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Predictors of Ethical Stress, Moral Action and Job Satisfaction in Health Care Social Workers

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Abstract

Value conflicts can be a source of ethical stress for social workers in health care settings. That stress, unless mediated by the availability of ethical resource services, can lead to social workers' dissatisfaction with their positions and careers, and possibly result in needed professionals leaving the field. This study explored social workers' experiences in dealing with ethical issues in health care settings. Findings showed the inter-relationship between selected individual and organizational factors and overall ethical stress, the ability to take moral actions, the impact of ethical stress on job satisfaction, and the intent to leave position.

Keywords

Ethical stress; moral action; health care social workers; job satisfaction

Just over 100 years ago, Dr. Richard Cabot added a new dimension to the hospital staff by employing a social worker to address the needs of the patient in the community (Gregorian,

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2005; Kitchen & Brook, 2003). He recognized that patients often had limited knowledge and/or access to the resources to comply with the health care team's recommendations for on-going care and experienced difficulty accommodating the physical and emotional changes that can accompany illness. Through the intervening years, social workers have continued to bring a contextual perspective focused first on assessing and supporting the patient's strengths and individual coping strategies, and then garnering available support from family and friends (Robbins & Birmingham, 2005). The social worker also accesses available community-based programs that can enhance and reinforce these strengths. If programs are needed but not available, the social worker advocates for their development (Barnes & Hugman, 2002). Bilchik (1999) noted that Ida Cannon, founder of the first department of social work at Massachusetts General Hospital, declared that hospital-based social work represented the social conscience of the hospital in caring for patients.

Social work is a profession rooted in a set of social values that are consonant with ethical principles. These values include service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence (NASW, 1999). Moral quandaries and conflicts may arise as social workers set priorities among these values in service to their patients. They may not be able to meet all the obligations mandated by adherence to their stated values (Sasson, 2000). Social work's mission statement has a particular focus on the vulnerable and underrepresented–“to make the invisible visible” (Jennings, Callahan, & Wolf, 1987). This focus directs the social worker to engage the health care team in the life of the patient as a whole person not just as an individual with an illness (Bronstein, 2003).

Manning (1997) describes the moral citizenship of social workers as requiring them to fully live by their social work values and participate in ethical action. Ethical action involves seeing an opportunity beyond one's self to act, to care, and then to take action. While the stated values of social work may be shared by other disciplines on the health care team and incorporated in institutional mission statements, there is often a difference in the hierarchy of the values held by team members and the institution. For example, honoring/facilitating a patient's right to self-direct in their care plan may conflict with the medical team's attention to beneficence as they provide what they believe is best for the patient. The needs of an individual patient may conflict with the institution's obligation to judiciously allocate its resources. Ideally, the team works together towards a common approach to resolve ethical dilemmas as they arise (Abramson, 1984).

The conflicts of values can be a source of ethical stress that, unless mediated by the availability of ethical resource services (such as consultation, the use of other ethics review processes, and ethics education), can lead to social workers' dissatisfaction with their positions and careers. Unfortunately, ethical stress and job dissatisfaction have sometimes resulted in decisions on the part of key professional persons to leave the field.

Study Purpose

The purpose of this study was to explore selected aspects of social workers' experiences in dealing with ethical issues in health care. Included were an examination of ethical issues

experienced by social workers, stress engendered in the organization around managing these ethical issues, the resources available to address these ethical issues, the ethical climate within the health care organization and the ability of workers to take moral actions, the impact of ethical stress on job satisfaction, intent of the professional to leave the field, and the role of ethics education in mediating ethical stress. The data presented here were part of a larger study that compared the experiences of social workers and nurses.

Literature Review

According to the literature, ethical issues were found to have added to the stress experienced by social workers in a variety of health care settings. These included the social workers' position in the organizational hierarchy and how position influences the actions social workers take when faced with difficult ethical issues, the resources available to address complex problems, and the sources of satisfaction and dissatisfaction with social workers' positions and careers. In previous studies, these factors not only determined the nature of ethical issues, but also the manner in which these issues were perceived and addressed.

