CONFIDENTIALITY AND RISK ASSESSMENT:

CASE STUDIES OF THE PROFESSIONAL JUDGEMENTS OF NURSES, SOCIAL WORKERS AND HOSPITAL CHAPLAINS

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Submitted in accordance with the requirements
for the degree of Ph.D. in Social Policy

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September 1998

The candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others.

ABSTRACT

This research examines the relationship between professional codes of ethics and ethics in practice. Key issues explored include: (a) to what extent do professionals use their ethical code when making decisions involving ethical dilemmas; (b) how frequently do they disclose information against clients' wishes and how is this justified; (c) are professional judgements so consistent that a common practice standard can be determined; (d) what differences in decision-making exist between nurses, social workers and chaplains and is this related to the extent of 'professionalization' of the occupation into an integrated network?

Vignettes describing low-risk community mental health cases, posing ethical dilemmas for the research participants about the disclosure of confidential information, were used as a focus for lengthy semi-structured interviews with 27 nurses, 21 social workers and 7 chaplains. Data was collected about respondents' professional membership and understanding of legal/professional/employer guidance about confidentiality. Responses were analyzed in relation to themes of 'consistency', 'conflict of loyalties', and 'rationalization' of choices.

Confidentiality was breached more than it was maintained, although there were considerable differences both within and between professional groups about the points of disclosure. In addition, no standard recipients for information could be determined. Vignettes were sometimes interpreted differently. Disclosure was justified through loyalties conflicting with responsibilities to the named client. This included loyalty to fellow professionals, to third parties, and to oneself. Disclosure could be motivated by desire to obtain a 'good result'. Participants displayed generally poor knowledge of legal/professional/employer frameworks for decision-making, and referred to their codes of ethics rarely as a reason behind decisions.

Implications for professional training and employer policy are discussed. Problems in professional accountability are raised, for practitioners, professional bodies, and employers. The utility of a code of ethics which espouses a standard of confidentiality so far removed from day-to-day practice is questioned.

ACKNOWLEDGEMENTS

Many thanks are due to the four members of the Department of Sociology and Social Policy who supervised my research and the writing of this thesis. Dr. Ray Pawson helped me to develop and refine the vignettes used in the interviews. Professor Alan Deacon was most encouraging and positive about my early struggles to write, and without his help I never would have decided on a title. Dr. Malcolm Harrison and Dr. Geoff Mercer provided valuable detailed comments about drafts, helped me to locate the research within a theoretical framework, and reminded me about references.

In addition, I must thank my mother, Dr. Cicely Watson, Professor Emeritus at the Ontario Institute for Studies in Education, for her continued intellectual encouragement and all those informal 'tutorials' over the breakfast table, as well as comments on draft chapters. Thanks are also due to my 87 year old father who kept reminding me of deadlines, saying how much he wanted to see me complete this before he "shuffles off this mortal coil". For most of the last five years I have been working part-time as a social worker for the Department of Social Services, Leeds City Council, which gave me leave of absence for several months so I could write the thesis. Thanks are also due to my colleagues at Buckingham House, who have expressed (sometimes slightly bemused) interest in my research.

I wish to thank the Department of Social Services in Wakefield and the Leeds Community and Mental Health Service Trust for assisting me to contact social workers and nurses. I am also immensely grateful to the people who agreed to be interviewed. Without their patience and extraordinary cooperation, this research would have been impossible.

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CHAPTER ONE

INTRODUCTION

This thesis investigates the relationship between the nature of professionalization and the development of degrees of professionalism. Specifically, it explores (1) the role of a profession's formal code of ethics and what might be termed its practitioners' "ethics in practice", and (2) the influence that the imperatives stated in the code have upon decisions taken in daily work as professionals encounter situations involving ethical dilemmas. Such dilemmas were investigated by reference to common practice situations in three of the 'caring professions' (nursing, social work and the chaplaincy). Specifically, I wanted to explore certain issues:

1. To what extent do professionals use their ethical code to assist them to make decisions which involve ethical dilemmas? What alternative ethical framework do they use?

2. How frequently do professionals disclose information against clients' expressed wishes and how do they justify these decisions?

3. Are professional judgements consistent to such a degree that a common accepted practice standard (to which practitioners should generally adhere) can be determined?

4. What differences in decision-making exist between the three professions, and is this related to the extent to which each profession is "professionalized" and integrated into an closely knit inter-professional network?

5 What implications do the research results hold for professional accountability, and the development of each occupation and for policy-makers?

Evidence was provided of "ethics in practice" by use of a number of

scenarios involving the dilemma to maintain client confidentiality or to disclose information against a client's expressed wishes, and questioning a sample of practitioners about how they would resolve the described case situation, listening to their examples of comparable conflicts and their reasoning as they analyzed difficult situations and justified their proposed decisions and actions. These responses were then contrasted with more general responses about the legal, professional and policy framework for uses of information, confidentiality, and information sharing. By including in the sample more than one type of professional worker, the differences and similarities of several formal ethical codes on the subject of confidentiality, and the different responses of the different types of practitioner could be compared.

A variety of workers operate within the field of community mental health: G.P.'s, district nurses, community psychiatric nurses, occupational therapists, social workers, day care attendants, home care assistants, psychiatrists, psychologists, chaplains, youth workers, social work assistants, etc. Debate and controversy over professional ethics and practice arise both between them and among different segments within the professions themselves. So the mental health arena is a fruitful setting in which to investigate the variances in practical implementation of ethical values in order to assess whether they are related to the degree of professionalization existing within a given occupation, to its endorsement of a wider public service ethic, or to membership in, and acceptance of, an interconnecting professional community.

THE ETHICAL PROBLEM AND THE PROFESSIONAL GROUPS

Nursing, social work, and the chaplaincy are all professions which in differing degrees encompass organised workers who lay claim to an ethical basis for their work. In Britain, those authorized to use the description 'nurse' are registered with the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (U.K.C.C.), which has a published

Code of Professional Conduct[1] setting out the ethical principles which must guide professional practice (U.K.C.C., 1992). Failure to comply can lead to de-registration. The British Code of Conduct for nurses is very similar to that adopted by nursing associations in other countries (Davis, 1989). Similarly, there is an organisation, the British Association of Social Workers (B.A.S.W.), which is the main professional organisation for persons undertaking roles designated as social work. It has an authorized Code of Ethics for Social Work (B.A.S.W.,1996), which bears remarkable similarity to the principles espoused by social work associations in other countries (e.g. Australian Association of Social Workers, 1988; National Association of Social Workers, 1993).

In Britain at present there is a less monolithic representation of pastoral care workers. Some hospital chaplains belong to a fledgling professional body, the College of Health Care Chaplains, but membership is not mandatory. Nevertheless, it also has a published Code of Professional Conduct (no date). Some chaplains belong to the British Association for Counselling (B.A.C.), as indeed nurses and social workers can as well, if they have completed a course in counselling which is recognised by this association. It too has a published Code of Ethics and Practice for Counsellors (1993) which bears considerable similarity to the principles espoused by counselling associations elsewhere (e.g. Herlihy and Golden, 1989).

