ethical dilemmas in social work education

Little is known about the education on ethics in social work schools in Greece. From a review of the social work schools' curricula, only two out of the four have a course for the social work ethics, which is held for one semester, one hour a week. In addition, no school has a course on critical practice. Importantly, the course book in the social work school where the group interview was held that is given to students is not about social work ethics, but for ethics in psychotherapy. In fact, the title of the book is "*Basic Principles of Deontology in Psychotherapy*". The book contains ethical issues raised during the relationship between the therapist and the client, including issues of dual-relationships, confidentiality, prejudices of the therapist and its unethical influence in the relationship. The appendix contains the code of ethics of the American Association of the Psychologists and the code of ethics of the British Association of Psychologists. Although, notes with the code of ethics of the Hellenic Association of Social Workers (HASW) and the International Federation of Social Workers (IFSW) are also provided to students. Evidently the social work education on ethics lacks any specialized academic knowledge on social work ethics in relation to the special nature and identity of the profession. More importantly, the course does not support students understanding of social work's identity and its ambiguities, but also turns the profession into a psychotherapeutic enterprise and may encourage social workers for engagement with individualistic values and ethics rather than collective ones such as social justice.

Key issues for social work academics emerged in their described ethical dilemmas in their role placement supervisors. These findings are important in order to understand how hospital practitioners are prepared to deal with the ethical challenges of the profession. Practice learning has been always an important part of social work education in Greece. Therefore, students become ethically informed not only through the theoretical course on ethics in their schools, but through their involvement in practice realities. Students witness the ways that ethical dilemmas

are dealt by their supervisors and learn from their attitude and actions. In fact, five hospital social workers argued that social work school remain distant from practice realities and questioned the ability of schools to effectively prepare students for practice. This issue was brought up in the group interview so as to deepen this understanding by exploring academics' perception. Although academics appeared to be opposed to hospital social workers' perception about the distance between theory and practice, in some instances they seemed to make ethical decisions without involving the students in ethical analysis of cases.

Interestingly, academics described similar ethical dilemmas with those of hospital social workers. The ethical challenges when social workers had to deal with power relationships were the prominent issues in their descriptions of ethical dilemmas. Importantly, the way that academics perceived power relationships appeared to construct the individualistic character of social work practice and emphasized their lack of engagement with the collective purposes of the profession. The sections below describe the above issues in more detail.

6.1.1 Social theory versus social work practice

As mentioned above, five hospital social workers argued that when they started to practice they were faced with practice related difficulties and obstacles that were never mentioned in their training. The social work academics shared a different interpretation on this issue. Yianna seemed to argue that the personality of the social worker and their personal values were as important for their preparation as anything that could be taught in schools. In particular, she said:

I don't believe that it is only a matter of preparation from social work schools, it has to do with the personal values that each person has, and their psychological maturity. These things also affect how the social worker will react when some issues come up. Besides, education can not prepare students for everything.

Yianna further defined what she meant by "*psychologically mature*". She specifically made reference to a textbook used in the department that defines this as a developmental process through which a person "*flies the nest*", but maintaining a close relationship with their relatives. The aim of this process was to enable a person to establish a condition of differentiation, autonomy and self-existent individualization (Johnson, 1998). Importantly, the emphasis here was on individualism rather than any notion of collectivism.

Anna also believed that the social worker's personality was the most important factor in managing practice issues. In particular, she determined that if a social worker had a "*powerful personality*" and had a valuable six month social work in a placement, they would have the ability to deal with any difficulties in their practice. In contrast, Georgia reflected on her practice twenty years ago. She agreed that she was faced with difficulties that she had never imagined as a student, and conceded that unavoidably students are not pressured by the real conditions. As such, Georgia suggested that without in-depth exploration of ethical dilemmas students would not be pushed to make decisions.

Overall, social work academics appeared to identify one's personal values with those of the profession's. In fact, they seemed to believe that once one became a social worker his/her personal values were identical to those of the profession. In that sense, practicing in accordance with personal values was consistent with practicing in accordance with professional values. In addition, the powerful personality appeared to be a virtue for the good professional. These findings were consistent with the perception of hospital social workers about the determinant role of personal values in the ethical social work practice. And finally, the social work academics appeared to challenge the significance of social work education in the formation of the competent or effective social worker. They all seemed to believe that the personality of a social worker, and specifically the ability to be autonomous, differentiated, and powerful, alongside appropriate personal values, were the factors that determined the good social worker.

6.1.2 Social work students and practice learning

Yianna described an ethical dilemma which she claimed was often raised by her undergraduate social work students who practised in an elementary school. Students argued that teachers forced them to deal with the daily educational program of the pupils and practice as teachers, whilst not offering opportunities to develop social work skills and their professional identity. In particular, social work students complained that teachers do not acknowledge the social work identity and expect them to have advanced teaching skills so as to help them in their educational program. Yianna argued that these types of situations often ended up with conflict between students and teachers, and she would need to intervene to again clarify that social work students in training did "*other things*" than teach. However, Yianna did not demonstrate any effort to present and discuss the social work role in schools. She implied that teachers should give

thought to her argument that social workers just do “*other things*”. Not surprisingly, Yianna stated that teachers do not seem to understand the social work role and identity in schools.

Interestingly, Yianna commented that she often did not tell her students about these conflicts with teachers, although students and their role in schools was so often challenged. She justified this decision by arguing that students were inflexible at times and they took any disagreements personally. Yianna said:

It is a matter of technique. I usually decide to hush it up. If someone insults them or says that they did not perform well, I keep it secret and I tell them that the issue is closed. However, if sometimes the issue is raised by the students, for example when someone insulted them or did not speak to them, we'll discuss it. Of course I am trying to reduce the tension when I judge that this is for the benefit of the students. I will reduce the severity of the incident and I will say to them that “these things happen”. They are colleagues from another discipline. They some times believe that you, as students, are not here to do whatever they want, we explain to them, but we say that this case is closed.

Although Yianna labeled such cases as ethical dilemmas, she appeared to have no dilemma on ethical grounds. Instead, she appeared to stereotype students as being “*inflexible*”. More importantly, she decided to hide from students the conflicts with teachers, and she seemed to not use such dilemmas as an educational process for ethical decision-making. Moreover, Yianna appeared to manipulate students’ perception about what was or was not important to focus or act on. In fact, she explicitly referred to herself as being certain to know and act for the “*benefit of the students*”, whilst she seemed to take a rather unconscious decision to hinder students by letting them decide on their own what was the best solution for them. Interestingly too, although she made a personal decision to “*close this case*”, she used “*we*” to indicate a collective decision between the students and herself.

Yianna also appeared to ignore the power relationship between students and teachers and the consequent conflicts. Although students appeared to be exploited by the teachers and forced to lose the sense of their professional identity Yianna appeared to make no effort to teach them how to emancipate themselves. Importantly, although Yianna was able to identify this situation as ethically problematic the absence of the critical approach was what framed her attitude towards this ethical dilemma.

What also emerged from the above illustration was that the social work identity and role in school placements was not very well defined. Although the role of social workers in schools has been defined and legitimated by a law since 1978 no public school in Greece employs social workers (Stathopoulos, 1999). Yet, some schools of social work collaborate with specific public schools to place students. It is not surprising that social work remained confusing to teachers and vulnerable to arbitrary definitions of its identity. Moreover, social workers both in hospitals and schools are not the key professionals. This means that social workers in a secondary role have less decision-making power or other influence. In this context, social work students although with limited authority, power, knowledge and experience, were left to defend the contribution of the profession within public schools. And, in terms of the role of the social work supervisor, Yianna indicated that she handled these situations with as little intervention as possible.

Another main issue that was discussed in the group interview was an ethical dilemma mentioned by Anna, who was supervising a placement in a local Borough. The issue was raised by her students that they felt used by some administrators who made decisions and presented student's work as their own in order to gain personal benefits and support their status. Anna described that after discussing this issue in supervision, she and the students decided to have a meeting with the mayor and the administrators of the Borough board to make a complaint. She argued that community development should be based on values such as transparency, collectivity, and group decision-making processes. She also indicated that during the meeting she defended these values and argued that social workers were tied to these values, and could only function according to them. Anna said that her dilemma was that the undemocratic processes did not fit social work's values, they should not compromise, and the placement setting be closed for students. On the other hand, Anna argued that this decision would mean that social work students would no longer work with a vulnerable social group (i.e. gypsies) to promote social belonging. But because of student anger and her own lack of time or energy to deal with the situation, the final outcome remained outstanding.

Anna further stated that she could personally deal with this situation if she had the time and the energy to work individually with each of the members of the Board and "*manipulate*" them. She mentioned group theory and the greater power that one group has in contrast with individuals who had not formed a group to support opinion or ideas. In that sense, she argued that if she had the time she would see these people individually to "*break*" their power. Anna said that this case was still under negotiation as the mayor claimed that he could not accept the students' arguments

that denigrated his colleagues. What was important to note in this case was Anna's thinking about how she would deal with the ethical dilemma if she was willing to devote some time to dealing with this case. Particularly, she demonstrated that she would challenge the undemocratic procedures, not with ethical justifications, but by manipulating the power of the group that fostered undemocratic procedures in the Borough.

This argument contradicts the ways that ethical dilemmas are perceived by ethic theories. In particular, ethical dilemmas are perceived as a part of a broader discourse on ethics and should be dealt with by opening a "*pure moral discourse*" in which ethical rules or values are openly challenged (Clifford and Burke, 2005; Hugman, 2003; Clifford, 2002). Anna seemed to have been certain of what was or was not democratic, and demonstrated no effort to engage herself in discussion with members of the Borough to challenge her own thinking and perception about the case. Instead, she appeared to see a discussion with the members of the Borough as a matter of power and she seemed to be only concerned with how she could manipulate their power.

Georgia commented that it was good that her colleague referred to social work values because this would function educationally for the students to build a capability to resist "*institutional authority and power*". Georgia also argued that social workers never agree with authority, and they must build strong personalities and have sufficient knowledge to avoid being absorbed by the system (e.g. defining their own rules and boundaries). A stereotypical image of the social work profession emerged from these comments. Georgia said that "*social workers are always opposed to the authority*", possibly because she perceived authority, by definition, as being unethical. She claimed that organizations that employed social workers should permit them to define their own purposes and roles. Georgia's claim about professional autonomy, in conjunction with her perception about the non-ethical behaviour of "*authority*", implied that social work's values, ethics or purposes should remain unchallengeable. Georgia also seemed to believe that social workers should defend their professional autonomy despite the profession maintaining a low status and its identity confusing to the majority of Greek citizens (Dedoussi *et al.*, 2004; Pediaditaki, 2003).

Yianna supported Anna's opinion that she should cancel this placement, as she believed that since it is an educational program "*we should not educate students to bow their heads*". However, she also argued that if social work students were qualified and employed in a similar organization they would probably not have the "*benefit*" of leaving their jobs, something they can do as

students. Yianna's argument raised the question whether students were actually educated to resist and provoke an unethical situation under real conditions. Possibly, if the students were educated with an artificial freedom they would never again have as professionals, they would never learn how to survive within real working conditions.

Georgia provided me with another dimension of Anna's ethical dilemma. She argued that the real source of Anna's ethical dilemma was the competitive relationship she had with administrators of the Borough. She particularly challenged Anna's perception that the case was about value differences. In fact, she argued that probably the administrators of the Borough saw Anna not as a social worker but as a notable and active person that challenged their authority to put forward their own rules. In that sense, Anna's values and argument would be challenged anyway because of competitive personal conflict. Georgia suggested that Anna should be replaced by another supervisor to eliminate the personal conflict. Georgia's perception of Anna's ethical dilemma raised the issue of the power of personal relationships in practice contexts. Hospital social workers also highlighted the role of personal relationships among practitioners and the power of these to develop or solve ethical dilemmas in practice.

Although Anna was not opposed to Georgia's argument, she claimed that the administrators of the Borough were only interested in the results of their efforts, and they adhered to the ethical rule of "*ends justify the means*" which is in opposition to social work ethics. She also argued that it would be very difficult for another supervisor to fight this situation, as all the administrators of the Borough were "*technocrats*". She also said she would be very disappointed if a new social work supervisor compromised to keep the placement open for the students. Importantly, Anna's account highlighted the ethical dimension of what was perceived as outcome in social work practice, and she highlighted the role of the process which has been ignored by the evidence-based movement. Interestingly, she also appeared to believe that social work ethics were opposed to the doctrine of utilitarian ethical theory which indicated that an ethical action was determined as good or bad according to its consequences and not by the means that were used (Cheetham *et al.*, 1992; Benn, 1998).

Interestingly, Anna felt certain that many supervisors working in the university are incapable of supporting and promoting the values of social work. Importantly, two of the participants at the time the interview was conducted were authorized by the social work department to be in charge of the student placements and supervisor issues. However, none of them felt responsible to

challenge unethical practices of their colleagues, although they had the authority by being placed in a position to control the social work placements of the school.

6.1.3 Whistle blowing

Further to Anna's comments on supervisors who were not sufficiently competent to do their jobs, she expressed there were numerous incidents of academics that neglected their duties. Both Yianna and Georgia supported her argument by mentioning their own examples about academics neglecting their duties. In particular, Georgia and Yianna mentioned statements from students who claimed that their supervisors had never appeared in the placement, or never supervised them, and others who during supervision, were continually discussed irrelevant issues yet marked their students with excellent grades. Other examples included academics who never appeared at theoretical lectures, and supervisors only giving one hour of supervision with six to nine students.

This discussion led to a debate on whistle blowing. Anna took the stance that she would never blow the whistle on one of her colleagues. In addition, the group expressed that the academic manager and the students were responsible to control the unaccountability and neglect of duties of academics. Furthermore, the issue of good professionalism was perceived as a personal issue for each individual, and for each professional separately. The following quote was part of the discussion about the issue of whistle blowing:

I. Would you report your colleague for neglecting his duties?¹⁵

A. No, no.

Y. I would probably report him, yes.

A. Yeah, right! No way, you wouldn't do this. Then, when the other came to you and evidently he had never supervised...

Y. If I were a manager, I would do that.

A. Excuse me, but you saw him in person and you spoke to him, and what happened?

I. What exactly happened?

A. It was one of our colleagues who had never been to supervise the students. She told him..

Y. Yes, but I wasn't the manager. I told him yes, and I told him that he had never supervised. I told him that the students said to me that he had never showed up at the placement..

A. And what?

Y. And eventually the manager didn't do anything about this.

A. Did you refer this to the manager?

Y. Of course I did.

I. And is it only the manager the responsible...

G. It is also the person who is placed to be responsible for the placements.

¹⁵ This excerpt has been selected directly from the audio-taped interview and appears verbatim. All names are pseudonymous and are used for analytical reasons (I=interviewer; A=Anna; G=Georgia; Y=Yianna).