Ethical Issues and Related Stressors

Reamer (1985) first reported the emergence of bioethical issues in social work resulting from the increasing complexities of medical decisions regarding quality of life, use of technology, and end-of-life issues that encompassed value conflicts for patients, families, and the health care team members. Patients and families increasingly turned to social workers to help them in their ethical reflection process. Studies of social workers in health care have identified a number of recurring issues, including establishing and following Do Not Attempt Resuscitation (DNAR) orders; confusion or conflict about advance directives; withdrawal or withholding treatment such as artificial nutrition and hydration, dialysis, and mechanical ventilation; physician-assisted suicide; futility; self-determination and team practice (Black, 2004; Csikai & Bass, 2000; Egan & Kadushin, 2001; Foster et al., 1993; Gellis, 2001; Mackelprang & Mackelprang, 2005; Manetta & Wells, 2001; Miller, Hedlund, & Murphy, 1998; Proctor et al., 1993; Walsh-Bowers, Rossiter, & Prilleltensky, 1996; Yen & Schneiderman, 1999).

Social workers' perspectives on ethics-related stress depends on their experiences with ethical issues arising in their jobs. For hospice workers, key concerns are the patient's medical condition, involvement of family, family denial of terminal illness, questions of legalization of euthanasia, access to services and resources, and unequal distribution of hospice care services among diverse racial and economic groups (Csikai, 2004). Social workers in home care agencies identify ethical concerns regarding the need to do good work for clients, clients' self-determination/autonomy, clients' control over decision-making, clients' access to services, the implementation of advance directives, and the assessment of mental capacity and competence (Egan & Kadushin, 1998; Gallagher et al., 2002; Healy, 1998). Sasson (2000) reported issues of autonomy in a case study of ethical issues faced by social workers in nursing homes.

Moral Action

Organizational support for moral action is essential for ethical discourse in professional practice and for preventing harm. In addition, differences in organizational structures, procedures, and interpersonal dynamics play roles in ethical decision-making and the subsequent moral actions of organizational members (Walsh-Bowers et al., 1996; Landau, 2000a).

Jansson and Dodd's (2002) examination of ethical activism, or the degree to which social workers in hospitals were involved in ethical deliberations with patients and professionals, found that many social workers do engage in ethical activism, particularly in the areas of seeking multi-disciplinary ethics training, promoting norms to encourage social work participation in multidisciplinary ethical deliberations, and educating physicians about social workers' roles in these deliberations. Those who participated at the micro level were more likely to also do so at the institutional level. However, the researchers found that ethical activists needed skill in determining the politics and power that is part of every institutional context.

When dealing with ethical issues, perceptions of powerlessness may be due to the role of the social worker and the locus of decision-making authority found among medical teams (Landau, 2000a). Social workers may view themselves as less powerful members of the medical hierarchy and be treated as such by physicians (Gellis, 2001), decreasing their participation and influence in ethical decision-making (Walsh-Bowers et al., 1996). Organizational support in a positive work environment strengthened social workers' ability to manage work-associated stress.

Ethics Resources

While ethics consultation is a common approach to dealing with ethical issues and dilemmas in health care, allied health professionals, including social workers, use this process less frequently than physicians (Gordon et al., 2000; Landau, 2000a; Olson et al., 1994) because of perceptions of powerlessness, communication failures, distrust among professionals from different disciplines (Growchowski & Blacksher, 2000; Joseph & Conrad, 1989; Kerridge et al., 1998, Landau, 2000a), and the individual's knowledge and understanding of ethics (Homenko, 1997; Joseph & Conrad, 1989; Landau, 2000a, 2000b). Ethics committees provide an ideal forum for discussion of difficult cases, for policy formulation, and for staff and community education about difficult bioethics issues. They are multidisciplinary and fairly widespread in hospitals, but this is not the case in many other health care settings (Csikai, 2004). Social workers identify peers as their chief, though informal, resource in dealing with ethical dilemmas. They also consult with team leaders, interdisciplinary team members (Csikai, 2004) or other colleagues external to the hospital (Walsh-Bowers et al., 1996).