Although the details of phraseology differ, in all these four cases the professional ethics and principles stated in the codes bear remarkable similarity. Therein the four professional associations lay claim to acting in the best interests of the client or patient, promoting his well-being (or at the least doing no harm); respecting the client as an individual, helping him express his wishes and assisting him to consider alternatives and make decisions. All four expect their members to accept personal accountability for professional practice and the need to acknowledge

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[1] Specific details of relevant parts of codes of conduct are reviewed in Chapter Four.

limits of expertise; the need to seek ongoing professional training and improve competence; a duty to avoid abuse of the professional relationship; a duty to respect client confidentiality; and a duty to act in the wider public interest (B.A.S.W., 1996; College of Health Care Chaplains, no date; U.K.C.C., 1992; B.A.C., 1995). In other words, all these professional codes, and indeed in one form or another, professions' codes of conduct generally, are statements of the ideal, expressed as high moral imperatives applied to specialized work and the exceptional opportunities offered by that work to "do good" (Millerson, 1964). For nurses and social workers these commitments, constraints and directives are based on the member's personal accountability in the professional role (U.K.C.C., 1992; B.A.S.W., 1996). Not all pastoral care workers accept such a professional commitment as the basis for their work - or, at least, not as the main and most important basis. They add (or substitute) the concept of a religious 'calling' to account for their recruitment to pastoral work. The basis for their moral imperatives and directives is their relationship to God (Cook, 1983). For some chaplains this relationship would require the negation of the professional code, if circumstances made that necessary.

However, even while agreeing that the ethical imperatives stated in the code of conduct are morally correct as a generality, nurses, chaplains and social workers often encounter practical problems in implementing them in professional work. For example: ethical questions arise when nursing demented elderly patients who are not able to feed themselves. What degree of coercion is allowable to ensure that the patient eats enough food to stay alive? The ethic of acting in the patients' best interests (by sustaining life through coaxing him to eat) might be seen as conflicting with the duty to 'do no harm', if continued life prolongs suffering. Akerlund and Norberg (1985) found that, for nurses such situations are distressing, a challenge to their ethical beliefs about practice.

The converse of this ethical dilemma is the situation in which a patient refuses treatment. "Is the patient's autonomy the most important or only

principle, overriding all others including the sanctity of life?" (Cassells and Redman, 1989, p. 468). Questions of how to determine the patient's competence to make decisions and the importance of full disclosure to the patient (informed consent) are important elements creating dilemmas.

Like nursing, the social work profession acknowledges that ethical dilemmas arise in practice situations in which two principles may be in conflict, or where there is a 'grey area' for professionals to differ in their judgement on how best to adhere to the professional principle while at the same time serving the client's best interests. One example in the area of client confidentiality: there are widespread computerized central records systems located within the network of personal service agencies in the United Kingdom. These commonly allow access to shared client records. This is a fairly recent development which has led to the need to set down more specific guidelines about the nature of the contents and the use of permanent records within social service agencies, which differentiate between the types of client, types of information user, and types of information entered, since some records contain more sensitive information than others, and the 'goalposts' on permissible access are constantly changing (Thomas, 1995, pp. 54 - 56). For information on the Child Protection Register, for example, departments permit relatively easy access to the professionals of such agencies as the Police, Prison Service, Probation Service, National Association for the Prevention of Cruelty to Children, Barnardos, and independent children's homes. But the more agencies that have access to the same data, the less individual client confidentiality can be maintained (Ashe, 1986). Therefore, social workers have to consider, more seriously than ever before, what client information <u>should</u> be recorded in permanent files over which their agency has less control than it had in the past. They also have to be aware of the long list of professionals who may have access to the information they are storing (Samuels, 1985).

Like nurses and social workers, the members of the pastoral care

profession in their daily work frequently encounter dilemmas relating to confidential information. Conflicts arise not only from two (or more) inconsistent ethical imperatives of their profession and from the 'grey areas' of differing professional judgement, but also from complicating variables which are specific to the context, the client's characteristics and the specific problem. The rights of clients have to be weighed against the rights of third parties revealed by the privileged information. Counsellors (including pastoral counsellors) have debated what are the appropriate boundaries of counsellor/client relationships and how to determine when unethical behaviour is occurring (Perls, 1969; Russell, 1990) and have encountered ethical dilemmas of confidentiality in dealing with potentially suicidal people (Bond, 1991).

In the latter half of this century, in the Western World (regardless of religious complexion) the focus of religious ministry has changed. This has occurred in terms of its orientation, in the variety of its daily work, and in the status and type of worker (Furniss, 1994). Vicar, priest, minister, rabbi and mullah have been joined by persons who are not ministers of religion but are exclusively pastoral counsellors. Theologians note the parallels in the changes which have occurred in the religious profession and those which occurred earlier in the secular professions. They point to similar processes which have been driving these changes. Inter alia these include the specialization of work, with much of the 'care' formerly provided by amateur volunteers now given by full-time employees. The specialization of labour has given rise to stratification within the older professions and the emergence of newer professions, with para-professionals undertaking some aspects of client care (under supervision or independently). Thus the amateur almoner has given way to the qualified medical social worker (Hugman, 1991) and the religious minister-part-time-hospital-visitor has been replaced by or supplemented by the full-time pastoral counsellor.

There now is competition for the client, with different groups providing specialized aspects of care and, occasionally, duplicating each other's

work. The 'domain' of 'care' is questioned and decided in terms of educational and experiential qualifications with reference to esoteric and discrete bodies of knowledge shared only by the members of a profession (and to a limited extent by the related para-profession). The 'boundaries' of daily practice change as research in the social, behavioral, physical and medical sciences add new knowledge and technique to the basis of work. Of equal importance is the social change which has reduced the absolute authority accorded to professional personnel. The challenge to their recommendations and decisions arises from the better educated laity and from the general scepticism and relativism accorded all authority in the more egalitarian climate of a modern democratic society (e.g. Illich, 1973).

The secularization and scepticism of Western society, with its insistence upon reference to the evidence of science and demonstrated 'proof', has affected those who provide the ministry of religion even more than other professionals (Davie, 1994). As a result, in recent years, religious leaders have been redefining the nature and parameters of pastoral work, who should enter the profession, and what should be their education and training (Goldner et. al., 1973, pp. 119 - 137). In the modern industrialized economy, in no area of work have the issues of jurisdiction been more acute than within and among the 'caring' professions.

In the United States, in the 1960s the debate within pastoral care centred on the twin issues of 'qualification' and 'exclusive recognition' or 'task monopoly'. At issue was the desirability of developing a pastoral counselling association which would serve both to define the necessary professional training and accredit the institutions which offered acceptable programs for the specialism of counselling within the wider old profession ('calling') of the ministry. Clinebell (1971), who was instrumental in helping to found the association, argued that there was need for a strong professional organisation to promote good training and ensure proper standards of pastoral care. In this he was following the traditional American route to ensure quality in advanced education.

'Accreditation' has been the chief means whereby the high standard of education for the various professions was established in a federal nation which set up no central controlling body.