A. Please, speak up honestly.

Y. What are you talking about? One must report it and things go by hierarchy..

A. Did you report it formally?

Y. I discussed this verbally, but she (the manager) told me not to push this forward..

I. Would you formally report this case?

G. Yes, if I were responsible for the placements...

I. Have you ever reported a supervisor?

G. No, but I would not be annoyed at all if my manager called him to apologise, because he is the one who has the responsibility of control and evaluation, how can I do it, how can I say that my colleague didn't come to work today?

I. So, you think that it is necessary to be a manager to charge someone..

G. Yes, I wouldn't be the one who would make the charges, because there are some higher bodies.

A. No, this is not the only reason

I. Tell me, why you wouldn't do that..

G. To do this to my colleagues?

A. To my colleagues no, I wouldn't do that, because I would think that that is the way my colleague works, that this is the level of his capability, and I have no say in the matter

G. No, but I would not be annoyed at all if my manager called him to apologise, because he is the one who has the responsibility of control and evaluation, how can I do it? To tell that my colleague didn't come to the work today?

I. Why not?

G. Why? No, I wouldn't tell that. Didn't we know some of our colleagues who never gave their lectures?

A. Yes, constantly...!!!

G. I can't go with this situation to my manager, and make a formal charge that my colleague doesn't give her lectures. It should be the students' responsibility to go... I saw a student once and he told me that he never saw his supervisor. I asked him what grade he was given, and he replied "8.5", and I asked him "did you accept that? Shame on you!"

Y. Of course he accepted the grade!

I. Are we serious? Are we transferring the dilemma and the responsibility for a whole system to a student who is totally dependent on the teachers?

A. And what are you suggesting? To finger each other like in Mao's system?"

Thus, in terms of professional colleagues who neglected their duties, the consensus was that it was important, but not their direct responsibility. Georgia argued that she got angry with those who held high posts and did nothing to control such incidents. Anna said that "each of us must have the responsibility of oneself". Georgia explicitly said that fingering each other was not in the culture, and the only thing she would do was to answer honestly if questioned by the manager about a colleague. Anna supported her argument by indicating that they were not an "investigative office" and compared the practice of whistle blowing to the oppressive political system of Mao.

Interestingly, the social work academics placed responsibility for whistle blowing on students. For example, Georgia stated that student accusations of supervisor neglect would be more credible than others. In particular, she said:

If a student says that I am not supervising her, everyone will believe her even if I say that I supervise her for 300 hours.

In response to the consideration of alternative solutions to whistle blowing, only Georgia replied by saying that “*everyone should work with their conscience*”. Once again, Georgia’s response signaled the individualistic character of the manner that bad professionalism should be dealt with. In fact, neglect of duties was perceived as a personal issue which had to do with each professional’s conscience. Georgia seemed to forget that the individual right to self-determination was often opposed to social right for justice or equality (Clark, 2000; Rhodes, 1986; Reamer, 1982). The above interpretation was also supported by Anna’s response when asked what they would propose a social worker to do if they knew of a doctor taking bribes from patients. A social worker’s personality was again referred to: “*Didn’t I tell you that this is a matter of a social worker’s personality?*” More interestingly, Yianna responded that she would probably do nothing about this. Not surprisingly, none of the hospital social workers that participated in this study declared taking action for challenging unethical practices of other health professionals including doctors (see section 5.4.5, pp.158).

Overall, social work academics seemed to be opposed to the practice of whistle blowing. In their elaboration individualistic values including self-determination and freedom seemed to prevail in contrast to collective values such as social justice, and its consequent ethical obligation to fight against unfair policies and practices. Interestingly, students were not perceived as being more vulnerable than academic members of staff. Contrarily, students were perceived as a group with power that could potentially control the unethical practice of academics. Moreover, students were also blamed for accepting good grades from supervisors who were not thorough in their jobs. Interestingly, if social work academics had characterized or acknowledged students as being a vulnerable group, this would probably form an ethical dilemma. The conflict would appear as protecting vulnerable people versus fellow-worker solidarity. If social work academics viewed the unethical practice of their colleagues as an ethical dilemma, as noted by ethics theories, the decision between two equally unwelcome alternatives would put them in an emotionally and consciously difficult situation (McAuliffe, 2005; O’Sullivan, 1999). However, they seemed to make a subconscious decision not to form an ethical dilemma.

In contrast, hospital social workers appeared able to identify the abuse of those who had authority as the major source of their ethical problems. In particular, for hospital social workers patients' rights were often violated by the unethical practice of health professionals and mainly from doctors whose expertise was seen as their main source of authority. Nevertheless, the hospital social workers were no more apt to advance emancipatory practice or challenge these practices. Importantly, both academics and hospital social workers defended their inaction by highlighting their powerless position. Ironically, the powerful personality of a social worker was perceived by both groups as an essential characteristic of a good social worker. However, building partnerships toward a collective way of obtaining power was never mentioned as a characteristic of good social work practice.

6.1.4 Accountability and social work academics

All of the social work academics explicitly indicated that there was no evaluative system for academics. Georgia argued that social work supervisors were not evaluated and this was the main reason why no one could intervene or remove those who neglect their duties from their posts. Interestingly, Yianna said that the social work department decided to stop evaluation meetings of the staff because everyone was lying about their practice and the development of the social work placements. Yianna described this issue:

When we met we would speak about how we do wonderful work. We had a meeting at the end of the semester in order to evaluate our practice. In the past we had meetings more often but we stopped those because people started lying. Nothing happened after the meetings because nobody found the meetings important.

Evidently, Yianna's description of evaluation was a process in which nobody from the social work department found important or where they were willing to speak the truth. As the academics apparently hold no value pertaining to dishonesty, the department decided to stop evaluative process. This possibly noted the reluctance of the academics to be involved and develop an ethical discourse for their practice and critically examine the ethical base of their evaluative process. Moreover, Yianna's description denoted the absence of critical practice, which is inherent in any notion of evaluation (Dominelli, 2002). Consistent with a study of social work practice in Greece (Pantazis, 2007), none of the social work academics appeared to be guided by the critical approach.

6.1.5 Summary

It appears that social work ethics is not appreciated as an important part of social work education in Greece. In particular, only two of the four schools in Greece have a course on ethics. The participants were working in one of the schools that a theoretical course on ethics was taught on the fifth semester of the study program. However, the text book used was about teaching ethics of psychotherapy and not of social work. Moreover, the participants who were involved in practice learning of students did not mention any effort to teach students recognize and deal with the social work ethical dilemmas. In fact, in some instances participants appeared to hinder students getting involved and participate in the ethical decision-making process of an ethical dilemma which was relevant to their practice.

Overall, the academics' accounts appeared to provide further evidence of the distance between social work education and social work practice in a real context. In particular, academics did not demonstrate the ability of the social work school to educate students to deal with practice realities. As indicated in the previous chapter, hospital social workers appeared to highlight the importance of personal values and the powerful personality of social workers for meeting the challenges of practice realities and ethical practice. Interestingly, academics also shared the above ideas and even challenged the role of schools in the formation of the competent social worker. Similar to hospital social workers too, academics did not recognize that personal values may be different with those of social work and they believed that personal values are necessarily identical of these of the profession. Psychological maturity was also highlighted as an important characteristic of a good social worker. This possibly indicated the psychotherapeutic character of social work education and the anticipation of the academics from social workers to develop psychotherapeutic skills.

The ways that academics perceived power relationships and the ways that they finally dealt with their ethical dilemmas reflected the dominant psychodynamic theory and the absence of the critical approach. In particular, they seemed to perceive students not as a vulnerable group, but rather as a group with the power and mainly responsible for controlling the unethical practice of academics. In fact, academics seemed to reject that students were dependent on them for marks, and while they themselves had expressed concern about the Department manager who took no action when unethical practice was observed. Moreover, even when students were exploited by other professionals in practice settings supervisors made no effort to teach students how to

emancipate themselves. In some instances, dishonesty, manipulation and stereotyping students appeared to be part of their effort to suppress the conflict between students and professionals in practice settings.

Overall, academics had a negative attitude towards whistle blowing. However, they described many examples of academics who constantly neglected their duties. In fact, it seemed that whistle blowing was perceived as unethical practice as it involved a practice of offending and charging a colleague. Therefore, the main factor that appeared to affect this perception was the value of fellow worker solidarity. Although solidarity is often regarded as a collective value, for social work academics it had a different meaning. In particular, they seemed to acknowledge the right of each professor or lecturer to decide by their own conscience how they would fulfill their professional roles. Despite seeming to reject the fact that some of the social work academics neglected their duties, they claimed that each person should be responsible for himself or herself and that each person should act according to their conscience. In general, social work academics seemed to adhere to individualistic values rather than collective ones. In particular, they seemed to be reluctant or unable to recognize the impact of the unethical practice of academics in the broader community of students, in the social work profession and in social values.

Generally, academics were unable to demonstrate efforts, even alternative to whistle blowing practice, to eliminate the unethical practice of academics. Moreover, they demonstrated no effort to enhance the notion of evaluation in the university. Similarly, hospital social workers appeared to feel unable to intervene in cases of abuse of authority and agreed that in the interests of their clients, maintaining good relationships with these professionals was preferable to reporting unethical practice.

6.2 Hellenic Association of Social Workers and the promotion of social work ethics

As described in Chapter 4, professional associations such as HASW are the official bodies responsible for the regulation of a profession (Clark, 2000; Banks, 1998). One of their primary roles is to develop ethical standards and provide a clear statement of the mission and the values of the profession. The professionalization of social work is strengthened by the existence of professional associations; therefore, ethical codes become an essential part of what constitutes a qualified professional. In this way, service users' interests are more efficiently protected and social workers have the ability to defend their practice on the ethical grounds endorsed by their

profession.

Although registration in HASW is not compulsory, its ethical code is endorsed by all social work schools in Greece. Therefore, commitment to HASW's ethical code is anticipated even from those who are not registered members of the association. Nevertheless, HASW cannot intervene in cases of malpractice when the professional is not a registered member of the association. As HASW is the official professional association it can also intervene in the case where an organization that employs a social worker challenges the social work identity or obscures the social workers' activities. HASW also negotiates with the Ministry of Employment the minimum salaries of social workers who work in the private sector.

The HASW representative in this study argued that the Association had limited its activities due to financial difficulties arising from the small number of registered social workers. Additionally, she stated that the very few active members limited the developmental abilities of the Association. Efi reported that being a member of HASW was a lonely effort as it was not collectively supported by professional social workers. She stated that she was tired of being an active member while others remained inactive and indifferent. However, she also expressed being emotionally and ethically motivated to ensure the continuation of the Association as it has represented the historical evolution of the Greek social work profession for more than fifty five years.

According to Efi, only a few older members were active in HASW. In fact, only one of the fourteen hospital social workers and none of the social work academics declared being an active member of the Association. However, eight of the hospital social workers were members of HASW, perhaps motivated by the fact that social workers receive the HASW journal with their annual fee which is forty Euros.

It appears that HASW is currently emasculated given the limited active participation of its members. Therefore, it is doubtful whether HASW currently has the potential to protect and promote the standards of ethical practice. In particular, HASW has provided a general statement on values and the associated ethical responsibilities, however, with no indication of the date that it was formulated and whether there will be an update of the code.

6.2.1 Roles and responsibilities for ethical social work

In reference to social work ethics, the representative of HASW challenged the authority of the ethical code of social workers, since social workers were also employed as public servants and obligated to practice according to the code of practice of public servants. She also argued that the ethical code was a theoretical document and cannot prescribe practice in real situations. Based on this argument, Efi stated that the social work ethical code could not provide the justification for the violation of the law, even when these practices were for the benefit of social work clients. In contrast, hospital social workers appeared to violate laws and this was perceived as an ethical duty for protecting the best interest of their clients.

Importantly, Efi challenged the idea that HASW should have a significant role in the promotion of the values and the ethics of the social work profession. She suggested that schools of social work and practicing social workers were responsible for teaching and promoting the values and the ethics of the profession. She further argued that schools of social work should prepare students to practice according to the code of ethics, although she acknowledged that schools were not very familiar with practical issues and ethics relevant to the settings where students were placed. Interestingly, Efi also argued that the character traits of practitioners were helpful for practice that reflected social work values and ethics. This expressed opinion echoed that of both the hospital social workers and academics. To reiterate, ethical social work practice was thought to be a matter of personal values or virtues.

Concerning the role of HASW in the promotion of social work values and ethics, Efi mentioned the existence of a Disciplinary Committee that was responsible for controlling unethical practice of social work practitioners. She did, however, stress that the Committee did not meet regularly and characterized the posts of the Committee as “*honorary*”. Thus, it seemed reasonable to question the how active this Committee was and its power to ensure the maintenance of professional practice standards. Efi’s commented on hospital practice issues to illustrate the HASW role:

It is not our responsibility. I will tell you something, that means that this is not our responsibility. I mean that we are not here only for this. We are here for many more things, but this should be part of the social work education, and one’s character must help for this. I can only intervene at a level of consultation, to choose what I will say to you, I can’t impose that you do anything. I am not the kind of person who plays it smart and tells others what to do, or if you prefer this is a matter of a personal attitude. I would never accept someone telling me what HASW believes is less professional than

the practice of a colleague who uses her health booklet to obtain medicines for foreigners, I am not using mine! I will do something else, I will find him a sponsor, I don't know what. (e.x, § 222)

Efi seemed to be familiar with illegal practices of hospital social workers and she claimed that the HASW was opposed to them. However, she argued that the HASW was not obligated to ensure that hospital practitioners were informed of the HASW opinion on the issue. In terms of defending the HASW position on not promoting social work ethics, as Efi suggested that every social worker should be personally responsible for embracing and promoting ethics:

You know... I am not interested about the scenario that HASW does nothing, I want to see what social workers do too. It is not my role to do everything. I want to see what others do too. This is not tough, this is educational. (e.x, § 230)

Efi also seemed very annoyed with the fact that social workers, while they do not actively participate, charge the Association for inaction or demand to be informed about social work issues:

Why I am obligated to inform members that do not care about everything? They should come to the General Meetings of HASW. I am nobody's employee. They should come here to be informed, and when they have a problem I want them to remove me, to put me before the firing squad when I am not doing what they want, but only if it is fair and legal. But they cannot blame me for giving them my opinions, I am not personally obligated, only when I am free you may call me and ask me "Efi, I don't know what HASW says about this issue", then I will tell you, but I am not obligated to publish it in the journal. (e.x, § 324)

Overall, it appeared that the representative of the HASW did not find it particularly important to promote the code of social work ethics through its activities or challenge the application of the code of ethics in social work practice.