Satisfaction

No literature was located that directly addressed issues of ethical stress, moral distress, and job satisfaction in social workers. Moral distress, first discussed in the nursing literature, is identified as a painful feeling and/or psychological disequilibrium that occurs when nurses

are conscious of the morally appropriate action a situation requires but cannot carry out that action because of institutional obstacles (Corley, Minick, Elswick, & Jacobs, 2005). Powerlessness to take moral action is one factor that could be considered a precursor or related to moral distress for social workers. Beemsterboer and Baum (1984) explored the concept of burnout and observed that a mix of personal and organizational factors had expanded the initial construct and led to misuse or mislabeling of some behaviors as burnout. Recent research about “compassion fatigue” as a phenomenon that can arise from constant exposure to others' pain suggests that the resulting stress can lead to a depersonalization and separation from the client similar to burnout (Figley, 1995). Coady, Kent, and Davis (1990) found sources of burnout for health care social workers to include becoming overly involved in client's problems, and a perception of poor support in their work setting resulting in an increase in the difficulty experienced in providing services. Several studies found a relationship between value conflicts and job satisfaction, but none addressed the relationship between job satisfaction and ethical compromise, which can be a source of moral distress.

Other studies have examined a number of factors related to career satisfaction of health care social workers. Several found a relationship between career satisfaction and personal factors such as a high psycho-social sense of well-being (defined as a low level of depression), high self-esteem, high motivation, self-actualization, and an ability to maintain personal boundaries in the face of patients' and families' suffering (DeLoach & Monroe, 2004; Gregorian, 2005; Koeske & Kirk, 1995; Pockett, 2003). Other studies found that professional factors, including the opportunity to develop and maintain strong working relationships, a sense of challenge and meaning in their work, autonomy, professional respect, and active problem solving were strong sources of satisfaction for social workers and other health care professionals (Acker, 2004; Deloach & Monroe, 2004; Egan & Kadushin, 2004; Gregorian, 2005; Kadushin & Egan, 2001; Marriott, Sexton, & Staley, 1994; Pockett, 2003). Researchers have also found that organizational factors such as role clarity, strong supervisory support, rewards/salary, a socially supportive work environment, inclusion of staff in decision-making, strong management of value conflicts, and opportunities for professional development were identified as significant to career satisfaction as well as intent to leave professional positions (Acker, 2004; Deloach & Monroe, 2004; Egan & Kadushin, 1998, 2004; Kadushin & Kulys, 1995).

In summary, although there is an increasing body of literature since 1985 describing the types of ethical issues experienced by health care social workers, there are only preliminary studies of the nature and degree of stress experienced, and the resources available to deal with these issues, by professional social workers who encounter ethical issues. Even though attention has been given to burnout and compassion fatigue in the profession, no literature was located that addressed the combined predictors of ethical stress, moral distress, and job satisfaction in social workers–the focus of the present study.

Hypotheses

The hypotheses for this study were as follows:

1. There is a relationship between overall ethical stress and moral action.

2. Social workers who report a positive ethical climate and ethics resources provided by employer will experience lower overall ethical stress.
3. Individual factors (age, gender, race, income, years in practice, ethics education, encountered ethical issues, ethics engendered stress, and education) and organizational factors (ethics resources provided by employer, ethics consultation service available, ethics climate, profit vs. not-for-profit, setting, and position) predict the level of overall ethical stress, moral action, job satisfaction, and intent to leave the job.
4. Social workers who have taken ethics educational courses or training will report more frequent ethical problems but less stress related to them.
5. Ethical stress will influence job satisfaction and intent to leave the job.

Study Design

As previously mentioned, the data for this study were taken from a larger study that was a cross-sectional design with a self-administered mailed or web-based survey of a random sample of 1,000 nurses and 2,000 social workers chosen from the state licensing lists of four states, one from each of the four census regions of the United States in 2004 (California, Maryland, Massachusetts, and Ohio). States were chosen based on the availability of state licensing lists for both professional groups. Currently certified and licensed registered nurses and social workers in each of the designated states were eligible for participation. Because social workers practice in a large variety of areas, we estimated that about one-third of social workers practice in clinical/healthcare situations and over-sampled this population to ensure an adequate number of responses for analysis (Ulrich et al., submitted). This article presents the findings from those social work respondents who reported working in a health care setting.

The original sample of 2,000 social workers was decreased by 257 (12.9%) ineligible subjects and 98 bad addresses for an adjusted sample of 1,645. Of the adjusted sample, 136 (8.2%) refused participation and 771 (48.2%) completed or partially completed the survey resulting in an adjusted response rate of 53.2% (Response Rate 4) (AAPOR, 2006). Of the completed or partially completed surveys, 62% (n = 478) of the social work respondents reported working in a health care setting. These settings include acute care hospital, specialty hospital, sub-acute/long-term care, home/community care, ambulatory, school health, mental health services, and/or substance abuse.