Clinebell maintained that, without such a body to protect the public, this rapidly emerging field of work would be open to people with dubious ethics, standards and credentials (Clinebell, 1971). This, of course, is the traditional argument used by workers in an occupation which is trying to establish its professional status and, hopefully, gain recognition of their monopoly over certain kinds of work procedures. The appeal to the public good and safety, the establishment and protection of standards, these are the basis for the power to define the required education and control the number of institutions offering acceptable programmes, and thus control (and limit) entry to the work of the profession.

The specialist professional approach to pastoral counselling was supported through textbooks and training manuals, published to help ministers of religion who wished to undertake individual or group counselling on a regular basis. The textbooks share a common framework, locating pastoral counselling within a broad context of professional work and acknowledging the need to cooperate with other professionals (Clinebell, 1984).

One issue that had to be clarified and which gave rise to considerable discussion was record keeping. Clearly there was need for adequate records of pastoral care, but the extent of the information contained in the records and who would have access to them were difficult questions to resolve satisfactorily. There is acknowledgement of the dilemmas that such questions present to clerics who hitherto have considered their records as "personal notes" and have not been concerned with professionally and systematically recording the details of their counselling activity (Autton, 1963).

But not all pastoral counsellors are clerics, and the debate has centred on the need for records in terms of supervision and administrative

routines. Should the supervision of the pastoral care workers be through their respective churches or through the clinical team (professionals such as psychologists etc.) within which they work? The supervision issue involves the question of the routing of records and hence questions of confidentiality as well as professional identity. Yet supervision is also viewed as necessary to ensure pastoral care is appropriately managed and genuinely helpful to the recipient, as well as ensuring the 'helper' receives the support he needs to do his task well (Foskett and Lyall, 1988).

Within the parent body of religious ministry, from which pastoral counselling has been emerging, there is disagreement. Not everyone considers the 'professionalization' of pastoral counselling and chaplaincy in 'applied' non religious settings a positive move. Some of the ethical debate and ethical dilemmas found in the pastoral literature involve the extent to which 'professionalization' itself is an 'ethically correct' framework for pastoral care. Critics argue that this work should not involve trained professionals applying specialised techniques or 'treatment' to the laity, but rather should be a "mutual search for excellence, with no acknowledged experts on the route" (Campbell, 1985a, p.40). From this point of view responsibility for pastoral care lies with the entire religious community - minister and congregation together (Graham, 1990). Clerics concerned about the 'professionalization' of pastoral care have also criticised the inherent power imbalance between the 'professional' and the 'client', arguing that this is "alien to the spirit of pastoral care" (Campbell, 1985a, p.50) and should at all costs be avoided by pastoral counsellors.

Such concern is another sign of changing western society in the final years of the twentieth century - one which affects all the professions although, probably, the clerics are more sensitive to it than others - the problem of the social distance created by the exercise of professional authority. Historically in Europe, the Christian pastoral worker (the Roman Catholic priest or the member of a religious order, engaged in what

today would be described as family welfare work, work with prisoners, and work caring for the sick, the destitute and the mentally ill) practised under conditions which accepted social distance between worker and client and the power imbalance that that implies. The religious were literate and knowledgeable when most of their clients were not.

The use of the traditional terminology of 'shepherd' and his 'flock' reflect the relationship. They not only had (and exercised in their pastoral care) the authority conferred by worldly knowledge, they had authority derived by knowledge of Divine Will and the laws of the Church. The Jewish Rabbi was also, traditionally, an authority set apart. That seems also to have been the case for those playing the religious role in all traditional societies. Some members of such societies may have railed at times against the specific dictates of the individual who was representing religious authority, but for centuries they did not challenge the legitimacy of that authority or even reject it as unreasonable and likely to be wrong, and the religious leader practised his ministry accordingly. However, in an increasingly secular age, the modern western religious leader seems reluctant to invoke the certainty of the professional who is the expert on questions of ethics and morals in relation to human conduct.

SUMMARY

Most aspects of professional work involve the application of esoteric, specialised (not universally shared) knowledge to form judgements as to the necessary and sufficient action to be taken to try to serve the needs of a client. The work generally entails making decisions and taking action in situations when the effects of action are unpredictable. Moreover, the work requires establishing privileged and confidential relationships between the professional and the client where the former's behaviour, attitudes and '<u>manner</u>' of weighing alternatives, making judgements, taking decisions and instituting actions are important elements in the success of providing the required client service - service which will satisfy the client's needs and address his problems. In professional work, the

worker's background and basic and specialised knowledge and experience, attitudes, behaviour and process are interrelated and are crucially related to the substantive outcomes of service. Therefore, in this kind of work, behaviour subsumed under the term 'ethical' is critical to 'success', which is defined as the provision of appropriate and effective service which addresses the client's needs.

However, in a modern society, the context and conditions of professional work are constantly changing. Recurring changes have to be faced about the knowledge entailed in the work: the technology used; the characteristics, culture and problems of the clientele; the social and economic conditions; the legal controls and requirements; and the settings in which the client's problems arise and the service must be provided. Hence there are changes in the governmental and legal response to the changed conditions and in the what the profession regards as a proper professional response to the new conditions and problem situations.

It is increasingly apparent that professional workers face double jeopardy in their work. Their professional bodies develop codes of ethical principles intended to act as a guide to their work and a constraint upon their behaviour. These principles are expressed in absolute but general terms and are, therefore, difficult to apply in complicated practice situations which tend to be anything but simple and clear cut. Situations develop in which one ethical imperative may be in direct conflict with another. Practice situations arise whose contextual and circumstantial details modify (or even nullify) the applicability and utility of the general principle. Practice situations arise where the worker is torn between the value systems of two clients holding quite different expectations of 'appropriate and proper' professional conduct. They also involve the expectations of professional colleagues who are sensitive to varying judgements but hold strong images of orthodox and acceptable professional behaviour ('That is something we do not do; that is a strong taboo for a ....').

When such situations occur, the worker is faced with a dilemma which influences professional judgement as to the proper delivery of service. An occupation's code of general ethical principles which guide practice, and the professional debate about the best way to adhere to them in a given set of circumstances signals to the workers involved in that occupation, and to the general public, the 'professionalization' which has developed for different types of work. The professional group may claim autonomy of judgement and decision-making in its practice (or share this responsibility with other types of organisations, such as the state or unions), but part of this "professional project" involves the dilemmas and debates about 'grey' areas of practice, and claims of expertise (Larson, 1984). The member of such a group, who makes a 'wrong' judgement and decides to act in a certain manner, risks censure not only from an immediate supervisor but from his professional colleagues generally. If the profession is self-governing, he may well face the kind of disciplinary action which bars him from further work of that type. Such a risk is unique to the professional worker. It goes well beyond that of the non-professional worker who may make an unfortunate error which costs him his immediate job, but does not exclude him from seeking comparable employment with another employer.

Detailed examples of the ethical dilemmas and risks which are the common practice experience of the three professions represented in the research for this thesis are described in Chapter Four. It considers them in terms of the clauses in their professional codes of conduct and the concept of ethics in action as distinct from ethics in theory - a concept which might be described as recognizing the 'space' between the philosophy of moral behaviour and the application of moral behaviour.

STRUCTURE OF THE THESIS

Chapter Two provides a review of the relevant academic theory and literature about professions and professionalization. The specific field research undertaken for this thesis is located within the general framework of the Sociology of the Professions and the connection my

research has to this body of theory is discussed.