6.2.2 New knowledge and knowledge transfer for ethical social work practice

The journal *Social Work* was first published in 1985 thirty years after the foundation of the Social Workers (HASW). Since then, the journal has been funded and administered by the Administrative Board of the HASW. The President is regarded the legal publisher, and there is an editorial board and a scientific committee who are responsible for financial and publishing issues. The editorial board is responsible for receiving articles and ensuring that the author has followed

the publishing requirements some of which are:

1. Articles must be relevant to the science and practice of social work; and
2. Articles must be first- published.

Generally speaking, the journal is receptive to accept a paper on any topic that is relevant to social work practice. Therefore, the coverage of scientific issues reflects not only the interests of HASW, but also the tensions in social work practice and research in Greece. The journal is published four times a year and it is characterized as a “*scientific review of social work*” as it publishes “*articles and studies of approved social scientists*” (HASW, 2008). At least 5000 social worker practitioners are the members of HASW and possible readers of the journal. Social work students also have access to the journal from the libraries at their schools.

Using thematic analysis in which the researcher looked for themes relevant to social work ethics (Boyatzis, 1998), nine articles were identified. All articles were theoretical and no research was found relevant to social work ethics. Table 3 provides a detailed summary. The theoretical analysis of the notions of social exclusion and human rights were the main issues in six out of nine articles. In particular, three articles provided a theoretical elaboration of human rights and social exclusion often by reflecting on specific theoretical approaches. For example, Voudaskis (2001) provided a conceptual analysis of human rights by using the Marxist theory and then he discussed the historical evolution of human rights after the collapse of socialism in Post Soviet countries. Similarly, Panousis (2004) provided a conceptual analysis of social exclusion following Tsomski’s theoretical framework and he discussed the current political ideologies, particularly globalisation and its consequences for human rights. Interestingly, only the three out of six articles on human rights and social exclusion were clearly related to social work purposes. More interestingly, one of the authors that related human rights with social work practice did not mention any theoretical framework for supporting her arguments. In particular, Loumidi (1990) referenced only the principles of the IFSW that briefly describe the commitments of the social workers to human rights. However, her elaboration of the principles was not explicitly supported by theories. Two articles discussed social exclusion in relation to the needs of older people. In particular, the authors discussed the ways that the older people are excluded due to the deficiencies of the welfare state. Furthermore, Maurogeni (2007) discusses the ethical conflict between the right of older people to autonomy and the social workers’ responsibility to ensure a

safe environment for the older people. The author reflects on her practice experience but she made no reference to her theoretical underpinnings.

The remaining articles were clearly related to social work and included: the code of ethics of therapists working in substance abuse organisations, one article analysing the notion of morality in social work and one analysing the notion of tolerance and its relationship to social work. Interestingly, KETHEA which is one of the two centres for therapy of addicted individuals in Greece, published its code of ethics in the journal however, it was not clear whether employed social workers are obligated to disengage from their professional code of ethics. In fact, the code of ethics of KETHEA (1996) identify all professionals as “*therapists*” and imply a common professional identification and standards despite the different orientations or standards of the disciplines involved. In contrast, Papaioannou (1998) described the ethical obligations of the social workers and mainly those derived by individualistic values such as: dignity, respect, confidentiality and self determination. However, she made no reference to collective values and the consequent conflicts of values. She also did not mention any factors related to the development of ethical dilemmas in social work practice.

Interestingly, when the representative of HASW was asked why the journal does not inform the social workers with articles relevant to practice ethics, she argued that the journal was “*scientific*”. Importantly, Efi seemed to differentiate between scientific knowledge and empirical knowledge. In fact, Efi seemed to imply that empirical knowledge was not part of what she defined as science. This argument raised questions about the role of empirical studies in the development of the social work profession in Greece. If the examination of practice was not a matter of concern for social workers, then empirical studies had nothing to provide to the development of the profession, and consequently to the quality of services. Moreover, social work theories remained unchallengeable with limited potential for renewal so that they could meet real needs in real situations.

Table 3: Social Work publications and professional social work ethics

	Year	Reference	Comments
1	1990	Loumidi, D. <i>"Patients' Rights and Social Work"</i> Vol.17	The author presents some of the ethical principles of the IFSW meeting (July 1976), and describes ethical obligations of social workers. She focuses mainly on the values of respect, the value of the inherent worth of all people and acceptance of diversity.
2	1991	Vagia, C. and Kremalis, K. <i>"Human and Social Rights of Older People: Risks of Violations and Preservation"</i> Vol.24	The authors explain some of the human rights presented at the International Declarations and the Greek National Constitution (1975), and they relate those to the needs of older people. Acknowledging these rights, the authors also discuss how the needs of older people can be satisfied through the social services department and social work interventions.
3	1996	KETHEA (Therapy Center for Addicted Individuals) <i>"Code of Ethics"</i> Vol.42	This article is the code of ethics of the World Federation of Therapeutic Communities. It is a code of practice of those who work in therapeutic communities for individuals who are drug dependent.
4	1998	Papaioannou, K. <i>"Values and morality in social work"</i> Vol. 51	The author presents her arguments about the relevance of values and ethics in social work practice. She makes specific reference to the ethical obligations of the social workers.
5	2000	Mardas, G.D. <i>"Social inequality: social and administrative policy at national and international level"</i> Vol.60	The author analyses some of the basic human values related to social inequality. Values such as equality, justice are analyzed in reference to the philosophical thinking of Aristotles, Marx and Rousseau.
6	2001	Vouidakis, V.K. <i>"The human rights: an effort of a sociological approach"</i> Vol.62	The author describes the social and historical evolution of the human rights. He refers to the differences in the typologies of human rights before and after the collapse of socialism in Post Soviet countries.
7	2004	Panousis, G. <i>"Social exclusion and those who socially exclude"</i> Vol.73	The author argues that in the face of world poverty and the political and social value of globalization, human rights are infringed. In addition, he makes an analysis of the value of equality in the face of the current political and social ideologies and values.
8	2004	Soubasi, N. <i>"Social Work and Tolerance: towards a model of social work which embodies their inherent relationship"</i> Vol.75	The author describes the meaning of tolerance as a value and the ways that this possibly could affect and enhance how social work is practiced. Additionally, through an historical overview of the evolution of social work profession, the author suggests the internationalization of social work through a more focused practice on the value of tolerance and human rights.
9	2007	Maurogeni, H <i>"Social exclusion of aged patients and social work"</i> Vol.85	The author describes the ways that social problems such as poverty and the deficiencies of the welfare state lead to social exclusion of older people and in particular of those who are hospitalized. In addition, the author presents many of the role conflicts and consequent ethical dilemmas of hospital social workers when they try to support the autonomy of hospitalized older people.

6.2.3 Summary

The representative of HASW challenged the idea that HASW should have a determinant role to promote the values and ethics of the social work profession. More specifically she argued that social work schools are the main responsible authority to ensure that social workers are able to

solve their ethical dilemmas or problems. Although she challenged the ability of social work schools to educate students in issues that are experienced only by practitioners in a real social work situation, she did not mention any effort to disseminate such knowledge. In fact, in reference to the journal of HASW she characterized it as being “*scientific*” and that it should not deal with issues relevant to real situations that one meets in practice. More interestingly, she characterized the ethical code of the profession as a “*theoretical document*” which is irrelevant to real social work practice and consequently a social worker cannot use this document in order to solve every day issues in their practice, including ethical dilemmas.

In reference to the thematic analysis of the journal *Social Work*, evidently no research about practicing social work ethics was found. Given the fact that it is the only social work journal in Greece, it may be concluded that there is no other published study relevant to social work ethics. In addition, only nine published theoretical articles relevant to social work ethics were detected.

Conclusion

Education is perceived as one of the formational factors for the professional identity and practice (Payne, 1997). In addition, professional associations such as HASW are responsible for the development of the ethical code of the profession and this is clearly part of their regulatory role (Clark, 2000; Banks, 1998). Therefore, understanding ethics within a broader social work context was appropriate.

Hospital social workers appeared to believe that ethical social work practice is necessarily identical with the practice of their personal values. Not surprisingly, this was a shared belief among social work academics and the representative of HASW. Moreover, neither the HASW nor the social work school appeared to appreciate social work ethics and day-to-day practice. In particular, the representative of HASW challenged the role of the Association for the development and promotion of ethical standards. In addition, she characterized the code of IFSW a theoretical document that was meaningless in real social work practice. Importantly, from the review of the journal of HASW from the publishing year of 1997 to 2007 only nine theoretical articles relevant to social work ethics were identified, and none were empirical studies.

Similarly, academics did not show any special interest and knowledge to prepare students on social work ethical dilemmas. In fact, in some cases they appeared to exclude students from the

ethical deliberation of their ethical dilemmas. This finding is particularly important as Clifford and Burke (2005) suggested that social work schools should enhance the ethical awareness of students by raising ethical issues in schools and by encouraging the involvement of students in ethical discourse. Moreover, the course on social work ethics was based in a text book about ethics in psychotherapy. Tragically, students appeared to be disorientated by their school to engage themselves in ethics that were irrelevant to their professional identity and mainly to the structural purposes of the profession. This came along with the complete absence of courses on critical social work practice. Thus, collective values and the consequent collective purposes of the social work profession such as social justice appeared to be completely ignored by the social work school.

Evidently, the individualistic character of hospital social work practice appeared to be formed in social work schools. In particular, social work academics appeared to value the freedom of the individuals' conscience over what they also acknowledged as socially just. For example, this was reflected in the way that academics dealt with the unethical practice of their colleagues. In particular, academics appeared to ignore that students' educational rights were violated by the academics who neglected their duties. Interestingly, this was partially influenced by the fact that social work academics did not recognize students as vulnerable group.

Importantly, academics appeared to believe that if a social worker has a powerful personality then this is sufficient for meeting the challenges of ethical practice. However, academics appeared to acknowledge that some of the structures were resulting in ethical problematic issues such as the absence of evaluative processes and power relationships. Nevertheless, academics appeared to ignore oppression as a result of these structures. Ironically, academics perceived students as being a powerful group despite their descriptions of incidents where students were exploited in practice settings and neglected by their supervisors.

Similar to the hospital social workers, and despite their academic status, social work academics expressed being powerless to bring structural changes to the educational system. Nevertheless, they argued that social work students had more power to impact structural change through voicing their complaints. For example, the unethical practice of social work academics along with the absence of an evaluation of the social work educational system appeared to be key issues within the school of social work. However, the academics did not demonstrate efforts to address these realities. In fact, the ethical obligation of fellow worker as collegian solidarity appeared to be

one of the major factors that determined their decisions not to get involved. Moreover, the absence of evaluative processes appeared to be tacit agreement among the social work academics. As a result, the educational system of social workers appeared to be structured without any kind of evaluative mechanism or control in order to ensure minimum standards of practice. In this reality even if social workers wanted to blow the whistle against unethical practice, the educational system of social workers would be completely unable to protect them.

While IFSW requires of its members to incorporate and promote the ethical standards along with a body of knowledge compatible to social work purposes, the representative of HASW and the social work academics perceived personal values as indicators of ethical social work practice. At the same time, the individualistic character of social work practice appeared to be clearly reproduced by social work schools, although social change and social justice are currently at the core of the social work definition (IFSW, 2005). Tragically, the future of social work in Greece appeared to be framed by the fact that executive members of the social work community disregarded the essential role of social work values and ethics, as well as the importance of ethical decision-making in social work practice. Therefore, it seemed that collective values and structural changes probably would remain excluded from the social work agenda of those who have a key role in the development of the profession.

CHAPTER 7

Discussion and Conclusion

Introduction

The purpose of this case study was to obtain a deeper understanding of social work ethics in Greek social work practice. Focusing specifically on practice in public hospitals in two of Greece's largest cities, depth interviews were conducted with practitioners, academics and the Hellenic Association of Social Workers to obtain insights into the complexities of applied social work ethics and values, particularly in relation to the ambiguities of the social work identity. In addition, hospital social workers' descriptions of everyday practice revealed the essential role of ethics in what we regard as the science of social work. This study also explored the place of ethics in the formation of what Greek hospital social workers perceived as "good" social work practice.

Importantly, this study represents the first empirical examination of social work ethics and daily practice in Greece. Furthermore, the qualitative orientation of the study permitted a first time opportunity for a group of social work professionals to share in their own words the realities of their day-to-day working lives in complex bureaucratic organisations that place little value on social work's contribution to a civil Greek society. Furthermore, the specification of the contextual factors in relation to the ethical commitments of the social work profession can enhance the potential for the development of ethical expertise in social work practice. It is anticipated that with the dissemination of the results, social work education in Greece may build a stronger training emphasis on ethics informed by practice realities. In this way, social workers can become more equipped to adequately address their ethical commitments. Moreover, the contextual understanding of ethical practice will enable practitioners to deal with the disappointment and frustration they encounter when client needs cannot be met due to structural obstacles.

The study's key findings draw attention to ethical dilemmas as an inseparable part of the social work identity. Specific attention to the profession's ethical commitments and the nature of the context in which these are expressed vis a vis practice, sheds light on a number of important considerations for social work in Greece. These include:

- The determinant role of personal values in ethical decision-making;
- The absence of collective values from the ethical decision-making;
- The consequent individualistic character of social work practice;
- Paternalism and parochialism as a result of the “*dark side*” of the ethic of care;
- A lack of attention in Greek social work education and the HASW on social work ethics; and
- The challenges for Greek social work to address the structural roots of ethical dilemmas.

The purpose of this chapter is to discuss the main findings of this study. The first section returns to the original research questions and the relevant findings discussed: (i) social work in Greek public hospitals; (ii) the meaning of ethics in hospital social work; (iii) ethical dilemmas and ethical decision-making; and (iv) the role of ethics in evaluating “*good*” practice. Following on from this, the study’s limitations, recommendations for further research, and the implications for social work policy and practice are reviewed.

7.1 The meaning of ethics and ethical dilemmas in public hospital social work practice in Greece

As argued throughout this thesis, ethics are an inherent part of professional practice which lead social workers, consciously or unconsciously, in their daily decision-making activities (Seedhouse, 2005; Goldenberg, 2005; Adams *et al.*, 2002; Schon, 1987; Rhodes, 1986). Through the analysis of practitioner descriptions of ethically difficult situations a number of key concerns about social work ethics emerged. By understanding the meaning of ethical dilemmas that hospital social workers confront in their daily practice and their subsequent decision-making and actions, key factors that construct the nature of hospital social work practice in Greece were identified.

The theoretical underpinning of this study in critical social work practice highlighted social change and social justice as inherent parts of what social work defines as its ideals and purposes. The focus of this study on social work ethics sheds light on the ways that social workers perceive their ethical obligations. Consequently, the ways that ethics take on a real meaning in social work practice and its evaluation become understood. In addition, the qualitative orientation of this study enhanced the contextual understanding of social work ethics. This means that contextual factors including public hospitals, policy and the social context were also explored so as to understand

how these influence individual practitioners to practice their values and ethics (Banks, 2008). This understanding is important in enhancing the development of social work as a science which can lead to structural changes in society for both societal and individual well being.