Instrumentation

The same questionnaire, paper and web-based, was used for both professional groups and was designed in conjunction with the Center for Survey Research at the University of Virginia. Respondents were offered either response option, but asked to respond to only one. Two Institutional Review Boards approved the study. Four mailings were sent to participants, in accordance with Dillman's tailored design method (Dillman, 2004), with the cover letter describing the purpose of the study and providing assurance that all responses would be kept confidential. All participants received an incentive of $2 in the initial mailing.

The questionnaire addressed the following domains: socio-demographic and practice characteristics, attitudes toward the workplace ethical climate, availability and type of organizational resources to assist with ethical issues, overall ethical stress, moral action, job satisfaction, intent to leave current position, type and frequency of ethical issues encountered, and encountered ethical issues-related stress. The questionnaire comprised five scaled instruments. The first, using an adapted version of Olson's (1998) 26-item Hospital Ethical Climate Scale, measured Ethical Climate: the influence of the workplace and organizational practices on the ability to reflect on ethical concerns, to resolve ethical issues, and engage in ethical practice. Scale item responses consisted of a on a 5-point Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). The more positive the respondents' perceptions of the ethical climate, the higher their scores. This instrument provided a measure of the respondents' perception of their relationships with peers, patients, physicians, managers, and institutional settings (e.g., hospital, clinic). For the health care social workers in this study, 25 of the 26 items remained following factor analysis and calculation of reliability estimates. The overall Cronbach's alpha in this sample of social workers in health care for the Ethical Climate Scale was .93.

The second instrument measured Overall Ethical Stress utilizing an adapted version of the Ethics Stress Questionnaire developed by Raines (2000). Overall, ethical stress is one of the dependent variables in this study. This scale assesses the degree of ethics stress experienced by the respondent, given the frequency and complexity of ethical problems the nurses and social workers encounter in practice. Thirty of the 52 original items from the scale were used in this study. The items were measured on a 5-point Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*), with five items reverse scored. For this scale, the higher the score the greater was the degree of ethical stress. For the health care social workers, 27 of the 30 items remained in the scale following factor analysis and internal consistency measurement. The Cronbach's alpha for this scale in this sample was .91.

Penticuff and Martin (1987) developed the Moral Action Scale, the third instrument, to measure moral activism. It measures the actions likely to be taken when faced with an ethical issue, was developed by to measure nursing moral activism. The scale was modified for this study resulting in a 12-item 5-point Likert scale ranging from 1 (*not at all likely*) to 5 (*extremely likely*). For this study the question “Seek an ethics consultation” was added. The Cronbach's alpha was .82.

The fourth instrument, the 32-item Ethical Issues Scale (EIS), measured the frequency of ethical issues encountered, and the stress experienced in relation to these ethical issues. The EIS is composed of two sets of identically worded questions, yielding two scales that measured two of the variables in this study: ethical issues encountered and ethical issues engendered stress. The ethical issues encountered was measured using a 5-point Likert scale ranging from 1 (*never*) to 5 (*daily*) with respondents being asked “to what extent have you encountered the following ethical and patient care issues in your primary practice setting during the past 12 months.” The higher the score the more frequently ethical and patient issues were encountered over the last year. The Cronbach's alpha for this scale was .80.

Ethical issues engendered stress measured the respondents' perception of their personal stress experience via a 5-point Likert scale ranging from 1 (*no stress*) to 5 (*very high stress*). They were asked to respond to the question, “To what degree have you experienced stress over the following ethical and patient care issues in your primary practice setting during the past 12 months?” The higher the score the more ethical issues engendered stress experienced over the last year. In this sample the Cronbach's alpha was .87.

The final instrument measured career satisfaction utilizing a modified version of the 12-item Physician Job Satisfaction Scale originally developed by Williams, Konrad, Linzer and colleagues (2001). The response set was a 5-point Likert scale with item responses ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Four items are reverse scored. A high score is interpreted as high satisfaction with the job. Cronbach's alpha for this scale was = .93.