Chapter Three further develops these themes by reference to professional codes of conduct in general. This is followed by a discussion of the concept morality in theory as belief and precept and the concept of morality in application as behaviour, and the difficulties of matching in perfect and precise fashion the two. Finally some of the similarities and differences between professional codes of ethics are examined.

Professional codes of conduct of those of the three professions studied in the research project are discussed in Chapter Four. Detailed examples related to the ethical dilemmas encountered by nurses, social workers and pastoral care workers are discussed. This is followed by a discussion about the professional imperative of client confidentiality and the primacy of the client's interest.

Chapter Five has three main sections. It first lists the assumptions upon which this study rests. It then lists and explains the general and specific research questions which were investigated for this thesis, illustrating the relationship between ethical diktat in codes, ethical dilemma in practice, and how dilemma is resolved so that the daily work of the professional may proceed successfully. The second section reviews the prior research in the area. The third presents the research design chosen for this project and describes the research steps undertaken.

Chapter Six gives a brief factual report of the characteristics of the research respondents, describing their sex, age, racial origin and professional background.

There then follow four chapters which analyze the rich anecdotal material which emerged during the interviews - the justifications for and the nature of respondents' choices, and the opinions offered in discussions of the case materials and the legal, ethical and policy framework. These four chapters have been organised in relation to certain themes which

became evident during the analysis. Each of the four vignettes is discussed in each of these chapters.

Chapter Seven considers this evidence in terms of the consistency of respondents' replies and decisions. Consistency implies predictability and is of great importance in the practitioner/client relationship. But even more important is the professional consistency on which colleagues and related professional workers rely. Therefore, it was important to read the interview materials analytically to find evidence of consistency/inconsistency of decisions about when to decide to disclose (what complicating variable triggered the decision to disclose), and to whom disclosure could be made and still be judged ethically acceptable.

In professional work which involves making judgements in complex situations, it is important for the practitioner to make consistent judgements, stable in spite of a set of urgent distractions. Do the interview transcripts reveal respondents who are able to predict their own decisions? If, in the initial stages of a vignette, a respondent decided that confidentiality should be maintained but discussed the circumstance in which disclosure would likely have been made (a common occurrence, with examples from experience of similar circumstances cited), did the respondent actually make the disclosure decision when such circumstances were present at later stages in the case story? The need for consistency of decision-making in professional work is an important issue. It implies reliability and predictability, a quality important to colleagues, the client and related third parties (e.g. the client's family). It is the reason that best practice norms are established; the norms of expected ethical response are no less important. Therefore, the question of respondents' consistency was used as one of the major variables for analysis of the respondents' explanations and choices.

Moreover, the question of consistency of response to a described practice situation which involves an ethical conflict has interest in own right. There is the question: to what extent was each vignette case interpreted

similarly across the three professional groups? Was there greater variance in consistency of reaction between the nurses', social workers' and pastoral care workers' decisions about the cases in the author's research instrument, than variance within each group? In the interviews when respondents drew upon their own training and experience to explain and justify their (hypothetical) reactions and decisions, did they not only stress different aspects of a vignette but also react differently to the same issue in the different cases?

This question of variations in judging the resolution of an ethical dilemma, led to the issue of conflicting loyalties which is the subject of Chapter Eight. Analysis of the conversations with respondents revealed an unmistakeable hierarchy of loyalties - to fellow colleagues, to one's own kind of professional generally, to clients, to the employing agency or institution, to non-professionals involved in their work area, to interested or related third parties, etc. The questions addressed in the analysis for this chapter were:

> Can the evidence of the transcripts be said to demonstrate the existence of a 'team ethic' which runs across the various professions represented?
>
> How did 'team ethic loyalty' affect decisions about the sharing of information?
>
> What happened when there were conflicts between the team ethic loyalty and other loyalties?

Throughout the interviews participants explained the reasons for their judgements and the decisions they would have made had they been faced with the case described in the vignette and later had been called to account for and justify their actions. Frankly and openly they considered the alternatives and argued for their choices. But how many participants fully acknowledged the ethical dilemmas they were facing and the difficult

choices which forced them to choose one principle or interest over another? Was every participant fully able to recognise the dilemma these vignettes were designed to test, or, amidst all this careful and deliberate reasoning did some workers demonstrate a kind of reluctance to face fully the implications of their choices? Did some participants avoid the issue? Ideally, professionals are expected to be able to make ethical choices which they know to be difficult and personally challenging. This involves an element of trust, on the part of the public and the profession, that the professional worker can be relied on to consider fully the ethical dimension of his choices, rather than hide behind some other rationalization for his action. Chapter Nine considers this issue of rationalization, describing how these rationalizations occurred, and attempting to examine why.

Chapter Ten considers the utility of the general framework of law, professional codes of ethics, and public policy (within which the respondents were operating), to assist or guide the practitioners in their decisions. Were participants aware of the law which affects information use and confidentiality? Did they take this into account in making their choices? Did they aspire to fulfil the codes of conduct held by their respective professions and cite them as a reason for their choices? Were their choices constrained by the policy of their various employers? This material is analyzed in terms of differences between the three professional groups.

The concluding chapter of the thesis returns once more to the research questions posed at the beginning, relating them to the evidence of the interviews to point out respondents' consensus on what is the common issue of confidentiality and the disclosure of client information, what similarities and differences of approach were revealed, what convictions about practitioner accountability and risk emerged, and whether the notion of a continuum of integration into a cooperating professional network, with the three occupations representing stages in development, was sustained by the information provided by this sample of respondents. The

chapter ends with a brief discussion of the implications of these findings in terms of professional regulation and public policy and the possibility of extending them with further research.

Note: In this thesis the word 'client' has been used throughout for reasons of consistency and clarity. Different professions have different accepted terms. Nurses often refer to people as 'patients', although community nurses are not always fully comfortable with this term when applied to someone they regularly see outside hospital, and they sometimes adopt the term 'client'. However, in Social Service Departments, the term 'client' has fallen into disrepute, as somehow derogatory, and 'service user' (or 'user' for short) is more commonly used by the new generation of workers (although many of the more experienced staff still use the term 'client'). However, 'user' is not a term favoured by some nurses who feel it suggests drug abuse. Chaplains use different terminology again: 'parishioner' and 'church member' (or 'member' for short) were terms which respondents often used, in addition to the less common 'client'. I have chosen to use the term 'client' throughout this thesis, because it was the one term which all three professions recognised with a common meaning, even if it is not the preferred terminology for any one of them.

Throughout this thesis I have used the pronoun 'he' (him, his, etc.) avoiding the clumsy usage of he/she (him/her, etc.) when referring to individuals whose sex is not specified, or where the singular pronoun is being used generically. This should not be misconstrued as indicative of sexist bias. It is in keeping with correct non-sexist academic English usage (Hawkins, 1986, p 375; and The Shorter Oxford Englsih Dictionary of Historical Principles (O.E.D.), 1973, pp. 935 -936). In addition, I have consistently adopted 'he' when discussing specific respondent's decisions, regardless of whether the actual person interviewed (from whom that particular example was taken) was male or female. This has been done to enhance respondents' confidentiality.