7.1.1 Social work in Greek public hospitals

Similar to other studies in Greece, the social workers who participated appeared to be focused on micro-level interventions mainly involving efforts to provide psychosocial support to patients and their families (Dedoussi *et al.*, 2004; Georgoussi, 2003). In particular, social workers working in psychiatric departments explicitly characterized their practice as psychotherapy and often identified themselves as being “*therapists*”. In medical units psychotherapeutic targets were more loosely applied, possibly because social workers had no complementary education in psychotherapy and patients were mainly described as having a greater need for community support. Therefore, social workers in medical units were more focused to ensure family or community support and resources for the patients. When community or family support and resources were not available then, social workers made efforts to postpone patients’ discharge from hospitals.

Advocating for a postponed discharge from hospital when this was believed as necessary and welcomed by the patients was at the core of the social workers’ purposes and mainly those who worked in medical units. However, this effort often resulted in conflicts with doctors as the latter were interested in keeping beds empty for patients who needed hospitalization for medical reasons. Until such an environment was ensured, social workers insisted that patients should remain in hospital for their security. Providing financial assistance and helping uninsured individuals cover their medical expenses was also within the purposes of hospital social workers.

Findings from this study showed that the hospital social workers argued that their professional identity was defined within the limited welfare state and/or the insufficient social provision by the state. This was not a surprise given the social policy literature identifies Greece as having a particularly low ranking in social protection in contrast to other EU countries. In fact, the welfare system in Greece is still characterized by the fundamental structures of a traditional welfare model, and particularly by fragmentation and preferential treatment both in funding and the delivery of social protection (Yfantopoulos, 2004; Guillen & Palier, 2004; Sotiropoulos, 2003).

Within this context, the hospital social workers identified themselves as those who deal with vulnerable groups that “*nobody cares*” about.

7.1.2 The meaning of ethics in hospital social work practice

The social work ethical code is a document that establishes the professional identity by providing a framework of purposes, ideals and, standards of good practice (Bowles *et al.*, 2006; Clark, 2000; Banks, 1995). More importantly, values and ethics provide a concrete meaning to the broad notions used for defining social work such as promoting social change and individual well being. Crucially, if social work can not maintain a common framework of purposes and standards of good practice, then it remains vulnerable to fragmentation and criticism for having no autonomous entity (scientific or professional) within practice environments (Clark, 2000; Banks, 1995).

Nevertheless, it has been argued that social work has never accomplished an adequate response to its structural purposes and to social justice (Dudziak, 2002; Gibelman, 1999; Payne, 1999; Figueira- McDonough, 1993; Beck, 1959). Ethical theories enable practitioners to understand the moral worth of their actions and explore the meaning of their ethical engagements. Moreover, ethical awareness enables social workers to appropriately answer the question “*who receives the benefit of social work practice*” as a mechanism to evaluate practice, and defend social work’s humanitarian character (Bowles *et al.*, 2006; Feather, 2002; Clark, 2000; Fritzsche, 1995). However, it is also argued that ethical practice is often decontextualized in the social work literature and there are no apparent linkages between ethical practice and policy (Banks, 2008). Consequently, social workers fail to understand the contextual factors that constrain their ability to act. In this thesis it has been argued that the critical approach places social justice at the core of social work’s purposes and enables practitioners to appreciate the political nature of their ethical engagements. This means that social workers, through a critical approach, become more equipped to understand ethics beyond interpersonal relationships and respond adequately to their ethical obligation to challenge social injustice (Rossiter, 2001).

Findings of this study indicated that the value preferences of the participants appeared to influence the way that they constructed their role and identity in hospitals as well as their perception of ethical dilemmas. This was also empirically illustrated by a study that explored individual ideologies and their impact in social work practice in a UK community care context (Sullivan, 2008). Similarly, social work practice in Greek hospitals appeared to be influenced by

social workers adhering to values, and specifically to those for the enhancement of individuals' rights or benefit. In particular, self-determination, the ethic of care and the inherent worth and uniqueness of the person were the prominent values of the hospital social workers. Accordingly, collective values such as the value of social justice and its consequent ethical obligations were missing from social workers' moral justifications of their practice and from what they perceived as ethically difficult situation. The absence of collective values appeared to define social work practice in Greek hospitals as lacking macro-level interventions.

Importantly, the adherence of the Greek hospital social workers who participated in the study to psychotherapy and individualistic values appeared to develop practices of social control, although they appeared ethically engaged to promote the best interest of their clients. In particular, in using psychodynamic terminology the hospital social workers were inclined to control patients by characterizing their behavior and appeared to ignore the structural deficiencies that oppressed their clients' rights in the first place. Therefore, social workers often manipulated patients to allow the structures of the hospitals to appear to be providing patients' needs.

Moreover, the version of the ethic of care which appeared to underlie their practice and ethical decisions often led them to paternalism and parochialism as the hospital social workers tended to be focused on their immediate relationships with the clients, while they seemed to have no macro level concerns for equal distribution of power and resources (Meagher & Parton, 2004). Importantly, and similar to Kirkpatrick's (2006) argument, this version of the ethic of care appeared to lead hospital social workers to encourage domiciliary care over services provided by the state. Even at the micro level their adherence to care and protection of the vulnerable often led them to dishonesty, purposeful concealment of information and control of their clients. As emphasized repeatedly throughout the presentation of findings, such practices are described as the results of the "*dark sides*" of the ethic of care (Meagher & Parton, 2004). Nevertheless, their commitment to the ethic of care appeared to orientate them to practice with sensitiveness, empathy and caring behavior. This is in contrast with the impersonal social services in other countries which are controlled by the managerial ethos and strict detached professionalism (Sullivan, 2008; Banks, 2007; Meagher & Parton, 2004).

Furthermore, the fact that the social workers who participated appeared to work as psychotherapists and the fact that they do not address macro level issues was reinforced by the nature of how they were educated and what the HASW supports. Importantly, social work ethics

and critical social work did not feature within the curriculum in the department of the interviewed academics. In particular, they indicated that the textbook on ethics addressed “*ethics of psychotherapy*”, and that there was no course on critical social work practice in any of the schools of social work in Greece. Not surprisingly, the academics appeared to highlight the importance of a powerful personality of a social worker as being sufficient for addressing the challenges of ethical social work practice. In fact, the academics appeared to ignore the structural roots of their ethical challenges, but even when they acknowledged them, they decided to take no action. Even when the exploitation of a vulnerable group of students was evident due to power relationships in practice settings, those interviewed tried to suppress the consequent conflict at the cost of student rights. Importantly, this practice appeared to be based on psychodynamic theory as they used its terminology to characterize and manage the students.

A similar lack of attention on social work ethics was evident in the HASW. In particular the Association appeared to challenge its responsibility to promote the ethical standards of social work. The representative of HASW challenged the authority of ethical codes in general and described them as “*theoretical documents*” that were meaningless in practice. In contrast, she highlighted the authority of laws that should guide professional practice. However, ethics theorists argue that laws are historically controversial and demonstrate that do not necessarily represent what is socially just. In this sense, laws are insufficient to indicate what social workers are obligated to do from an ethical perspective (Clark, 2000; Banks, 1995).

In addition, the absence of MA programs which would potentially enhance research in Greek social work schools and the complete absence of empirical studies in social work ethics published in the social work journal of HASW indicate that empirical research is likely not appreciated as a developmental feature within the profession. The fact that the representative of HASW seemed to perceive that empirical knowledge was not part of scientific knowledge raises questions about the role of empirical studies in the development of the social work profession. Therefore, if the examination of social work practice has nothing new to provide to scientific knowledge and questioning, then social work theories remain unchallenged and have no potential for renewal so as to provide the appropriate solutions for the real problems where social work ethics are involved. In addition, as other studies have also shown, there is no evidence that social workers in Greece have benefited from an international exchange of knowledge and educational opportunities for social workers are considerably limited (Dedoussi *et al.* 2004; Georgoussi, 2003; PEDIADITAKI, 2003). In addition, the dominance of the psychodynamic approach appeared to be

reproduced by the absence of any alternative theory of social work such as the critical approach (Pantazis, 2007).

However, some identity characteristics of the profession appeared similar to social work in the UK and US. Empirical studies in these contexts indicate that overall, social workers are more adherent to individualistic values such as self-determination than to collective ones such as social justice (Woodcock and Dixon, 2005; Banks, 2005; Kugelman, 1992). Moreover, social work authors have strongly argued that practitioners are educated and devoted to psychotherapeutic practice while they ignore their professional obligation to social change and social justice (Rossiter, 2001; Payne, 1999; Gibelman, 1999). Therefore, whether we are thinking about the UK, US or Greece, the individualistic character of social work practice plays a determinant role in the way that social workers perceive and respond to social problems. The absence of an orientation towards social justice is an identified shortcoming that should be addressed cross-nationally. This is a prerequisite for developments in social work education so as to equip practitioners with the ability to acknowledge and develop responses in both local and global economic and political processes that impact on individual and societal well being.

In reference to the way that the Greek hospital social workers who participated in the study perceived ethical practice, the majority of the hospital social workers demonstrated that the ethicality of their practice was not necessarily ensured when practice was consistent with social work's ethical code. Although ethics appeared to be very important in their practice, personal values and individual consciousness were the determinant factors that guided social workers to ethically informed practice. This argument was reinforced both by the HASW and the social work academics. Commonly, the participants were not able to reflect on the distance between personal and professional values as they believed that once one becomes a social worker professional values are internalized. But even when some social workers differentiated the personal from the professional values, they placed their personal value system above the fixed professional codes of practice. Nevertheless, with the exception of one, they seemed to consciously reject the ethical code or placed themselves in opposition to its specific principles. It was rather an unconscious rejection of the written or "coded" determination of the "what is ethical?" question. Not surprisingly, none of them declared having used the code of ethics. Moreover, they all seemed to ignore that personal preferences on values violate the professional responsibility of the social workers to equally treat all of the values and ethics that the profession is committed to promote and preserve (Banks, 2001; Clark, 2000).

Importantly, these findings would appear to reflect the inability of social work in Greece to follow international developments within the profession. In particular, Banks (2008) argues for a growing interest in social work ethics indicated by the availability of text books, empirical studies and revisions of ethical codes in the US, UK, and Australia, but also in less developed countries or in countries that social work is a new profession. In contrast, although social work in Greece dates from 1945 and its professional association since 1959, social work ethics are ignored both by the Association and social work education.

However, values and ethics were applied in practice even in Greece where the code of the profession seemed ignored. This is supported by the understanding that all human activity, including scientific activity, is underpinned by values (Taylor, 2006; Seedhouse, 2005; Goldenberg, 2005; Adams *et al.* 2002; Everitt and Hardiker, 1996; Schon, 1987). In fact, all the participants acknowledged their moral values as indicators of “good” social work practice. Moreover, the majority of hospital social workers explicitly indicated that they practiced according to their ethical engagements. Therefore, values were applied in practice, although not necessarily those embraced by the social work ethical code.

Although ethics obtain their meaning through the conceptual analysis provided by the various philosophical approaches, this study was limited to applied ethics and did not provide an in-depth exploration of the philosophical assumptions behind the values and ethics that the hospital social workers who participated in the study reflected through their descriptions. In fact, Banks (2008) recognised the difficulty of identifying the relevance between philosophical and empirical ethics. For example, some values or virtues, such as care and courage, appeared to be important for the hospital social workers. However, it was difficult to make assumptions in relation to their philosophical origins as different approaches often end up building a shared set of ethical principles or values, although provided with a different rationale or meta-ethical assumptions. For example, self-determination is believed as rooted only in individualistic approaches to ethics as they highlight the inherent ability of humans to sense themselves as autonomous individuals. Collectivistic approaches and Greek philosophy also value self-determination, however, by acknowledging that individuals are necessarily connected with society. This means that according to collectivistic approaches individuals are truly liberated only when they sense their selves as united with “others” and society (Walsh, 1974).

Nevertheless, some values appeared more important than others as the Greek social workers who participated appeared to ignore the dualities of values such as individualisation and collectivization (Payne, 1996), or showed clear value preferences that were reflected through their descriptions of ethically difficult situations and crucially through their ethical decisions. In fact, and as previously discussed, the participant social workers appeared to show a preference to individualistic values such as self-determination, autonomy and care for the vulnerable individuals in need.

7.1.3 Ethical dilemmas and ethical decision-making

The meaning of ethical dilemmas and problems appeared to be constructed by a complex interplay of several factors including the way that hospital social workers perceived ethical practice, the inattentiveness in social work education and the HASW to social work ethics, a professional emphasis on individualism rather than collectivism, and insufficient social protection in Greece.

Despite the fact that hospital social workers appeared to develop only micro level interventions and had a clear preference to individualistic values, they all declared that they worked under unethical structures within a system. In particular, the major factors that appeared to develop ethical problems and dilemmas for hospital social workers were the unsatisfactory level of social protection in Greece, and the unethical practice of professionals. In fact, the bulk of the literature extensively shows that both the health sector and the welfare state in Greece suffer from multifaceted deficiencies, including lack of sufficient public expenditure for social protection, lack of management and evaluation, unethical practices and preferential treatment, expansion of privatization, hazardous decision-making and dysfunctional bureaucracy (Mossialos *et al.*, 2005; Yfantopoulos, 2004; Ballas & Tsoukas, 2004; Guillen & Palier, 2004; Sotiropoulos, 2003). Dissatisfaction about the dysfunctions and deficiencies of the welfare and health sector was indicated in all participants. Similar to Conrad's study (1988), this study showed that insufficient community resources were a source of ethical dilemmas. However, it was also indicated that hospital social workers in Greece, in the face of these types of dilemmas, often choose to violate laws to be able to support their clients in informal and often illegal way. Evidently, violating the laws was a part of social work practice and a conscious decision that was justified on ethical grounds. However, it also seemed that the decision to violate the laws was a response to provide support to the *"immediate person in need"* while the collective interest for equality was ignored.

This is what Meagher and Parton (2004) named as parochialism and was described as one of the “dark sides” of the ethic of care.

The majority of cases described as ethical dilemmas or problems contained issues relevant to poverty. Typically, the social worker’s clients suffered from financial difficulties while they were disabled or too old to work. Social work clients were also uninsured immigrants with great financial difficulties that were made worse by the medical expenses that were needed for their hospital treatment. Contextual factors including the absence of rehabilitation institutions, residential care and welfare support, all indicators of the insufficient policy of social protection in Greece (Yfantopoulos, 2004), were involved in all cases described as ethical dilemmas. Contrarily, findings from the studies of Proctor *et al.* (1993) and Boland (2006) suggested that hospital social workers working in American hospitals did not indicate cost containment cases as ethical dilemmas. In fact, the majority of the participants in the first study indicated the ethical dilemma was between the pursuit of the client’s best interest versus his/her right to be self-determining. Whilst in the second study, the majority of social workers identified ethical dilemmas were clinical cases relevant to medical issues. Interestingly, ethical dilemmas that do not involve contextual factors indicate a value conflict within the clients' best interests or needs. In such cases it is assumed that contextual factors do not necessarily have an effect on the ethical decision-making process. Contrarily, when contextual factors are acknowledged in ethical dilemmas, it is also assumed that the decision-maker has a relatively little control on them.