Intent to leave the job was measured by two items: *would you like to leave your current job* (1 = Yes, 0 = No) and *do you think you will leave your current job within the next 12 months* (1 = Yes, 0 = No). Each item was used as a dependent variable in the analysis.

Ethics consultation service available, an independent variable, was measured by the question “Does your organization have an Ethics Consultation Service or an ethics committee to address ethical issues?” The responses were coded “Yes” (1), “No” (0) or “Don't Know” (0). Ethics resources provided by the employer, an independent variable, was measured by the question “To what extent does your place of employment provide resources to help you with ethical issues in your work?” The response set ranged from 1 (*no resources*) to 5 (*extensive*).

A number of the independent variables were collapsed for use in linear regression analysis. “Income,” originally measured using six ordinal categories, was collapsed into two categories: $45,000 and below, and above $45,000. Though not exact, it is very close to the reported median income of licensed MSWs of $46,825 (Center for Health Workforce Studies, 2006). “Social work degree” was originally a nominal variable with four categories. The four categories were collapsed into two categories: BSW or less, and MSW or more. Having training or course work in ethics was originally a nominal variable where the respondent was able to select more than one type of training or coursework. This was collapsed into two categories: “Yes,” or “No.”

Findings

Demographics

The respondents included in the analysis presented in this article were all social workers who reported working in a health care setting (n = 478). The demographic data they provided were representative of the NASW data on health care social workers (NASW, 2006). Most respondents were female (79.3%), white (83.8%), possessed an MSW or higher degree (82.6%), employed full-time (77.9%) and worked in a not-for-profit organization (74.6%). Just over 51% reported that there was an Ethics Consultation Service at their place of employment, with 33.6% not having one and 15% of the respondent not knowing if one was available. More than 64% of the respondents reported that there were adequate or

extensive resources available at their place of employment to address ethical issues (see Table 1).

The average age of the respondents was 45 years (S.D. = 10.8) ranging from 24 to 74. The mean years in current position was 6.3 (S.D. = 6.1) with a range of .8 to 40 years. The mean number of years as a social worker was 14.9 years (S.D. = 9.5) with a range from a new social worker to 42 years.

The respondents' work settings and the types of positions held are presented in Table 2. Most social workers work in home/community care (26.8%), followed by acute hospital care (16.1%), and mental health services (15.9%). The positions held by the respondents were mostly patient care (77.1%), followed by administration (15.3%), with the remainder in positions of teaching, research, and combined (any combination of the other positions).

The types of ethics training or courses are presented in Table 3. The mean number of ethics trainings or courses taken by the social work respondents was 1.7 (S.D. = 1.1) with a range from zero to five trainings/courses. Just over 44% of the respondents have had one ethics training/course, 7.7% have had no ethics trainings/courses, and just fewer than 40% took two to three trainings/courses with the remaining 8% reporting four to five ethics trainings/courses.

Scales Results

Respondents reported a positive ethical climate within their institutions (mean = 3.85, S.D. = .52), low to moderate levels of overall ethical stress (mean = 2.54, S.D. = .59), and a likelihood that they would engage in moral action to address ethical issues (mean = 3.23, S.D. = .70). The largest frequencies of ethical issues encountered was “Seldom” (1 on the scale) to “Sometimes (3 on the scale)” (mean = 2.40, S.D. = .51), the stress engendered based on their experience of ethical issues was low (mean = 1.9, S.D. = .55); and most experienced some degree of career satisfaction (mean = 3.75, S.D. = .75).

Bivariate analysis was conducted and only those variables that had statistically significant linear relationships with the dependent variables were included in multiple regression analyses (MRAs). These analyses revealed a number of significant bivariate relationships. Of note are the following: health care social workers whose organization or institution had an Ethics Consultation Service reported a better ethical climate ($r = .15$, $p < .01$), more ethical issues encountered ($r = .21$, $p < .01$), more ethical issue engendered stress ($r = .12$, $p < .01$), yet, importantly, a greater likelihood that they would take moral action ($r = .21$, $p < .01$).