CHAPTER TWO

PROFESSIONS AND PROFESSIONALIZATION

This chapter contains five main sections, which discuss the general theory behind the research. A theoretical framework for this thesis is located in the Sociology of the Professions. The relevance of much of this theory to the very specific and detailed "practice-oriented" approach taken in the field-work or data collection and analysis section of this work is not immediately apparent, and so this issue is discussed in the first section of this chapter, locating my specific research project within the wider body of sociological theory. This chapter then includes a brief review of some of the literature relating to the History of the Sociology of the Professions, and main themes discussed by this body of academic theory. The general theory leads on to a more specific discussion about issues of professionalism and ethical accountability, which, although still theoretical, are nonetheless more central to the field research undertaken about professional ethical decision-making and boundaries of confidentiality. This, in turn, leads to a brief discussion about difficulties in inter-professional relationships, which is also central to this research since it involves a comparison of three related professions all working in the same general field with the same type of clientele. Finally, I look at how my particular research findings add to the body of knowledge about professional behaviour. It must be noted that my literature review is not intended to be entirely comprehensive and exhaustive. There are many examples of scholarly academic work which have not been included. The literature review is intended simply to place my field research in context rather than serve as a thorough analysis of the development of the Sociology of the Professions.

RELEVANCE OF THE SOCIOLOGY OF THE PROFESSIONS TO THIS RESEARCH PROJECT

During the twentieth century, and particularly in the last fifty years, western industrialised nations have experienced a tremendous reorganisation in most aspects of their societies, not least in government and industry. New technology, which transformed transportation and communication systems (e.g. fax machines and computers), and widespread

re-organisation of business and industry (e.g. industrialization of third world nations and loss of heavy industry and manufacturing in western nations) as well as the proliferation of large bureaucracies in all walks of life (e.g. Food: Productions quotas and farm subsidies administered by the British Government and European Economic Union), have changed the ways in which work is organised. Few established occupations have been exempt. Work has been transformed as a result of these changes and many new specialized occupations have developed, each claiming unique expertise and, sometimes, trying to establish a monopoly over the same work procedures. This century has also seen the expansion of occupations whose workers provide such personal services as nursing, providing social and welfare advice and counselling, etc. (Hugman, 1991). Tasks, advice and assistance which formerly were provided within the extended family now are offered by professional experts employed in large institutions and bureaucratic organisational settings. Since 'people' workers are employed in a variety of settings and perform a variety of tasks, they have developed a number of unique occupational organisations. However, this movement in western society toward the 'professionalization' of labour now pervades the entire economy - occupations in business and industry, government, the law and the armed services, as well as the personal service occupations in health, education and welfare. Writing more than thirty years ago, Hughes pointed out that:

> Professions are more numerous than ever before. Professional people are a larger proportion of the labour force. The professional attitude, or mood, is likewise more widespread; professional status, more sought after. These are components of the professional trend, a phenomenon of all the highly industrialised and urban societies; a trend that apparently accompanies industrialization and urbanization irrespective of political ideologies and systems. The professional trend is closely associated with the bureaucratic.... (Hughes, 1963, p. 655).

Hughes, of course, was writing of the United States where, it may be said, the "professionalization" of the labour force expanded early and rapidly. But what he observed in North America is now as evident in 1990's Britain. One has only to compare the 1921 and 1991 census occupational classifications of western nations to observe how greatly the 'technical

and professional' occupations have proliferated. Harris (1989) noted that occupational organisations and codes of professional conduct have increased with the specialisation of work. As new technological advancements create demands for different consultants and 'experts', many who work in specialised fields have found it beneficial to develop formal links with others who have the same expertise in order to pursue common occupational interests. In some cases this has led to unionization (e.g. Police); in other cases professional associations have been formed which take on some characteristics of unions but which also reflect broad professional concerns and issues (e.g. National Association of Probation Officers). In some instances both unions and professional associations have been created with members belonging to both organisations for different purposes (e.g. U.K.C.C. is the professional association for nurses, but many also belong to the Royal College of Nursing, which acts as a union), but the unions and associations act in concert whenever their interests dovetail (Rabban, 1991).

Considerable interest has developed about the nature and function of professional associations and their impact on the work environment and other social institutions. Many broad questions have been raised about professions and professionalization which still are the subject of academic discussion. For example, researchers have investigated what characterises a professional association as distinct from other types of organisations (e.g. Hickson and Thomas, 1969; MacDonald, 1984; MacDonald, 1985; Halliday, 1985 and 1987). They have also considered the effects professional associations have on conditions of work (e.g. Abbott, 1988). Questions have been raised about the kind of relationships professional organisations have with each other and with other types of organisations (e.g. Burrage, 1990; Burrage and Torstendahl, 1990). Some people have studied the location of professions with the class structure (e.g. Crompton and Jones, 1984; Penn, 1985; Savage et. al., 1992). Academics have also considered what impact professionalization has on the work being done (e.g. Arney, 1982)? Other issues raised have included: to what extent do professions control their work (e.g. Murphy 1990); to what extent are

they part of a wider controlling network of social structures (e.g. Siegrist, 1990; Morgan, 1990); to what extent are professions rivals for control in competition with other power networks (e.g. Johnson, 1982; Fielding and Portwood, 1980; Cooper, et. al., 1988)? Social scientists have examined the 'macrocosm' of the movement toward professionalization of work in this century by analyzing the inter-relationships of professions with various aspects of complex modern western nations (MacDonald, 1995).

Complementary to this, interest has also developed about the 'microcosm' of the individual professional's work and the process by which people are 'professionalized' through their training, work environment and their occupations' governing bodies. One question which is repeatedly asked is which has more influence on the individual practitioner: the professional organisation or the employer (Whittington and Bellaby, 1979; Glastonbury, et. al., 1982)? How are professional imperatives of one's own profession altered by the need to cooperate with people from other professions, and how does the practitioner reconcile these differences (Gamelspacher, 1986)? What part does ethical rhetoric - which often suggests the individual practitioner and the profession are supposed to act altruistically in the client's best interests (rather than self-interestedly) play in this (Saks, 1995)? Do professionals recognise their own function of providing legitimacy to established social institutions (Bailey and Brake, 1975; Beaumont, 1976; Simpkin, 1983; Rodger, 1988)? All these issues have been discussed by social scientists.

My research project does not attempt to provide 'answers' to all these complex questions. Excellent work has been done in these fields of study but many of the issues (in particular those focusing on the 'macrocosm' of professionalization) are adjacent to the focus of my research, and in many ways irrelevant to the specific field research undertaken for this thesis. Nonetheless, they are mentioned in order to acknowledge the overall framework and contributions provided by the general study of the theory about professions, within which this particular research is

located. The data presented and analyzed in Chapters Six through Nine of this thesis contribute to the body of research about the 'microcosm' of professional work. Chapters Seven and Eight jointly demonstrate the considerable disparity between the ethical rhetoric about the importance of confidentiality in the three chosen professions, and the reality of day-to-day practice. Chapter Eight details how the need to cooperate with other professionals (and para-professionals) can affect professional decision-making. Chapter Nine contributes to our understanding of individual accountability for professional decisions. The data presented in Chapter Ten examine the extent to which legal requirements, professional codes or employer guidelines do or do not overtly influence individual ethical decisions.