Importantly, the previous section (7.1.2, pp.220) indicated that the individualistic character of social work along with an adherence to individualistic values were evident in Greece, and also in the UK and US. However, Greek hospital social workers appeared to more persistently highlight the structures of the health and social welfare as the major sources of their ethical problems. These findings probably indicate the notable difference between social protection in these countries. In fact, the standards of living in Greece are far more lower than the rest of the members (Yfantopoulos, 2004; Guillen & Palier, 2004; Sotiropoulos 2003).

Another important factor that appeared to be involved in the creation of ethical problems and/or dilemmas was the personal relationships between the Greek social workers who participated and other professionals, mainly those with an administrative position in public organizations. In fact, personal relationships appeared to have a dual contradictory function. In particular, the hospital social workers declared that good relationships with public servants and doctors were vitally

important to their practice even when these professionals had no hesitation to practise arbitrarily. On the one hand, by ensuring good relationships with these professionals, the hospital social workers were able to promote the best interest of their clients by helping them to overcome malfunctions within hospitals rules. On the other hand, other patient rights (e.g. for appropriate medical treatment) were obscured due to the unethical practice of the same professionals. The hospital social workers, instead of challenging such practices, tried to maintain good relationships with these professionals to ensure that at least their clients' needs would be met. However, in this way social work actions were viewed as favors rather than as patient rights. Once again, the inability of social work education in Greece to prepare students to address the ethical dilemmas developed by their personal relationships with other professionals emerged. In particular, academics appeared to feel an ethical certainty that collegian solidarity should be protected even at the cost of the violation of rights of a vulnerable group.

Overall, both hospital social workers and social work academics did not perceive whistle blowing as an ethical practice mechanism to challenge the abusive authority of professionals. For hospital social workers whistle blowing was perceived as a practice that would have questionable results. In particular, they argued that damaged relationships with professionals who abused their authority would eventually constrain client benefits. Instead, social workers appeared to try to manipulate the administrative authority so that it could be used for client benefit. Interestingly, for Herzfeld (1992) who conducted ethnography of bureaucracy in Greece, indifference to human suffering was produced by the reluctance of bureaucrats to deal with unethical practice or the bureaucratic dysfunctions that damaged citizen rights especially when these were controlled by individuals with authority. Similarly, the hospital social workers who appeared to have a "caring" image were also reluctant to accept responsibility when patient rights were violated by the unethical practice of the more powerful professionals (e.g. doctors). For example, both hospital social workers and social work academics argued that challenging unethical practice was not part of their role. Social work academics expressed an absolute negative stance toward whistle blowing and argued that they would never interfere with their colleague's work, even when the purposeful neglect of their duties was evident. In fact, for social work academics whistle blowing was unethical practice since it would violate their commitment to group solidarity. Social work academics also disagreed that students were vulnerable to the authority of academics.

Evidently, none of the hospital social workers, the academics and the representative of HASW perceived whistle blowing as a form of advocacy for human rights (IFSW, 2005; NASW, 1999).

Their perception of whistle blowing appeared being affected by the fact that individualistic values including self-determination and freedom seemed to prevail in contrast to collective values such as social justice and its consequent ethical obligation to fight against unfair policies and practices.

Personal values, the dominance of individualistic values, and the consequent individualistic character of the social work profession appeared to be interrelated factors and determined the ways that the Greek social workers who participated constructed what they perceived as ethically problematic. Moreover, these factors led to a fairly consistent response to ethical problems and decisions with similar characteristics.

The first important consequence was that hospital social workers hardly ever described stories of their practice as dilemmas grounded on a conflict between two equal values (Banks, 2001; Clark, 2000). Contrarily, ethical dilemmas were defined by the majority of the hospital social workers as a situation that clearly constrained their ability to promote the best interest of their clients due to various reasons including the limitations of the welfare system, insufficiencies in health care, the absence of residential or rehabilitation institutions, bureaucracy, and the unethical practice of other professionals. Most commonly the expression that the hospital social workers used when referring to a case that was named as an ethical dilemma was "*What am I supposed to do now?*" and seemed to reflect being at a "*dead-end*". This response was different from the theoretical definition of ethical dilemma, as the respondents did not reflect the existence of uncertainty due to a conflict of values. In fact, their definitions were similar with what Banks (2001) defines as "*ethical problems*". In particular, an ethical problem contains a certainty of the ethical obligation for the actor. Nevertheless, by reflecting on various philosophical approaches on ethics and on the critical approach the researcher identified that value conflicts were always there, but hardly ever acknowledged by the hospital social workers.

The second consequence was that hospital social workers appeared to make ethical decisions by "*placing themselves in their client's shoes*". This was particularly influenced by the individualistic character of social work practice and their guiding value to always act for the benefit of their clients. The fact that the majority of the social workers who participated argued that a good practitioner must be emotionally involved with clients was also a possible factor affecting their practice reality. Moreover, the hospital social workers' emotions seemed to influence not only the process of decision-making, but even when they were acting according to their initial decision. In such cases a social worker was guided, rather unconsciously, by his/her emotions to act in

contradiction with his/her initial ethical decision. Importantly, these findings strengthen the framework of the ethic of care that sees emotions and the caring feelings of the care-giver as always involved in ethical decision-making (Koehn, 1998).

Importantly, the above findings contribute to the development of empirical knowledge on social work ethics especially when considered with other studies, although conducted in different contexts. In particular, Banks and Williams (2005) argued that the ethical dilemmas of social workers in a UK were only broadly defined and did not reflect elements of value conflict and decision-making. However, they did not provide any explanation of these findings. Contrarily, the findings of this study suggest possible explanations such as the inability of the hospital social workers to reflect value conflicts when describing cases as ethical dilemmas. In particular, it was suggested that three factors influenced the Greek social workers who participated to feel ethically certain, and therefore unable to recognize value conflicts. These factors included: (a) the significant role of personal values in ethical practice; (b) the adherence of hospital social workers to individualistic values; and (c) the exclusion of collective values from ethical discourse. In this way, no ethical dilemma involving a conflict between collective and individualistic values was identified while hospital social workers felt ethically certain that their personal values were sufficient enough for making an ethical decision. Moreover, as hospital social workers ignored collective values their multiple ethical obligations were not acknowledged and they identified their clients as only those who had a direct relationship with them. Therefore, the ethical obligation to promote the best interest of individuals formulated a far more straightforward ethical decision-making process. In fact, it was argued that there were three main factors that created ethical dilemmas in social work practice: (a) the multiple obligations of the social workers; (b) the dual professional purpose to ensure personal and societal well-being, and (c) a commitment to mutually opposed ethics (Clark, 2000; Banks, 1995). Since the participants identified themselves as being ethically engaged to promote the best interest of their clients, their ethical dilemmas were formed only by the third factor. In particular, the majority of the participants described ethical dilemmas that involved a value conflict, however, only within the individual's own range of interests (e.g. autonomy versus safety, and truth telling). Therefore, their ethical dilemmas involved only individualistic values which were also the values that appeared to be their personal ones.

The empirical literature on social work ethics indicates a relative weakness in social workers to ethically analyse their cases and the absence of using ethical codes (Furman *et al.*, 2007; Banks

& Williams, 2005; Manetta & Wells, 2001; Csikai, 2000). Similarly, there seems to be agreement that social work interventions in the US and UK are strictly controlled by managerial policies which imposes predetermined criteria reflecting strict adherence to the managerial ethos (McBeth & Webb, 2002; Gibbs, 2001; Clark, 2000; Banks, 1998). In contrast, Greek social workers appeared to decide and act according to their personal values. In fact, moral values appeared to be determinant of “good” social work practice. Interestingly, social workers in Greece appeared to appraise social work as a value laden profession, although they tended to think personal values were an appropriate guide for their practice. However, the majority argued that they had little power to enhance the well being of their clients, and even less power to affect change in what they themselves described as unethical structures. Again, these findings highlight the importance of the level of social protection in countries where social work is practiced, but also raises questions whether individualistic values can adequately meet such challenges.

7.1.4 Ethics and the evaluation of “good” social work practice

Evaluation is often acknowledged as a corner stone of social protection (Yfantopoulos, 2004). However, an important structural characteristic of both Greek public hospitals and the Greek social work department was the absence of evaluative procedures, also evidenced in other studies (Rovithis, 2006; Mossialos *et al.* 2005; Sotiropoulos, 2003; Yfantopoulos, 2004; Ballas & Tsoukas, 2004). In fact, the majority of hospital social workers and academics who participated in the study declared that the unethical practice of professionals and preferential treatment were, at least, partially fermented by the absence of evaluative procedures in their workplaces. Hospital practitioners, however, argued that the complete absence of any interest in the effectiveness or the outcomes of social work interventions reflected the indifference of the state to address marginalized and vulnerable people. Therefore, managerial control of social work interventions was not evident in Greek public hospitals like in other European countries and the US (Banks, 2007; Meagher & Parton, 2004; Dominelli, 2002; Gibbs, 2001). The absence of evaluation in social services departments partially reflected one aspect of the deficient social protection in Greece. In this way, however, hospital social workers appeared to exercise a form of professional autonomy as they were able to practice according to their own evaluative criteria. Possibly the significant role of personal values in social work practice in Greek hospitals was reinforced by the absence of organisational evaluative processes that can possibly influence the professional standards of “good” practice.

Personal values, and particularly the feeling of having a clear conscience and having specific character traits, were described by the participants as indicators of good social work practice. The lack of community and welfare support for social work clients in Greece created the effective practitioner as one who had a powerful and imaginative personality in order to fight for any informal resources. A clear conscience was ensured when a hospital social worker could practice according to their personal values and this often resulted in the pleasant feelings of being a “*helper*”. When these indicators were met, then the hospital social workers felt they were being good practitioners. Except for psychotherapy that was perceived as an experience that enhances the competencies of social workers, no other technical knowledge or skill was appraised as an indicator of good practice. As previously indicated, hospital social workers appeared to perceive social work as a value laden profession, but also appeared to disregard the importance of knowledge and skills. However, as Clark (2000) argued technical skills and knowledge are intimately related with ethical practice, and a practice lacking in skills should also be regarded as unethical practice.

7.2 Implications for social work policy and practice in Greece

The values of the social work profession are the vehicle by which social workers define their professional role which is defined as a dual duty to help individuals meet their needs and to bring social change and social justice (Bowles *et al.* 2006; IFSW, 2005; Clark, 2000; NASW, 1999; Banks, 1998). Therefore, social workers ought to work in a scientific manner based on the practice of their values. However, individuals continue to be diagnosed with a specific pathology although they suffer from a collective problem emerging from oppressive structures. As these structures continue to be ignored, individuals are guided to adjust in what the participants named as “*unethical system*”. In this way, social change remains a professional endeavour that stands in the definition of social work but without a real meaning in practice.

Social workers are perceived as moral agents since they are authorized to make and apply moral judgments on behalf of society (Clark, 2000; Payne, 1999). This means that social workers should not be perceived or allowed to perceive themselves as individual possessors of this role unless they are cognitively and explicitly committed to a concrete body of values. In this sense, the role of the moral agents should be framed within a specific and publicly known statement of professional values which is the code of social work ethics (Clark, 2000; Payne, 1999; Banks, 1998). The effect of personal values in social work practice in Greek hospitals appeared to be

immense. The Greek social workers who participated appeared to feel confident that their personal values are good indicators of ethical practice. In this way, asking help from a social worker meant asking help from a person whose ethical practice is mainly informed by his/her personal values. Undoubtedly, the absence of a concrete body of ethical standards puts social work's clients at risk. Furthermore, the identity of social work remains in the lap of individuals' interpretations and therefore social work is far from a collective identity and endeavour towards mutually acceptable purposes.

However, the identity of the social work profession is enormously impacted by the context where it is practice. In fact, as Bowles *et al.* (2006) argue, social work is a deeply contextual profession. This is because the contexts where the social work profession is practised are not given. Different contexts form different ways of practice, and different purposes and, finally, contexts have an impact on the visionary aims of social work as organisations have their own aims and values. Therefore, although social work's ethical documents define specifically the purposes and the values of the profession, it is seen that practice contexts have an enormous impact on the nature of the social work profession. As this study was qualitatively approached and contextually oriented, it highlighted the impact of the organisations that employ social workers as well as the political and economical environment where social work operates. The social work education in Greece as well as the HASW were also acknowledged as the greater context of social work practice in Greece and formational institutions of the social work identity. Therefore, the method of this study helped us to understand the role of the social work profession contextually. In particular, it was evidenced that social work education in Greece and HASW pay little attention to social work ethics. This understanding enables developmental interventions both in the curriculums of the social work schools and to the ways that HASW defines its role in relation to the ethical engagement of the profession.

It is anticipated that publishing and presenting the findings of this study will lead to an increased awareness and appreciation of empirical research as a developmental factor of the social work profession. In fact, this is particularly important in Greece given the absence of MA programs, the complete absence of empirical studies in social work ethics published in the social work journal of the HASW, and the absence of Greece from international and European social work literature (Pediaditaki, 2003).

Social workers in Greece have limited opportunity to acquire experience and knowledge in reference to social work ethics and their impact in practice. The analysis and the interpretations of the data were supported by reflecting on theories about social work values and ethics developed in the UK and US. Therefore, the dissemination of this study to Greek social workers is an initial effort to enable social workers to develop their ability to be ethically aware and learn to reflect on the ethical dilemmas of their practice. Moreover, this study could encourage Greek social workers to advance and engage themselves in an ethical discourse of their practice within their practice placements and consider issues of their practice not previously explored.

Studies which explore the role of ethics in social work practice enhance the potential of the social workers to develop their capacity for making moral judgements and defend these within their role and responsibilities. More importantly, studies also capture the contextual factors impacting on the moral agency of social workers, and thus substantiate the role for social work in a world with structured oppression. As Sen (1999) argues, the individual's freedom to practice according to their ethical obligations is defined not only by their own capacities, but crucially by the contextual realities. In this sense, even if Greek social workers were appropriately educated and ethically aware to work for social justice they would still be unable to bring about structural changes, as their individual capacities would be constrained by social arrangements.

Furthermore, findings of this study demonstrated cases where Greek social workers appeared to manipulate social work theories in order to justify unethical practice, for example, dishonesty or characterisation of patients by using psychodynamic terminology (e.g. "defensive", "inflexible"). In addition, it was demonstrated that the version of the ethic of care which appeared to underlie hospital social work practice has "*dark sides*" which lead hospital social workers to control their clients and/or to further ignore the macro-level concerns of social work. These findings highlight the importance of critical social work practice, as well as the importance of reflecting on social work's values and ethics. The uncritical adherence and thoughtless usage of theories without consideration of social work ethics or alternative theories denote possible malpractice that harms social works' clients (Clark, 2000; Banks, 1995).