A number of demographic variables showed statistically significant linear relationships with the major study variables. Those with MSW or DSW/PhD degrees reported greater career satisfaction ($r = .10$, $p < .05$) and fewer ethical issues encountered ($r = -.17$, $p < .05$). Social workers in health care settings who were older reported greater career satisfaction ($r = .14$, $p < .01$). Those who were younger reported greater overall ethical stress ($r = -.16$, $p < .01$), were more likely to report wanting to leave their current position ($r = .182$, $p < .01$), and were more likely to report that they think they will leave their current position within 12

months (r = .187, p < .01). Gender was related only to ethical issues encountered (r = .11, p < .05) with females reporting more ethical issues encountered than males.

Hypothesis Testing

Hypothesis 1

As hypothesized, there was a statistically significant linear relationship between overall ethical stress and moral action (r = −.261, p < .01), with the relationship being a weak inverse one. This means that the greater the overall ethical stress, the less likely that moral action was taken by the professional. However, less than 7% of the variance in moral action can be explained by ethical stress.

Hypothesis 2

As hypothesized, ethical climate and ethics resources provided by employer explained 26% of the variance in ethical stress reported (F = 68.6, p < .01). Total ethical climate had the greatest negative impact on ethical stress (Beta = −.386) while ethics resources provided by employer have a smaller, though still significant, negative effect (Beta = −.194). This means that the more supportive the ethical climate and the more ethics resources provided by the employer, the lower the ethical stress experienced by the social worker (see Table 4).

Hypothesis 3

To investigate the ability of various individual factors and organizational factors to predict overall ethical stress, moral action, career satisfaction, and intent to leave, five stepwise multiple regression analyses (MRAs) were run. For each MRA the following predictor variables were included: age, income, years in practice, ethical issues encountered, ethical issue engendered stress, level of education, ethics resources provided by employer, ethics consultation service at workplace, ethical climate, setting (acute care, sub acute, and school), and position (patient care, administration, and combined) (see Table 5).

For the dependent variable of overall ethical stress, we found that income, ethical resources provided by employer, ethical climate, ethical issues engendered stress, sub acute setting, and administrative or management position predicted 43% of the variance in ethics stress (F = 42.081, p < .001). The strongest predictors were ethical issue engendered stress (Beta = .378), followed by ethical climate (Beta = −.318), ethics resources provided by employer (Beta = −.198), income (Beta = −.115), sub acute setting (Beta = −.093). The weakest predicator was being in an administrative or management position (Beta = −.091). Those who reported higher overall ethical stress were those who experienced greater ethical issue engendered stress, poor ethical climate within their organization, fewer resources provided by their employers, lower income, working in non sub-acute settings, and non-administrative positions.

For the dependent variable moral action we found that stress related to ethical issues encountered, ethics resources provided by employer, the availability of an ethics consultation service, ethical climate and job responsibilities, and combining more than one primary duty (e.g., administration and patient care) predicted 23% of the variance in likelihood of moral

action (F = 20.849, p < .001). Of these, the strongest predictors of moral action were ethical climate (Beta = .298) followed by encountered ethical issues engendered stress (Beta =.180), ethics resources provided by employer (Beta = .176), combined position (Beta = .132). The weakest predictor of moral action was having an ethics consultation service (Beta = .108). In order of predictive strength, this finding suggests one is more likely to take moral action based on a more positive ethical climate, the greater stress engendered by ethical issues, the more ethics resources provided by the employer, job responsibilities combining more than one duty, and having an ethics consultation service.

For the dependent variable of career satisfaction among health care social workers, the statistically significant predictor variables included ethical issue engendered stress, ethics resources provided by employer, and ethical climate (F = 44.568, p < .001). These predictor variables explain 30% of the variance in career satisfaction. The strongest predictor variables were ethical climate (Beta = .391), followed by ethics resources provided by employer (Beta = .157) and ethical issues engendered stress (Beta = −.137). Specifically, the more positive the ethical climate, the more ethics resources provided by employer, and the less the ethical issues engendered stress the higher the reported career satisfaction.