History of Sociology of the Professions: Early work in this area examined the characteristics of professions, to determine what distinguished a true 'profession' from a 'semi-profession' or a 'union', and examine how a professional association could promote its members' collective interests (e.g. Goode, 1957; Etzioni, 1969). The key roles which specialised education, codes of ethics and codes of conduct, and professional discipline could play in establishing a well-respected profession, and the inter-relationship between these three factors was closely examined (Millerson, 1964, p. 120 - 180).

Although, in the early study of professions, by sociologists like Carr-Saunders and Wilson (1933), the inherently controlling nature of professional associations was recognised, analysis was generally positive and optimistic. Some occupations, otherwise dismissed as not 'real' professions, became keen to assert their claim to true professional status, arguing either that they did really meet the identifying criteria, or modifying the criteria slightly to reflect their own circumstances. The personal service professions have been at the forefront of this approach (Flexner, 1915; Bennett and Hokenstadt, 1973).

Critics of this 'attribute' analysis noted that study of attributes could

focus improperly on outcomes (in effect counting the number of professions) rather than examining the process by which an occupation becomes a profession, and the effect this status has on a given profession's relationships with other occupations, employers, or clients (Roth, 1974). Hughes (1963) argued that the real focus of sociological enquiry ought to be the circumstances which drive an occupation to assert professional status, rather than the simple question whether or not any given occupation was or was not a 'profession'.

More critical accounts of professional activities such as Illich's work (1973, 1977) represented a minority opinion not widely held in mainstream sociological analysis of professions. However, interactionists did note a disparity between the interactions of individuals and groups of professionals as they constructed their day-to-day working relationships and professional careers and the abstract standards which they formally espoused, often through their codes of ethics. Thus doctors' ethical ideals of altruism might be expressed in cynicism in practice (Becker et. al., 1961).

More recent study of the professions has examined the power relationships between professionals and their clients, between professions and other types of organisations, and between different professions. Industrial sociologists have noted the increasing bureaucratization of work as government and governmental services (e.g. Rowbottom, et. al., 1973 and 1974), and business and their various agencies developed into large hierarchical organisations employing vast numbers of workers (Braverman, 1974; Jackson, 1970). Synchronous with this was expansion in the number of professional associations and variety of work settings for professionals, and generally increasing level of skilled workers (Littler, 1982; Wood, 1982 and 1989). Although discussion about the degree to which any given occupation may have 'professionalized' (in the sense of organising itself, its members and seeking to gain autonomous control over a particular area of work or knowledge, separate from any employer), has not been completely abandoned, in the tradition of Weber, sociologists

have also examined the inter-relationship of professional power with organisational interests, as competing forms of occupational control (Kornhauser, 1962). Some agree with Harries-Jenkins (1970) that:

> No longer can it be assumed that the 'ideal-type' professional, if such a man ever existed, is the independent free practitioner who practices his calling in a purely entrepreneurial role. The professional of today is often a salaried employee, performing his activities within the structural framework of a bureaucratic hierarchy.... He is a member of two institutions - the profession and the organisation. Each of these attempts to control his occupational activities, and the manner in which the former establishes standards and norms for the conduct of professional activities, contrasts with the way in which the latter specifies task objectives, and controls the means whereby these objectives are realized (p. 53).

This analysis has considerable appeal for personal service professions such as social work and nursing, whose members work in very diverse settings and who may express a fluctuating sense of professional solidarity *versus* identification with employer objectives, depending on their circumstances (Roach Anleu, 1992). However, Oppenheimer (1973) argued that this led to the increasing 'proletarianization' of the professional as he lost autonomy and power, becoming merely a cog in a bureaucratic machine, with the professional organisation an ineffectual means of promoting individual interests.

> While professionals maintain an unusual degree of skill and discretion in carrying out specialized technical procedures, they are increasingly stripped of authority to select their own projects or clients and to make major budgetary and policy decisions. This suggests less a post-industrial 'new class' of governing experts than a new stratum of semi-autonomous highly credentialed and privileged technicians (Derber, 1983, p. 334).

This is a continuing theme which Haug (1988) and Murphy (1990) have also debated.

An alternative thesis argued that professions and bureaucracies complement one another (rather than compete) in the way they organise work, workers and work ethics (Hall, 1968). The apparent 'anti-bureaucracy' position of professional associations, which is based on individual expertise and a

service ideal as exemplified in codes of ethics, is deceptive (Larson, 1977). Professional legitimacy usually relies on state bureaucracy and legislative power to enforce its claims to ownership of specialised knowledge and expertise - ownership which is central to any given professions' ability to promote itself. Larson noted that professions are deeply involved with most aspects of everyday life in modern complex capitalist societies and enjoy close proximity to powerful governing and bureaucratic bodies. Although their interests may not always be identical they may frequently act in mutual support of one another rather than opposition (1977).

More recently, Bertilsson (1990) postulated that professions have emerged (or become increasingly successful) as components of the welfare state, both administering it and being regulated by it. Bertilsson argued that there is an intrinsic relationship between state authority, professional power and the development of citizen's rights which has driven the development of formal professions and professional discipline as a way of protecting various different interests.[2] Many professionals now recognise the underlying social control function inherent in their work.[3]

Johnson suggested that "occupations which are associated with peculiarly acute tensions... have given rise to a number of institutionalised forms

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[2] Approaching this from a different, complementary, perspective is Foucault (1965), who examines how the redefinition of deviance into insanity was intertwined with the advancement of 'civilization', and development of various 'experts' (e.g. medical doctors specializing in the study of the brain and madness) whose new responsibility it was to control this problem.

[3] This is particularly evident when one reads the professional literature of mental health occupations (psychiatry, psychology, nursing, social work, etc). The history of mental health law and treatment in western industrialised nations demonstrates very clearly how the professions involved with the mentally ill have often clearly served as a 'soft' method of social control, complementing the overtly controlling functions of the police, Criminal Courts and prisons (Szasz, 1962; Strumpf and Tomes, 1993; Davis et. al., 1997). Clearly some of the legislative and policy developments in Britain in mental health during the last ten years (e.g. the implementation of comprehensive post-discharge care plans for certain types of mental patients on discharge from hospital and development of registers for volatile mental-health patients; Gunn, 1996) - developments which are administered by the new 'caring professions' of nursing and social work - are evidence which supports Bertilsson's thesis that some professions are developing as components of the welfare state, both administering it and being regulated by it.

of control, 'professionalism' being one", and that "a profession is not, then, an occupation, but a means of controlling an occupation" (1972, p. 45). He argued that power relationships (particularly unequal relationships between professionals and their clients) assist some workers to define their own expertise, areas of work, and working conditions which in turn affects the degree to which a given occupation 'professionalizes'. He argued that the extent to which the producer of services (i.e. the professional) was able to control the relationship with the consumer of those services (the client) determined the extent to which the professional was successful and benefits (Johnson, 1980).