This study showed that applied ethics is both a vague and often complex endeavour. Therefore, empirical studies which highlight the factors that intervene in practice support social workers to use conscientiously their role and have a clear perception of their effectiveness. Undoubtedly, what social workers do or not do in their daily practice is the outcome of a series of decisions that

consciously or unconsciously social workers make. In reference to ethics, the ways that social workers think of the ethical dimension of their practice form the nature of social work dilemmas and problems that they daily face, and then, ethics take on specific meaning to practice as social workers are obligated to act upon them. This knowledge contributes to the advancement of professional expertise as it enables social workers to control their practice in the service of their professional purposes.

7.3 Study limitations

This study has certain limitations that need to be taken into account when considering its overall contributions. First, generalizing the findings to other populations is not possible. The purpose of this study was to provide in-depth and rich data into the real practice of social workers and the meaning of their ethical dilemmas, rather than, for example, measure the frequency of ethical dilemmas. In addition, the sample of this study was relatively small and focused on hospital social work practice rather than other types of practice. Furthermore, the fact that the sample was not considered large enough did not enable the exploration of variations in terms of gender, age, length of practice experience, and so forth.

A second limitation was that the ethical dilemmas and problems that were presented in this thesis were not observed, but described by the participants. This means that the data was dependent only on what participants could recall from their memories. The accuracy of the data also relied to they way the participants perceived their stories. Therefore, the researcher did not have direct access to work activity itself, except as filtered through social workers' reports.

A difficulty in completing this study was negotiating access to settings where social workers worked. Recalling that social work ethics were examined within a specific cultural and organizational context, I found it very important to reflect upon the cases where social workers declined to participate in the study, and when negotiations to find settings for data collection failed. It is expected that these reflections permit a clearer understanding of issues that the interviewed social workers raised, as well as an understanding of the meaning of research ethics in Greek hospital settings.

My request for a permission letter to enter the hospitals was a surprise for both administrations and hospital social workers. As they were unfamiliar with the formalities that would permit me to

officially enter hospitals as a researcher, they were reluctant to get involved in what was perceived as a time consuming bureaucratic process. In addition, some managers in SSD dealt with my invitation to participate as a personal matter without consideration of the social workers in their departments who had expressed a willingness to participate. In one case, my commitment to protect the participants' right for privacy and confidentiality also resulted in limitations because there were no private rooms in one SSD to conduct the interviews. Interestingly, my commitment to privacy and confidentiality was perceived by one manager as disrespectful of their situation. She commented that since I wanted to conduct a study exploring their practice realities I should abide with the circumstances that frame their practice. Since they did not have a private room for their job, I should also do my study without a private room. My denial to conduct interviews without ensuring privacy to the participants was perceived as an assumption that they do not do their job good. Protecting the reputation of the country and/or hospital was deemed a duty by two social workers which led to their refusal to participate in this study.

7.4 Recommendation for future research

Overall, findings of this study raised questions whether empirical studies in general have a real meaning for the development of the social work profession in Greece and its scientific knowledge base. Although hospital social workers seemed to be willing to participate in the study, they seemed to be motivated by the fact that the study design was based on interviews. In particular, hospital social workers seemed satisfied with the fact that in this study they could tell the truth about their reality in their own words as in journalistic research. Similarly, the representative of HASW seemed to perceive this study as a means by which she could be heard by the body of the social workers and speak of her own views about social work practice, as well as her own thinking about ethical problems and dilemmas. In addition, research ethics were not a concern either for the participants or the hospital administrations.

Hospital social workers and hospital administrations seemed to be loosely committed to the advancement of empirical research. However, as this study focused on the exploration of social work ethics, little data was elicited for understanding the meaning of empirical research in the development of the social work profession, as well as whether social work is actually perceived as a science that can be enhanced through research. Researchers are ethically committed to how and if their research findings will be used and for what purpose. Therefore, future research in Greece should concentrate firstly on understanding and secondly on enhancing the meaning of

research in the professional development. In particular, future studies should be also concerned with the exploration of the ways that social workers understand the contributions of social work research. Conducting studies without this understanding and without developing a discourse on the very meaning of research contradicts the basis of research ethics which is that every study should have a reason to be conducted which must be devoted to enhance human happiness.

Given the above mentioned reasons, an action research approach could strengthen the relationship between social work practice and research. By bringing together the research knowledge and techniques with the efforts of social work practitioners to provide effective and value based services, studies can have an immediate contribution to the scientific development of social work practice. As Lees and Lees (1975) argue, researchers must meet the challenge to communicate their findings with practitioners and crucially to build their research questions according to what practitioners want answers for. Therefore, research questions and findings should be built on co-operation between researchers and practitioners in the real context of every day practice.

A difficulty for this study was to examine in depth the ethical decision-making process from descriptions of cases where hospital social workers had dealt with already and they were just telling the story about their decisions. Hospital social workers had the tendency to conclude their story and present their decision without focusing on the decision-making process. In addition, for some hospital social workers it was difficult to remember the exact thinking or factors that led them to the decision. In fact, decisions and their outcomes were more easily drawn from memory than the process. Therefore, the use of vignettes may be more appropriate in the examination of the process of decision-making. A researcher by presenting a case to an interviewee can enable the disclosure and exhibition of the thinking, emotion, values and ideologies and their relationships which structure the process of decision-making. Moreover, the vignettes can be developed in consultation with practitioners so they reflect real daily practice. This study provided an outline of cases that hospital social workers face in their daily practice which can be used for the formation of effective vignettes contextually relevant to social work practice in public hospitals.

Participant observation should also be considered for studying social work ethics as it provides an immediate entrance to rich data. The researcher gains an insider status and has the potential to understand ethical dilemmas of social work practice through firsthand experiences. Therefore, the researcher has more opportunities to capture the lived-reality of the workplace.

The exploration of factors affecting the choice of social workers to “*blow the whistle*” on the unethical practice of professionals is also a potential for further research. This study provided some initial findings that social workers may have a negative attitude towards whistle blowing. In addition, one hospital social worker declared that although she had officially reported one social worker for unethical practice, her action had no effect. Probably, this issue also involves the absence of social work evaluation in Greek public hospitals. However, a more focused and deep exploration of these issues is needed.

Another issue that needs a further exploration is the violation of laws by the hospital social workers. In fact, some practitioners argued that violating laws was an ethical action as the deficiencies of the welfare system obscured patients’ rights. However, it is interesting that the representative of the HASW argued that violating laws was the choice of social workers who did not know how to use the laws in order to protect patients’ rights.

Political ideology and education as factors effecting the perception on ethics in social work practice could also be the focus of future studies. In particular, the exploration of psychotherapy as a system of values that guide professional practice could be explored in more detail and provide more information to those who are interested in exploring what forms ethical practice and ethical decisions of the practitioners.

This study was focused on the specific context of public hospitals in Greece. However, social work, as it is also practiced in a variety of placements, is formed in a different way and structured according to specific local contexts. It is anticipated that organisational differences will alter the way that social work ethics are perceived or applied by the social workers. Therefore, further research should be focused in the examination of social work ethics in placements other than public hospitals.

Conclusions

The insufficient social protection in Greece appeared to be the major source of social work ethical problems. Crucially, these ethical problems denoted human suffering caused by policy structures that, tragically, were perceived by the Greek social workers who participated as “*taken for granted*” and unchallengeable. In fact, the individualistic character of social work appeared rather

insufficient to enable practitioners to deal with what they perceived as unethical practices or policies, including the inefficiencies within the bureaucratic functions of public services and the deficiencies in the Greek welfare state.

The exploration of social work ethical dilemmas enhances our understanding in relation to the underlying values that guide social work practice. However, it appeared that the contextual orientation of this study enabled to further this understanding from the nature of social work practice to the nature of social policy in Greece. The cases that hospital social workers described as ethical dilemmas and problems provided a detailed illumination of how policy issues have an enormous effect on human suffering. Therefore, through these descriptions policy was bridged with the everyday experiences of citizens or individuals who are not provided with a citizen's status in public hospitals. This understanding is extremely important for social workers whose practice is detached from politics (Dudziak, 2002; Gibelman, 1999) and their ethical practice is often decontextualized as their ability to act on given structures is not recognized (Banks, 2008). Beyond the ability of social workers to deal their ethical dilemmas it is important to understand the implicit decisions of social policy to act or not towards the elimination of social problems which frame human suffering. Besides, the exploration of social work ethical dilemmas is meaningful only because their core element is human suffering which must be eliminated.

The findings of this study framed the necessity of a liberating approach in social work practice for the benefit of both social workers and their clients. The social workers appeared to be able to articulate their identity only as being "*survivors*" of an unethical system. Although they appeared to speak up about the structural realities of their practice, they seemed to try to make clients adjust to any unethical structures. In fact, they seemed unable to even acknowledge the structural purposes of social work. In this sense, the critical approach to social work practice emerges as an adequate framework which allows practitioners to acknowledge themselves as agents of social change and social justice. This acknowledgment would be liberating for social workers because the critical approach offers the prospect of transformation by not being bound by the status quo (Payne et al., 2002). In this way, social workers would be empowered not only for survival, but to use their power and expertise to address unethical structures.

Critical social work practice would also be liberating for social work clients who would be acknowledged not as "*those who need therapy*", but as citizens. Moreover, through critical analysis and reflection their oppression would be reframed by appreciating the political and social

context in which they live. In this way, social workers would also be able to gain insight into how their own values and beliefs may contribute to dominant power relations and the oppression of vulnerable people (Morley 2007). Therefore, the critical approach could advance the potential for a genuine partnership between social workers and people. Then, critical knowledge would be shared and the power relationship between experts and clients would be transformed into a powerful union of citizens against injustice.

APPENDIX 1: Letter to hospitals

Brunel
UNIVERSITY
WEST LONDON

Dimitra Giannou

Mphil research student
School of Health Sciences and Social Care
Mary Seacole Building
Phd room 111
Brunel University
Uxbridge
Middlesex
UB8 3PH
Tel. 0044 7726464818
e-mail: dimitra.giannou@brunel.ac.uk

To: Management Board of General Academic Hospital of (name of the hospital)

Cc: (name)
General Manager of Social Services

Subject: Participation of the social workers who work at the social services department of your hospital in a research with the subject:
'the meaning of ethics and the encounter of ethical dilemmas in social work practice: A qualitative study of Greek hospital social workers who are practicing in Greek public hospitals'.

Dear Sirs/Madams,

My name is Dimitra Giannou and I am a qualified social worker and a Masters of Philosophy student at Brunel University in London. Within the scope of my MPhil, I am conducting a study to explore the ethical issues and dilemmas in social work practice in Greek public hospitals. For this purpose, I would like to interview social workers to explore the ethical issues and/or dilemmas that hospital social workers experience in their daily practice. If possible, I would like an opportunity to contact your social services department to recruit volunteer participants. The supervisor of this research is Dr. Mary Pat Sullivan, School of Health and Social Care in Brunel University.

I will personally interview the social workers and I will be responsible to ensure all the necessary conditions for the protection of confidentiality and anonymity of the interviewees.

The participation of the social workers will be entirely voluntary, and they will have the right to withdraw their participation at any stage. The study will only commence once it has received ethical approval from the School of Health Sciences and Social Care's Ethics Committee of Brunel University.

With this letter I am requesting permission to contact social workers of your social services department to participate to my research. If you require any additional information, I would be pleased to send it to you. I will follow-up by telephone within the next two weeks.

Thank you in advance for your consideration.

Yours sincerely,
Dimitra Giannou

APPENDIX 2: Participant information sheet

Brunel
UNIVERSITY
WEST LONDON

Dimitra Giannou

Mphil research student
School of Health Sciences and Social Care
Mary Seacole Building Phd room 111
Brunel University
Uxbridge
Middlesex
UB8 3PH
Tel. 0044 7726464818
e-mail: dimitra.giannou@brunel.ac.uk
Correspondence tel. in Greece: 6936682858

Research Participant Information Sheet

'The meaning of ethics and the encounter of ethical dilemmas in social work practice: A qualitative study of Greek hospital social workers'

Dear Sir/Madams,

With this letter you are invited to participate to in a study investigating the ethical issues and dilemmas experienced by social workers who work in public hospitals in Greece. This study is being conducted to fulfil the requirements of an Masters of Philosophy, Social Work. The study has received ethical approval from the School of Health Sciences and Social Care's Ethical Committee.

It is anticipated that this research will contribute to a growing body of literature on ethical decision-making in social work and the continuous efforts of social work practitioners, academics and researchers to understand the implications of ethical social work practice. It is also expected that this knowledge will assist those who are dedicated to enriching and advancing the quality of social work profession in Greece.

Your participation is entirely voluntary. If you decide to participate you will be asked to provide 1 to 1.5 hour of your time to participate in an audio-taped semi-structured interview. Written consent will also be obtained. The interview time and location will be scheduled at your convenience. All participants and information shared will remain confidential. You are also free to withdraw your participation at any time.

The outcomes of this research will be available after the presentation and reporting of the research, which will probably be soon after October 2007. Any publication of these research outcomes will be with the protection of your personal or organisation's details.

If you have any question about your participation terms, about this informative letter or about the subject of the research, please do not hesitate to contact with me or to my supervisor.

Yours sincerely,

Dimitra Giannou

Tel. 6936682858
e-mail: Dimitra.giannou@brunel.ac.uk

Dr. Mary Pat Sullivan, Supervisor

School of Health Sciences and Social Care
Mary Seacole Building
Brunel University
Uxbridge
Middlesex
UB8 3PH
τηλ. (0044) 1895 268846
e-mail: mary.sullivan@brunel.ac.uk

Appendix 3: Consent Form

Please tick the appropriate box

	YES	NO
Have you read the Research Participant Information Sheet?		
Have you had an opportunity to ask questions and discuss this study?		
Have you received satisfactory answers to all your questions?		
Who have you spoken to?		
Do you consent to be tape-recorded by the researcher?		
Do you understand that you will not be referred to by name in any report concerning the study?		
Do you understand that you are free to withdraw from the study:		
- at any time		
- without having to give a reason for withdrawing?		
- Do you agree to take part in this study?		
Signature of Research Participant:		
Date:		
Name in Capitals:		

Appendix 4: Interview schedule for hospital social workers

Interview schedule

1. What would you call an ethical dilemma?
2. Describe me a case that you would call ethical dilemma of your daily practice
3. How did you justify your decision towards this dilemma?
4. What are the obstacles and the support that you had for this decision?
5. What are the evaluative procedures in your department?
6. Who evaluates you and with what criteria?
7. How do you evaluate your self?
8. What are the characteristics of a good social worker?

Appendix 5: interview schedule for the representative of Hellenic Association of Social Workers (HASW)

Interview schedule

1. Please describe me your work and activity in HASW

Prompt: How do you think your experience in HASW affected your practice as a social worker?

2. What HASW do about social work deontology?
3. What are the characteristics of a good social worker?

Appendix 6: interview schedule for social work academics

Interview schedule

1. What kind of ethical dilemmas do you encounter in your practice as social work supervisors?

Prompt: what did you do for this dilemma?