For the final dependent variable, intent to leave the position, two regression analyses were run. One with the dependent variable wanting to leave position and the second with the dependent variable thinking will leave within next 12 months. For the wanting to leave position the predictor variables ethical climate, ethics resources provided by employer and years practicing were statistically significant (F = 31.063, p < .001) and explain 19% of the variance in wanting to leave current position. The strongest predictors were ethical climate (Beta = .275), followed by ethics resources provided by employer (Beta = .232). The better the ethical climate and the more ethics resources provided by employer the more likely one would want to leave current position. For those thinking of leaving within the next 12 months, the predictor variables of age, ethical issue engendered stress, level of education, and ethics resources provided by employer were statistically significant (F = 21.793, p < .001) and explain 14% of the variance in thinking about leaving current position within the next 12 months. The strongest predictors were ethics resources provided by employer (Beta = −.303), followed by age (Beta = −.174). The less ethics resources provided by employer and the younger the social worker then the higher the reported thinking will leave current position within 12 months. The findings for these four criterion variables provide support for hypothesis three.

Hypothesis 4

The number of ethics trainings or courses reported the more frequent the ethical issues encountered (r = .12, p < .05) and the more encountered ethical issues related stress (r = .11, p < .05). Both of these correlations are weak but positive thus providing partial support for hypothesis four.

Hypothesis 5

There was a statistically significant negative moderately strong linear relationship between overall ethical stress and career satisfaction (r = −.461, p < .01) and a positive weak linear

relationships between ethical stress and the two variables measuring intent to leave, would like to leave ($r = .248$, $p < .01$) and thinking will leave within 12 months ($r = .171$, $p < 01$). This indicates that the higher the level of ethical stress, the lower the reported career satisfaction and the more likely the social worker is thinking about or planning to leave. Twenty-one percent of the variance in career satisfaction, just over 6% of the variance in wanting to leave position and 3% of variance in thinking about leaving within 12 months can be explained by ethical stress.

Discussion and Recommendations

These data are rich with implications for health care social workers with respect to the ethical competence of the individual professional, the rate of job turnover in the work setting, and the structure and resources available in the institution/organization. For example, although the degree of ethical stress and the ethical stress engendered by experiencing ethical issues was low among this study population, it is important to note that these levels were influenced by the ethical climate within the institution/organization and the resources available to deal with them. This finding points to the importance of positive support for ethical reflection and decision-making from team members, and for ethics-sensitive supervision within the work unit. As Pellegrino and Thomasma (1981) point out, the contemporary professional needs the support of a moral community.

Further, in view of the finding that 26% of the variance in ethics stress from ethical issues encountered is related to the combination of ethical climate and ethics resources, it is imperative that health care organizations address this issue. The organization must set a climate that allows for Ethics Review Committees or Ethics Consultation processes as well as on-going ethics-related forums that permit continuing education and open discussion of the issues (Kalvemark et al., 2004). Appropriate time is needed to carry out the work of these groups. The availability of appropriate resource persons, such as ethics consultants knowledgeable about the work setting and the psychosocial factors related to dealing with ethical issues, is essential.

Finally, these data indicate that the organizational climate and the organizational resources available influence the likelihood of moral action. It should be noted that those social workers whose job descriptions combined direct service with management roles were more likely to engage in moral action. As Manning (2002) points out, when social workers have the opportunity to influence the organization, they have an ethical responsibility to take on moral leadership. These data indicate that this is most likely to happen when the organizational climate is supportive and useful resources are available.

It needs to be recognized that the present findings were obtained from a self-selected population who chose to respond to the mail questionnaire. Little is known about those who did not respond to this survey. Responses were, for the most part, quantitative in nature and only minimal attempts were made to elicit open-ended and/or qualitative data. As explained earlier, the researchers adapted the instruments used to elicit the study data from social workers.

It is anticipated that further study on the ethical issues encountered by social workers in different types of health care settings, as well as comparison of the experiences of health care social workers with social workers in other settings would enrich the current understanding of the nuances of ethical problem solving within the profession. Consistent with the call for evidence-based practice, there is a need for further technical refinement of quantitative and qualitative instrumentation for the further study of social work ethics. In light of the increasing emphasis on continuing education in the ethics of social workers by licensing and accrediting bodies, further study on the effects of ethics education, and education's impact on the work setting are also indicated.