Larson noted that:

> Professionalization is an attempt to translate one order of scarce resources - special knowledge and skills - into another - social and economic rewards. To maintain scarcity implies a tendency to monopoly; monopoly of expertise in the market, monopoly of status in a system of stratification. The focus on the constitution of professional markets leads to comparing different professions in terms of 'marketability' of their specific cognitive resources (Larson, 1977, p. xvii).

In other words, although professions may frequently act in concert with one another, and with other kinds of powerful bodies (e.g. government bureaucracies), they are also often in direct competition with one another. Their particular spheres of expertise and work may overlap. The extent to which one profession is more effective in asserting its influence and expertise over another competitive profession affects the power, status and financial reward which accrue to its members:

> A fundamental fact of professional life [is] interprofessional competition.... It is the history of jurisdictional disputes that is the real, the determining history of professions (Abbott, 1988, p. 2).

Cultural and historical differences have also affected how professions become established in different places. For example: Burrage (1988) discussed how the legal professions developed in different ways in the U.S.A., England and France, which was related to the different political

and cultural influences operating in those three countries. The differences in the political power networks affected the relationship between the legal professions and the state, which in turn affected licensing and monopoly of professional interests.

In the last twenty years there has also been increasing awareness of the impact which sexual[4] divisions have had on professions and professionalization. For instance, Witz (1992) points to how the medical establishment effectively excluded females from the profession in the 19th Century, using a variety of other organisations to assist this process of group closure and exclusion (while the women excluded staked out their own sphere of eligibility and boundaries of practice in the new "women's" professions such as nursing). The extent to which a given occupation evokes a specialised body of esoteric knowledge as the basis for professional monopoly can have a tremendous effect on the acceptance which a newly emerging profession receives from other already established organisations (e.g. other occupations, government regulators, the legal establishment, etc.). Many of the female dominated professions (of which two are social work and nursing) emphasize occupational experience, a personal vocation and aptitude, and 'caring' as being at least equally important to the professional task as specialist academic knowledge (MacKay, 1990). It is argued this has affected the development of these 'female' professions as a whole, the roles the occupational associations play within the wider community (and relationships with other professions and employers), and their power bases and acceptance by the state (Abbott and Wallace, 1990). In some cases, the professions have created their own body of esoteric knowledge or developed a new field of study (Sheppard, 1990). Within other professions, not openly viewed as necessarily being

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[4] In current academic and professional literature the terms 'sex' and 'gender' are often both used, sometimes somewhat confusingly, to refer to whether a person is male or female. Grammatically, however, 'sex' is the correct usage within English (Hawkins, 1986; O.E.D., 1973). 'Gender' is a term used for grammatical classification of objects roughly corresponding to the two sexes and sexlessness (and English is a language which does not include gender classification of words in the way some other languages do, for example: French). In the interests of clarity and consistency I have chosen to use the term 'sex', rather than 'gender'.

the preserves of either males or females, it has been argued that the concept that the better practitioner should have some innate talent which could not be overtly taught in a formal curriculum, has been used to exclude women from certain aspects of the profession (Atkinson and Delamont, 1990).

Regardless of the exact nature of the relationship between professional organisations and other kinds of organisations (such as bureaucracies or unions), between one profession and another, or between the state and professions, MacDonald (1995) has argued that "in order to achieve monopoly, or at least licensure, an occupation must have a special relation with the state" (p. 34). Once this has been achieved, it then must "compete in the market place against others who can provide similar or substitute or complementary services" (MacDonald, 1995, p. 34). In contrast, Johnson has suggested that:

> ... the state is viewed as an ensemble of institutions, procedures, tactics, calculations, knowledge and technologies, which together comprise the particular direction that the state has taken; the residue or outcome of governing. One strand in the plethora of such outcomes has been the institution of expertise in the form of professions (Johnson, 1994, p. 140).

Tied in with this is the issue of regulation of individual professionals by their professional associations and/or the state and regulation of the professional associations by the state and/or market place. The state can, at times, sponsor the professional association whose task it is to regulate the practitioner's work; it can use the regulatory body to promote particular actions desired by the state and it can also act to regulate the professional body itself (Turner, 1992; MacDonald, 1995). The ideological necessity of this regulation is usually endorsed by the profession (Robson, et. al., 1994). This is a process which is currently occurring within the field of social work in the 1990s. In Britain the long campaign for a state-endorsed (and funded) regulatory social work council has been spearheaded by the British Association of Social Workers (in concert with other social work organisations, such as the Social Care Association and National Institute for Social Work), which has published

many articles endorsing the project in its professional magazine (e.g. B.A.S.W., 1998). Central to this professional regulation is the issue of accountability.

PROFESSIONS AND ETHICAL ACCOUNTABILITY

Professionals employed in bureaucratic settings, whether in the public sector or not, find themselves subjected to frequent controls in the exercise of professional judgement, controls imposed by virtue of agency or institutional 'policy', regulations, traditions and decision-making structures. This applies to all professional workers, not merely those in the 'caring' professions, but it is particularly acute for those employed by government or organisations funded by government (such as Health Trusts)[5]. For example, architects and town planners usually have to reconcile the wishes of several different bureaucratic offices and political and community groups, represented on review and approval committees whose membership changes and whose interpretation of 'policy' depends upon their prior agendas.[6]

The theoretical debate about the nature of professions and professionalism, bureaucracy and work organisation, and personal *versus*

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[5] Witness the additional pressures for public accountability which have been placed on various health professionals (not simply nurses, social workers and hospital chaplains) by the development of the Patient's Charter (Department of Health, 1991). However, contrasting with this, is the perceived lack of accountability demonstrated through cumbersome complaints procedures, leading one critic to comment:

> *If someone of negative intent had sat down to create a system for patients to complain about health care they would have been unlikely to have come up with anything as unhelpful as the present system, if that is what it can be called (Simanowitz, 1995, p. 61-62).*

[6] For example, in 1985 a study was undertaken to examine the problems associated with the Radford Flats housing estate (inner city council housing which was notorious for a variety of structural and social problems). Since the planners who undertook this study could not agree on their final proposal, in the end several proposals were incorporated into the report offering a variety of different solutions which nonetheless would all solve the problems of the complex and fulfil the criteria for town planning regulations, etc. (Institute of Planning Studies, 1985). In their report, the planners openly acknowledged that the 'correctness' the different proposals, and their varying levels of acceptability to the approval committee which would review them, was dependent on committee members' own agendas and priorities about which type of housing was most needed.

collective interests has taken place within a societal context of growing demand for accountability and "openness", for the definition and practice of acceptable standards of competence and morality[7]. The growing demand for publicly stated behavioral standards and individual and collective accountability has not been confined to professions; it has been applied to politicians and others in public office in the form of intense scrutiny for conflicts of interest (e.g. the recent 'cash-for-questions' furore which dogged the former Conservative Government) and recently to corporate directors in terms of liability for public safety.

However, the demand has had a peculiar significance for professions since their members generally claim unique authority based on specialised knowledge used within an ethical framework (via codes of ethics, codes of conduct, or codes of 'best' practice). The governing professional associations use this to justify the claim for autonomy of decision-making in applying professionals' unique expertise (Barber, 1963, pp. 676 - 678). However, there seems to be some inconsistency if professions or employers justify individual practitioners' work judgements, decisions and activities by virtue of their unique ability to recognize and solve complex problems (by using special knowledge and expertise) and then collectively constrain practitioners by adopting prescriptive codes of ethics and codes of practice.