2. What kind of ethical dilemmas do your students bring to supervision?

School of Health Sciences and
Social Care

Research Ethics Committee

School of Health Sciences and
Social Care
Brunel University,
Uxbridge
Middlesex UB8 3PH
Telephone: +44 (0)1895 274000
Web www.brunel.ac.uk

1 May 2007

Proposer: Dimitra Giannou

Title: The meaning of ethics and ethical dilemmas in social work practice: A qualitative study of Greek social workers

Reference: 07/03/PHD/04

The School Research Ethics Committee has considered the amendments recently submitted by you in response to the Committee's earlier review of the above application

The Chair, acting under delegated authority, is satisfied that the amendments accord with the decision of the Committee and has agreed that there is no objection on ethical grounds to the proposed study. Approval is given on the understanding that the conditions of approval set out below are followed:

- *The agreed protocol must be followed. Any changes to the protocol will require prior approval from the Committee.*

NB:

- **Research participant information sheets and (where relevant) flyers, posters and consent forms, should include a clear statement that research ethics approval has been obtained from the School of Health Sciences and Social Care Research Ethics Committee.**
- **Approval to proceed with the study is granted subject to receipt by the Committee of satisfactory responses to any conditions that may appear above, in addition to any subsequent changes to the protocol.**

David Anderson-Ford
Chair, Research Ethics Committee
School of Health Sciences and Social Care

Appendix 8: Interview transcript

I: Interviewer

K: Maria (hospital social worker)

I. like I told you, what I am interested for is to obtain deep descriptions of your reality...the ways that, as a social worker, you experience your daily practice in a public hospital... I will then focus on the deontological issues of this reality.... but, I would like us to start with something else... yesterday, you told me something very interesting and 'spicy'...you said that social work is an alchemy.

K. yes, this is my 'moto' ...

I. moto?

K. yes, it is my moto, namely... moto is what we usually say, and we say it in our daily life, it is an Italian word. It is an expression that we repeat and the fact that social work is an alchemy is my moto... but now I am thinking that you chose hospitals to do your research, and I would like to start with this. A hospital is a primordial service, namely the social services department in a hospital is not a necessary service. Namely in the hospital we are a tertiary service meaning that we are not necessary to the system. In a hospital the doctors and the nurses are necessary.. All the rest of us help their mission. Namely, social workers are an elemental service in a psychiatric hospital coming before the doctors and the rest of the system. In other types of hospital we are not as important. In a hospital we are not so much important. In our hospital, like I told you, we are 8, my opinion is that we are too many in this organization... this is reactionary.. and a minimum number of social workers in the hospital that could cover its needs, and because of the way that we work, is 3 social workers ...and we would be ok, but for labor reasons and because we, the older, must take care the younger all along, and always and in the future, we will demand places for the rest of our colleagues because this is the deontological and the ethical, namely we can not apply the brakes and say that we are many for this organization, because in this way the next generation will not find a job. One is this, and the second is that although we do not have the tools, namely we are not like the surgeons who have the lancet, they cut, they sew, they do, they fix or like the nurses who have the cotton, the surgical spirit.. we do not have the tools because the welfare state in Greece isn't so much developed with services and supportive systems for all the categories of patients, I will say patients, I am not speaking generally because we are in the health sector... despite all these....although we don't have the tools, we try these problems not to become big issues, and we try to find solutions from where there is nothing, that is why I am focused on this and I am saying that eventually social work is an alchemy, that without having the tools, we try, we do, we fix, we find and we search in order to help a person, without, I am telling you this again, having the tools...Because if we see the welfare state and the social policy in Greece we will see that there are no services... and if we want to be consistent with what we do, with ourselves and with the morality and the deontology....the social services department of a hospital what should do? It should be the conjunctive ring to link, to make reference to other organizations, namely, I have a person in a clinic, when this person will leave the hospital, he must go somewhere to rehabilitate his health since the hospital is not an asylum, or to rehabilitate his social problem, his psychological problem, I cannot do all these here, I cannot do all these here... The role of the social services department of a hospital is to make the connection between the person and the services that function in the community...in the Borough or similar services

that belong to the Administration of Health, I will do the connection, so I must, and this is like I say....I would be a very happy mother if my children became social workers because the social workers learn to think: while I have nothing how can I find something?', do you understand what I am saying?

I. mmm..

K. and I believe that the social workers who really work are very smart... I mean those who really work, who are not those who stay and lean up to the things that they already have, the formal, the unavoidable.. He is a very capable social worker the one who opens the case, who tries at the place that there is nothing, he tries to find a light of hope, to find at least a light in the tunnel.. you can learn many things from those guys... and I say that the social services of a hospital, and I am coming back to what I said in the beginning, has a connective role, clearly consultative role, this is its role, however, because there is no social policy and we cannot do this job successfully, we get into a thousand other things in order to be okay with ourselves and to say that we did the best we could to help a person. Namely, if a family come to me and has a problem with a patient in the hospital I may discover from its social history that an additional problem in this family is that a person is unemployed. I will do the best I can to find information through the Borough, through other programs. If I can, I will help also the other member of this family because they say that we have health when all the rest of the sectors of our lives are well, namely, if our health the psychological and the social sectors are in a smooth condition. If one of these sectors is ill, it is like a grandfather clock which will sweep along all the other sectors, namely if we are not okay because of a social problem our health will be affected and our psychology will be affected. That's why I say that when a case like this come to me I cannot stay deaf and say that I am not hearing this problem. I will try to do something for this too. And also the staff... perhaps because they know that we, the social workers, sometimes we have too much job, namely a case may be nothing to them because it is a case that they hear it like a gossip, but for me who I see it as a professional it is soul-destroying, and the physical tiredness is one thing but there is also the psychological tiredness.... to carry all this burden of a person that laid to you rather than to be tired to do something like the things that the other employees do... so, many employees know that the social workers may have a case that can work on for a month and they may have no case for two months... so, they know that we have free time and they take our advice, namely, speaking for myself, many people from the staff consult me for various issues, employment, for their children, for themselves..

I. this is within the scope of your duty as a social worker?

K. I do not reject anything. I say that if I can be useful and help a person in any problem he has, because I may have an information, as we say that the social worker has an information and give it in the right moment... and if I can do it, I will do it...and I am not going to say that this a job and this not a job.

I. is this an expectation of the organization? Namely, does your manager evaluate you for this?

K. ee.... We are not evaluated for this... the only thing that... each of us...may feel better...by helping a person.. namely, I have this as a guidance...e...if I can do something for a person, if a problem comes up and I can see that there is a solution I will do it anyway, namely I have so much guilt that I will try to see if I can help him, and if I cannot do it, I will tell him that I exhausted all my powers.

I. guilt for what?

K. I myself have so much guilt and if you ask something from me I will exhaust all my latitudes to tell you that I cannot do anything, namely.. I will not let him pass and see him just like that and say... ok it is not within the scope of my duties so I don't have to do something, namely, what I told you about the unemployed person of this family, I could say that this doesn't concern my patient, if we see it narrowly with the notion of social working I will say this doesn't concern my patient so I don't have to do something... although social work is also social work with families, social work is not occupied only with the individual... but only a few times here in the organization we practice social work with families... usually we practice casework.

I. mmm... this is something that... namely, do you feel that you have the freedom to choose?

K. Here... not only in our hospital, but in the rest hospitals too, if you want to work you will work, there is no one who will ask you how much you work, neither will they criticize how you did this, as long as you can reach the outcome that you like.

I. yes... so, what do you believe is the anticipation of the organization by you?

K. I will not say the anticipation of the organization....but of the administration of the hospital.... It is to be capable, and in the particular administration by whom.... I wrote you in the note that you gave me that I am working the last two years in the social services so I haven't experienced the previous administrations. I just have heard, I don't have my own experience. So, speaking for this administration which I find very socially sensitive... The administration, I believe, anticipates from the social workers that if you confront a problem and you cannot manage to deal with it, then, the administration is open to intervene with political means to solve it, so as the problem to be solved and not to cover up it, and this is its expectation. But as I told you before Dimitra... this is not easy.. it is not easy because the state has no social organizations, doesn't have social organizations... namely, let's say... a usual problem that.. comes up in the social services, and unfortunately there is no solution for this. So, those who lead, the Ministry or the administration which is the continuity of the Ministry... must intervene with political means... a problem that is usual in Greece is that we can't refer a case after its recovery to a rehabilitation institution, we must keep him stay here because he is a loner or something... the institutions have rules, all these rules, without any exception, exclude some categories of patients... those are the addicts in drugs, the addicts in alcohol, and the mentally ill, three big categories of patients who are excluded from the rules of institutions.

I. yes

K. and this is a big problem, there are no social organizations for these people, to put them if they are loners.

I. give me an example.

K. yes, for instance, now... the case is not mine... so, I cannot say the length of this problem, but I will describe it to you... it is my colleague's case.. we had in the orthopedic clinic a man, he was 60 years old.. he left with his own initiative from a hostel, he is a loner, he has no family, may be he has but he has no relationship with his family, he hides from us that he has a daughter, we detected and we saw that he has a daughter who hasn't ever come, she doesn't want to know

that he exists, he also has a sister that she doesn't want to know him and in reality he is a loner in his life.

I. did you see his relatives?

K. it wasn't my case, so I cannot have all the details

I. yes, yes..

K. so, this person was lodged in a hostel for homeless people in Athens. He left from there, and he came back and he lived as a homeless in Patra. He was lodged by a socially sensitive woman in her house whose son met him as a beggar... she kept him in her house, she was living here in Patra, she lodged him for a while, but he left, because he was an alcohol addict, and a mental health patient with paranoid ideas... one day he had an accident and he came to the hospital... the doctor believed that this man with a conservative treatment, and when we say conservative treatment we say no surgery, we put the patient in a bed and we wait the bone to heal on its own.... They believed that this solution was the best, but, every time doctors forget things, what is the social profile of this patient, often this is our mistake because we haven't given the doctor the appropriate information, we need what we call team work, so we can collaborate with the team to decide what would be the best provision of services for this patient with a precise profile.. So, he is a bugger, to follow a conservative treatment means that he must go back to his home and someone must take care of him, this person had no one to take care of him, so we should follow a more aggressive treatment, we should operate him. They didn't do that, so this man was in the orthopedic clinic, and at some point the manager of the clinic decided that after the treatment the man should go home...but he has no where to go! There is no one to accept him, he is an alcohol addict, mentally ill and he is a loner, there is no organization... and finally the administration intervened... the administration influenced the manager of the psychiatric clinic to accept him in his clinic. However, once it is decided to leave from this hospital, this person, the problem exists, it is a real problem because there is no organization to accept this person.

I. what the social services department did in all this?

K. so, the social services... he was uninsured, right? We put him in the welfare insurance, which is a long bureaucratic process, too much bureaucracy for a welfare insurance, we communicated again with his sister lest she changed her mind, of course, we didn't communicate with his daughter because since he hide her from us, you cannot present to this man a person when he doesn't say to you that he has a daughter, to say what? That I found her because I am the detective Sainis and I found that you have a daughter.. you cannot say that since he doesn't say something on his own... we communicated again with the lady that she had lodged him before lest she can reaccept him again, of course, the woman denied, we communicated with a series of social organizations that exist, with an asylum here in Patras, with other institutions of the church because the state has no social organizations.. The Eparch in Ilia is a very sensitive man and he has created various institutions, however, he also excludes some categories from his institutions. However my colleague sent his papers there, and the patient told her: 'have it as a crime in your throat if you send me in Ilia', so, at this point the dilemma of my colleague enters and she says: 'should I send the papers or not?' ... she herself, because she sees it a little bit emotionally she says that I don't want a person to go in a place that he doesn't want to go.. yes, this is right, that we must hear what is the patient's will, but in order not to be accused that we neglected of our duty we must have his signature in what he is saying to us, that I denied to go in this place... because if you go to the court and say what the patient told you... the patient can take back what

he said... if there is nothing written, a letter saying that I didn't want to go there, you lady wanted to send me there but I didn't want... anyway... the administration came and by replacing and by trying to cover holes of the system, it decided to keep him in the hospital illegally until he would be rehabilitated, until he would walk again.. my colleague managed to find a lady that rents some rooms for 100 euros, so as, this man can go there... this is all the story of this case, of this patient who had no where to go...

I. yes... at some point you called it dilemma, right?

K. yes, yes and this is what it is...because when the man shifts the responsibility on you and say that you will have it as a crime in your throat.. namely for the Greek facts, I don't know what is happening abroad, namely how an English, a French social worker would experience that... in Greece where we are a little bit more emotional, and the family still works, less but still works.. that we are.. that this person, this man will see him again in the town, because Patra is not so big... this put a mound in her job... yes... and you must know Dimitra that always, despite the fact that we are educated in the social work school regarding the empathy, not to be emotionally involved with the cases that we see, not to identify ourselves with the person and all these... many times we are emotionally involved either because we have common experiences with these people.. we put ourselves in their position, and not only by understanding but we get involved emotionally, namely I will see a mom with a different eye.... when she has a problem with a little child, because I am a mom too and I have two little children so I will understand her.

I. has this ever happened to you?

K. with a child? only once something happened with a child... but no, I didn't met its parents, but I consulted a doctor what he should do in a abuse case where he believed that a child was abused.

I. yes.

K. I didn't saw the child because the doctor called me in my home. I wasn't on duty at that day so as to see with my own eyes the child. The doctor himself believed that the child was abused and he was asking me what we could do... I told him that the formal way is to call the police in hospital and after that the district attorney should call a medical examiner to see if actually the child was abused, in the meanwhile the child should be in a pediatric hospital where a child-psychologist would see the child in order to understand if the child is actually abused, the social worker there would see the family, because in this hospital we see children over 16 years old... the children who are under 16 go to another hospital, the "K", but the "K" had no oculist, so they referred the child to our hospital. We don't hospitalize children in this hospital, simply the doctor called me to ask what I would do in this case. I told him to call the "Children's Smile" which is a volunteer- no-profit organization which functions in Greece and it has social workers, psychologists, layers who could advise him what he could do... the doctor called the "Children's Smile" organization and they told him the same things, that formally he should call the medical examiner and in case that the child should removed from his family they could take care the child to have a place in a hostel, anyway they have this service... they have hostels which can lodge abused children, children that have no family.

I. what happened with this child?

K. the doctor believed that it was... you know many times in Greece when the system of justice gets involved we see all this thing with a fear.. when the doctor sent this child to the "K" hospital, he advised the doctor who would attend the child to do all these processes, the other doctor evaluated that the child wasn't abused, he believed that the whole story was a neglect ion, he didn't evaluate that it was a case abuse so he didn't do something for this, and when the psychologist saw the case and heard that our doctor had communicated with the social worker of the hospital he was surprised and said: "really? this issue went too far!"... this is what I know about this case... I don't know if something else happened eventually..

I. it's impressive that... all right... rightly or wrongly this case came to this hospital ..the doctor chose to call you in your home and...