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Table 1
Demographics of Health Care Social Workers

	n	%
Gender		
Male	98	20.7
Female	375	79.3
Ethnic Background		
Asian	14	3.0
Black or African American	36	7.7
White	392	83.8
Other	26	5.5
Level of Education		
Associates Degree	3	.6
Bachelors Degree	80	16.8
Master's in Social Work	376	79.2
Doctoral Degree	16	3.4
Income		
≤ $35,000	103	22.2
$35,001-$45,000	128	27.5
$45,001-55,000	95	20.4
$55,001-65,000	65	14.0
$65,001-75,000	43	9.2
> $75,000	31	6.7
Current Employment Status		
Full-time	371	77.9
Part-Time	100	21.0
Unemployed	5	1.1
Type of agency		
For-profit	107	22.7
Not-for-profit	352	74.6
Don't know	13	2.7
Ethics Consultation Service at Place of Employment		
Yes	243	51.4
No	159	33.6
Don't Know	71	15.0
Extent place of employment provides resources to help with ethical issues in your work		
No Resources	8	1.7
Minimal	63	13.7
Limited	90	19.6
Adequate	246	53.6
Extensive	52	11.3

* n's that do not total 478 due to missing data, % is based on non-missing data.

Table 2

Type of Setting and Position Held

	n	%
Setting		
Acute Care Hospital	77	16.1
Specialty Hospital	58	12.1
Subacute/Long-Term Care	55	11.5
Home/Community Care	128	26.8
Ambulatory	65	13.6
School Health/Student Health Service	10	2.1
Mental Health Services	76	15.9
Substance Abuse	9	1.9
Position		
Patient Care	368	77.1
Administration	73	15.3
Combined	26	5.5
Teaching	5	1.0
Research	2	.4

Table 3

Training or Course Work in Ethics (more than one could be checked)

	n	%
Basic Professional Program	231	48.3
Advanced Professional Program	125	26.2
Fellowship Program	6	1.3
Continuing Education Ethics Program	284	59.4
In-House Training Program	179	37.4
No Course Work in Ethics	37	7.7
Other	28	5.9

Table 4

Stepwise Multiple Regression Analysis

	β	Beta	t	sig
Criterion Variable: Overall Ethics Stress				
Predictor Variables				
Total Ethical Climate	−.378	−.386	−7.564	.000
Ethics Resources Provided by Employer	−.105	−.194	−3.803	.000
Constant	4.234		25.416	.000

F = 68.597, p < .001.

Adjusted R Squared = .26.

Table 5

Stepwise Multiple Regression Analysis

	β	Beta	t	sig
Criterion Variable: Overall Ethics Stress				
Predictor Variables				
Income	−.114	−.115	−2.620	.009
Ethics Resources Provided By Employer	−.109	−.198	−.4001	.000
Encountered Ethical Issues Related Stress	.350	.378	8.770	.000
Ethical Climate	−.312	−.318	−.6458	.000
Administration	−.128	−.091	−2.074	.039
SubAcute	−.150	−.093	−2.194	.029
Constant	3.496		17.435	.000
F = 42.081, p < .001				
Adjusted R^2 = .42				
Criterion Variable: Moral Action				
Predictor Variables				
Encountered Ethical Issues Related Stress	.234	.180	3.604	.000
Ethics Resources Provided By Employer	.137	.176	2,726	.003
Ethics Consultation Service Available	.151	.108	2.085	.038
Ethical Climate	.414	.298	5.245	.000
Combined	.397	.132	2.726	.007
Constant	.579		1.816	.070
F = 20.849, p < .001				
Adjusted R^2 = .23				
Criterion Variable: Career Satisfaction				
Predictor Variables				
Encountered Ethical Issues Related Stress	−.194	−.137	−2.899	.004
Ethics Resources Provided By Employer	.133	.157	2.911	.004
Ethical Climate	.585	.391	7.215	.000
Constant	1.392		4.275	.000
F = 44.568, p < .001				
Adjusted R^2 = .28				
Criterion Variable: Like to leave current position				
Predictor Variables				
Ethical Climate	.243	.275	4.197	.000
Ethics Resources Provided By Employer	.114	.232	3.544	.000
Constant	.374		1.940	.053
F = 31.063, p < .001				
Adjusted R^2 = .19				
Criterion Variable: Think will leave within 12 months				
Predictor Variables				
Age	−.007	−.174	−2.945	.004

	β	Beta	t	sig
Ethics Resources Provided By Employer	−.140	−.303	−5.127	.000
Constant	1.071		7.932	.000
$F = 21.793, p < .001$				
Adjusted $R^2 = .14$				