K. yes, because it was night when it happened...

I. ah,so, it didn't become a piece of your responsibility...

K. no, no, no.. because the "K" hospital that the child would go has a social worker, a child-psychologist and a child-psychitrist, namely it is an organized hospital that is related to this specific group of patients... this age group, the children and the adolescents, we don't have children and adolescents in our hospital. I have other clinics... I have the surgery clinic, the neuron- surgery clinic and the Intensive Care Unit... and I do night-shifts every Friday like all the rest of my colleagues for the clinics that are open nights and those are the emergencies and the regular outpatients surgeries... all the rest of the clinics have a social worker... it isn't one social worker for one clinic... one social worker has more than one clinics.

I. what kind of cases can one meet there? What cases do you have?

K. what cases do I have... they are cases that are related to the Intensive Care Unit... I work with the family because the patients are in a respiration tube, we are talking about badly wounded people or with severe illnesses and they are in a respiration tube, that's why they are in the intensive care unit... I see the family and I speak to the patients once they leave the intensive care unit and go to one of the rest of the clinics that are in my responsibility, if they go to another clinic I will inform my colleague with the information that I have gathered from the patient's social history, so as to know about my actions.... A case that I currently have in this unit and which is a difficult case... he is a patient, he is a foreigner from Roumania, he had entered illegally in Greece, he hadn't followed the rules to enter in Greece, he was working somewhere in South Peloponnesus where he was injured by a car... the driver left him in the street and left... we don't have his details.... He came in our hospital and he was in the intensive care unit for a long period, he is a foreigner, uninsured, here in Greece he has only his sister, so you can understand, I am saying this and I am laughing, that since there is no welfare for the Greeks, imagine how much difficult it is for a person like him who cannot have an insurance from the welfare state... he also entered in Greece illegally, so, at some point the issue of his entrance in Greece will come up, he has no one in Greece to take care of him... I collaborated with his sister by whom I selected some information about this person... in continue I communicated again with a socially sensitive lady from Sparta who is a businesswoman, she deals with exports of olives, and because I saw that she was socially sensitive and she told me that whatever you need for this person we are on his side because we know him since we have his cousin in our business as an employee... the amount of money for the intensive care unit is very big, namely it is in thousands of euros. Yesterday I was looking his record and the amount has already reached the 60,000 euros... too much money... but anyway I have managed, I have earned the trust of this lady and therefore

she will pay a large amount of money to the hospital, but this doesn't happen every day... namely, in another case I had before, he was also a foreigner, he needed an operation, I pushed someone who is not very close to me, that's why I am telling you that social work is an alchemy, but in order to bring money to the hospital and not let the hospital look that has too many expenses that it cannot cover them, I was impelled to force his employer and he brought 5,000 euros to the hospital, a lot of money.. he brought the money to the hospital.. I have talked about this Romanian with the manager of the Traffic Police in order to see what is happening with the investigation of this case, if they have found the person that hit him so as to pay his bill in the hospital... I have communicated with the Rumanian embassy to see what will happen in the future, I have sent him in supportive organizations for immigrants, I have supported his sister and her boyfriend because they hadn't money to stay here in a hotel, things that many times veer from our duties but I cannot see two young people, because they didn't have a passport- one of those two hadn't a passport and they had to stay in a hotel and give 50 euros a day... but they had no money! I tried to find them a cheaper solution by practicing alchemy again, as I told you before, so I told him to take his cousin's passport and tell to the hotel keeper that it was his, I suggested this to him in order to help....this is not my role but I did it.

I. yes... can you push the social sensitivity of the hospital? How do you experience that?

K. you mean that if all the social workers...

I. no, you said that some people pay the medical expenses of patients.. what is happening with the hospital? Is the hospital flexible to this issue?

K. yes... I will tell you regarding the legal thing With this new administration which is, like I told you before, socially sensitive, I personally see that, because its doors are open at any time to approach them and tell them that 'I have this problem, I have exhausted all my powers but I haven't found a solution, help me if you can politically'.. so, because the administration is socially sensitive, with our urge... they now give us an annual small amount of money ... a tinny amount of money if you think the contemporary circumstances where the finance thing is too difficult for all people, where the unemployment is great, where there is a financial hardship... they gave us 300 euros for the half of the year... they give this money to the social services, this year they will give us 600 euros, so as to have the ability to cover some small expenses, for instance when a person come to us and something bad happen in his life and he has no money to go back to his home... we can give him from these money 5 or 10 euros to take a taxi to go home... for instance, I gave 40 euros to a lady, wrong, I bought 40 euros food for this lady... who has a child with diabetes, and you can understand that having a child with diabetes who needs a special diet is very expensive... she is unemployed, divorced, she also has another child who was attending the last year of his school and he was in an exam- period... I took an amount from this money and I went to the market to buy her some food... the social services department of the University hospital in R, last year, gave in such things... hang on! 6000 euros!! We, here, try now to ... We receive this money from the poor box of the church which is in the hospital's yard, the R. hospital has a chapel inside the hospital, so that a patient or a person who has a relative in the hospital can light a candle and give one euro. We have a church but it is in the hospital grounds, not inside the hospital and now the administration will build a small chapel inside the hospital, so that every patient will be able to light a candle before an operation and pray for it to go well, to pray to God, but also we social workers will be able to receive more money, so as, to help some people in emergency situations... for the urgent needs... for a ticket, to be able to buy someone slippers, or a pair of pyjamas, to give money to someone to buy food ... the social services of R hospital

has also paid electricity bills, big amounts, it has a bigger ability to do things, we are talking about larger amounts of money...

I. this difference exists only because there is a chapel inside the hospital?

K. yes, that's it. There is no other reason... and of course another reason for having more money is that our hospital here has 400 beds, the other hospital has 1500, the sizes cannot be compared, they are bigger... more beds so, it is right to have a bigger amount of money, however, they have, indeed, a bigger amount of money than we do.. we accomplished it last year, we demanded this money and finally we got it, even this tiny amount of money is welcome because it was an embarrassment for social workers not to have the funds to help buy a ticket for a patient to go home ... so, this has helped us... that we have this money to manage.

I. what is for you the meaning of deontology?

K. what is for me... I will not tell you a some sort of a scientific term, I will tell you what it is in the way I experience it... to do good to someone by exhausting all the resources and possibilities by trying to satisfy his claim, of course, provided his claim to be connected with what I believe it is right... I will not satisfy... it never happened to me to have a claim that is against my personal philosophy- philosophy ,which is also derived from the rules of the profession, right? Because, in our personal life we can function a little bit different, although, I believe that eventually the way that we practice as social workers is correlated with our personal life style, those two cannot be completely different... cannot be different... namely, I speak for myself because I am the one who you are taking the interview... in my personal life if one of my friends, just a familiar person, a fellow-villager, has a problem and asks for my help, independently that I am a social worker, I will function in the same way, and I always in my life function in this way, that's why I started as a nurse, but while I was working as a nurse I was functioning as a social worker, I was trying to help that's why eventually became what I wanted to be...

I. how long before did you work as a nurse?

K. I was working in this hospital as a nurse for 20 years.... And afterwards I became a social worker and I went to the social services department.... I am telling you that even as a nurse when we had a case that needed an exploration of the social part of it.. to find a relative... or because I had the will to hear someone, to help him... the others, you know, either they were tired because we had many cases since I was in the emergencies.. and the emergencies were... I always had the need to... I had the need to give. And I want to tell you that for me deontology is to be able to help someone... accordingly with his claim... and if his claim isn't too far and it is not against the rules of our profession... how can I say it.. I will not help someone who will ask me to give him... it never happened to me, but anyway, if ... for instance, if someone murders a person and ask me to give him money in order to go and find his family... I don't discuss it... I will not do it ...no, no..

I. what do you feel is the duty of the social worker in a case like this... in order to be deontological correct ...correct in quotes or not..

K. I am thinking now.... because I don't have an experience like this.. what could be a case like this...

I. he has taken someone's life right? And for his profit wants... the money let's say that it was for revenge..

K. yes, this is what I am saying, I wouldn't help him in this case, however, if he had another claim, for instance if he wanted to redeem himself from this, if he wanted to get over this, overcome this, to work with himself, to apologies for what he did in the family, if he wanted to do these actions, in these actions I could help him...

I. yes.. so, the social worker sometimes functions with...

K. yes, with positive discrimination for someone or aversion.. yes.

I. does this ever happened to you?

K. yes, I already told you an example that I could function more positively ... in the case with a mother... I would see more positively the mother... something that it is not so good... namely, I remember in the school they were keep telling us the empathy and the empathy and nourish the empathy..

I. so, this empathy, when it is good and when it is bad?

K. can I tell you something? For me, I believe that we should be emotional, because only if we put our emotion in every case we work, only then, we can truly help the people, provided not to be governed by it and function completely emotionally, we must be able to control it, we must say that I must help this person and I will put all my powers for this but not because ...how can I say it... not because he reminds me my father, or my mother or because I had the same experience with his... but we must get involved emotionally.

I. if you don't get involved emotionally?

K. If you don't use your emotions and function coldly as a professional, and put your job security first, you will lose the game... in Greece... because you don't have the tools, I told you that before... there is no chance... the processes are so time-consuming The employees in the other departments can be insensitive to the social problem of a patient... I am speaking about patients because we are in a hospital... if you don't make efforts and if you don't try to change the attitudes of those people in the ways that they see the social problem of a patient, probably, nothing will be done for the patient's problem

I. so the emotion is a motive..

K. yes, yes, yes a motive to do a good job.

I. you said before... I am speaking about the things that you said about the deontology... to do something good for a person, to help a person... is it possible not to know what is the good... to face conflicting interests?

K. e... yes... you mean conflicting interests between the family and the patient... somewhere else can be different...this is what you mean..

I. did something like this ever happen to you?

K. I am trying to think... I will tell you something that happened but ... for the greek reality I don't find that the interests are so conflicting... In Greece, if you hear that your man has cancer it is ...how can I say it... in Greece, cancer is a word that we don't want to use, we call it the loathsome disease, the cursed, we have given various other words in order to say that this man has cancer

I. yes.

K. so... with this fact, this was an introduction to say to you a case..

I. yes.

K. in the surgery clinic that I work... I see women with breast cancer and my mission is to see them, to talk with them, to take their social history.. to inform them that here in this town there is an association of women with mastectomy with the same disease as theirs, without entering in their medical issues, that's why I am telling you that there are some prohibitions for the cancer in Greece, the word prohibitions in quotes, and the patients in some cases they don't know that they have cancer.

I. is this an explicit rule? Has anyone told you that?

K. I am saying in quotes, but I, as a social worker that I cannot enter in the medical issues, namely to be the one who informs the patients for his illness.. I take the information from the patient based on what the patient himself knows about his illness, I work with what the patient tell me, if he doesn't want –he doesn't want, I will never inform him for something... because I am telling you that here in Greece we still have cancer as a social stigma.... And because in many cases the patient doesn't know of what is going on, we inform his family. But, most of the times, the family will say nothing to the patient, the family will keep it hidden, the family will keep it , the family will work it up in order to see what to do with the patient, that's why I am telling you that I couldn't say that it is a conflicting interest.. I could and I couldn't ... I could and I couldn't because at this point the family takes the responsibility of the patient's life and this is where the conflicting interests is... on the other hand, we all tolerate for Greece and we accept and say what the scientists also say that the patients shouldn't know the truth.... Because, they say that... and we, the social workers do not agree with that, but who takes the responsibility to tell the patient the truth of what he really has, should we take this responsibility, even if we are not doctors? Of course not, doctors have this responsibility and they decide not to tell the truth to the patients, so as, the family can manage this issue... so, I had a case once... I went to a lady who had breast cancer, she had done mastectomy and I advised her to go to the association, I told her that she could find there other women who have the same problem, they could discuss, take some help, share her problems, share their experiences, and the help of a volunteer would be substantial ... so, when I discussed this with her family and I told them that I suggested this to the lady, the family went crazy, 'with what right you said something like this to her?'. I relieved their mind by saying that I didn't mention to the woman about what she has or doesn't have.. but the family decided the woman not to go to this association, this was her family's decision, speaking now about conflicting interests, namely, the family decided on behalf of this patient.. it wasn't the patient's decision who was actually very positive when I suggested this in the first place..

I. how made you feel the family's reaction?

K. I will tell you something.. because I live, I work, I grew up in Greece and given the Greek facts, I didn't see that it was beyond the usual facts, despite the fact that I personally wouldn't do that, I believe that I wouldn't like this, however I didn't dispraise this because I know how the system works in Greece..

I. do you believe that this benefits the patient?

K. no, no I am completely contradictory to that, right? Simply it is not strange to me..

I. eventually, if the family wouldn't be involved and the woman would go to the association... I have the feeling that in this association they would put this woman in a process to accept her cancer and to deal it as a cancer ...with its name...

K. of course, of course, because in the association they would tell the woman about the cancer.

I. so... indirectly she would learn there...

K. I wouldn't say that to her, of course I wouldn't say that to her, I don't have this authority, but in this association this woman would take her life in her hands, she would say I have this, I will decide whether I will be part of a social group to help other women too or to help myself or to decide in a collaboration with my doctor what treatment will be given to me, what I will do, from where I will ask for help if I need something and, eventually, I will decide for the years that remain to me... about what in this years that are left, even one hour I have, how I will use it.... I believe... I am absolute in this that the patient must know... I am not discussing that, I don't even see it as a debate...

I. yes. You are describing this with such a certainty... so you believe that finally the patient would lose many things...

K. yes, I was certain about that... I believe that the patient has the right to know the truth, this not debatable for me, I am sure about this, however, I can not ignore the fact of the environment that this woman will live in, this family, eventually and in the long term, will take all the responsibility and the initiative of taking care of her...right? Besides, when we want to rehabilitate a person we will firstly count on the family, because here the family still works, the family exists in order to help a person who suffers, its a member who suffers, and the family is the first thing that we will try to motivate and use, so we don't want to spoil this relationship.

I. yes... how the collaboration with this family ended?

K. the lady didn't go to the association... the woman left in the 3rd day of her surgery ... they don't stay.. so, I don't have much time... I will see the patient in the 2nd day, and she will leave in the 3rd day ... so, I must consult the patients in the 2nd day, they will leave in the 3rd day ... but if someone accepts the program that I am suggesting, there is a supervision by a social worker with whom I collaborate and I learn the continuity of my cases.. if she doesn't accept I don't now what has happened.. but many times by giving this message... when the patient will discuss it a second time or think about it a second time, or if she face up with the difficulties, she has the information that I gave in her back of her mind and she can use it in a secondary phase and have the profit that she would have.

I. is this thought something that relieves you?

K. yes, of course, of course, I feel reassured because of the fact that I gave them the information, the way that they took this information maybe is something coincidental, maybe at a second level and in time they will tell her ... maybe at a second time they will think it over, what is important is that I told them.... that I have given them the information.

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