Unthinking trust in, and acceptance of professional behaviour and decisions is a thing of the past. Haug (1973) suggests that the growing demand for accountability and the defensive reaction of specifying acceptable behaviour may actually lead to de-professionalization, rather than increased professional discipline. However this prediction runs counter to the traditional theoretical perspective about professional development and accountability which places accountability and the development of a professional organization with code of ethics (or

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[7] For example: the Social Work Inspectorate Services states part of its purpose is to inspect services to ensure they "genuinely meet people's needs, and the public has confidence in them" (S.W.I.S., 1996, p. 1).

conduct) at the pivotal centre of the development of a profession (Moore, 1970) - particularly as an institution which provides a public service (rather than simply a self-serving occupational association which a trade union is often perceived as being).

Despite the proliferation of codes of ethics and professional guidelines about ethical behaviour, and (in some cases) the development of disciplinary mechanisms to deal with infractions, critics point out that the governing bodies of professions have frequently acted in ways which protect their own members (Smith, 1989), or their organisation's public reputation, rather than serve the public interest (Saks, 1995)[8]. In short, professions have not been immune to severe criticism about their own lack of accountability. For example: the General Medical Council and the U.K.C.C. (and the Health Trusts which employ the practitioners) have been accused of covering up malpractice and failing to protect the public, and instead sacrificing patients' interests in favour of protecting incompetent individual doctors and nurses (Lloyd-Bostock, 1992; Stacey, 1992; Hunt, 1995). Social Services Departments[9], and the social work professionals employed in them, have also been harshly criticised for failing to promote good practice in the public interest and instead accused of acting out of expediency and self-interest (Hunt, 1998). Even when clear covering up of bad practice has not taken place, complaints can sometimes point out how the common day-to-day accepted practice of professionals and/or organisations better serves professional needs and operational organisational interests rather than the wishes or needs of the client (Burke et. al., 1995; Tschudin, 1995).

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[8] This type of criticism has not only been levelled at professional associations. Employers have also been criticised, particularly in cases where an employee complains within the organisation about some problem, only to find there is no adequate avenue for the complaint to be heard, and the employee himself is then targeted as a 'troublemaker'. This has led to the development of guidance for employers to assist them in developing an accountable workplace (National Health Service Management Executive, 1993; B.A.S.W., 1995).

[9] Currently there is no one professional governing body for all social workers, and it is generally employers and/or individual practitioners who have been criticised.

Professions are not static organisations; they progress and change. Bucher (1961 and 1962) argues that within any profession there are different segments which develop distinctive identities and compete for control of the organisation, acting like social movements and, in the process, transforming the profession as a whole. Often it is the more highly educated members of a professional group, located within the professional schools whose task it is to train neophyte professionals, who spearhead these changes, although tension can develop between the educators and field practitioners, who view the former as overly theoretical and divorced from day-to-day reality (Derber, 1990).

McKinlay (1973) notes that professions 'regulate' change. They often use their ethical claims of public service, expertise, and trust, to bolster their power and increase their ability to control any change which might adversely affect their professional interests. The bureaucracies which represent the professions to Government and the public also use the 'ethical accountability' argument to steer their members' compliance toward their own image of 'correct' professional behaviour.

For example, within the 'people' professions competition between different factions to direct change and regulate their work can be seen. The development of a professional code of ethics and debate over how to implement it becomes one focus for this intra-professional competition. For example: Pinker has warned that within social work, the occupation's perceived preoccupation with ethical ideals and moral transformation may lead to its discredit and eventual powerlessness (in Humphries et. al., 1988, p. 19). But, in contrast, Utting praises social work's pursuit of an ethical framework, claiming that its "surest claims to professionalism... lie in an ethical basis and a standard of conduct...." (Utting, 1991, p. 24). Certainly, in social work in the 1990s, we can see a prime example of an occupation in a state of change, with the ongoing debate about the scope of its work, 'professionalism', and organisational change (Hugman, 1991).

INTERPROFESSIONAL RELATIONSHIPS

Disagreements over appropriate ethics and standards of competent practice are not, of course, confined to different segments within a profession. Professions also compete among themselves for direction over work procedures, behaviour and standards. This competition can become particularly acute when the locus and range of a profession's work changes, or when professions must cooperate or share responsibility for a particular area of service (Freidson, 1986). One example is that of the health visitors who encounter inter-professional conflicts in child protection situations; they have been criticised by social workers for their ethical stance on confidentiality (Taylor and Tilley, 1989). Another may be seen among nurses and doctors where difficulties in professional cooperation are attributed to their different professional orientations, ethical frameworks and moral reasoning (Uden et. al., 1992).

Interprofessional conflict undoubtedly arises from the 'mind set' developed as young professionals are educated, trained in the procedures and practices of their future work and socialized into its approach to analyzing problems and making decisions, all of which enables them to apply their professional knowledge with skill to the task they face (Freidson, 1994). In short they are inducted into the profession's orthodox way of thinking. To them, subjectively, an important part of becoming a 'professional' (as opposed to an interested lay person) is learning the norms of behaviour and ethical decision-making which they expect to share with other members of their profession.

Thus Dingwall (1979) noted how health visitors acquire a repertoire of behaviours and learn the norms and values appropriate to their work from their professional tutors. Professionals' socialization involves not merely learning a series of scientific facts or skills necessary to perform the job function, but goes beyond this to include assimilation of a comprehensive style of service and method of 'professional' interaction with the client. Once this is achieved, interprofessional disagreement can arise over perceived differences in norms and values between members of

different (albeit related) professions - particularly if they share a client group (e.g. doctors and nurses who may work on the same hospital ward).

It can also arise through overlapping definitions of their work boundaries, and from the conviction that certain services can only be well provided by persons working from their perspective who share their background. The boundaries of professional work are constantly changing and they are not immutable; they depend upon circumstances, technology and settings (Hugman, 1991). For example, the nurse practitioner in some settings undertakes, in limited form, some of the work of the physician (diagnostic and prescriptive functions for a limited range of conditions; Pitcairn and Flauhaut, 1974). The public health nurse, now frequently named the community health nurse, takes over the health promotion role, part of the work of the community social worker or the health education worker (American Public Health Association, 1980; Archer, 1982) The pharmacist goes beyond filling prescriptions to become an adviser on the effect of the prescribed medication, particularly to the elderly customer who is already taking a variety of other drugs, a task doctors also fulfil, but a kind of usurpation of role the medical establishment is prepared to tolerate while it does not substantially interfere with the medical monopoly (Watkins, 1987). In the area of mental health, the various professions which serve the mentally ill have all played an enormous part in defining the field of study, 'scientific' knowledge, overlapping areas of expertise and responsibility, and control of work (Daniel, 1998).

SOCIOLOGY OF THE PROFESSIONS AND THIS RESEARCH PROJECT

This research reflects one small aspect of the wider theoretical framework provided by the Sociology of the Professions. It falls within the tradition of social science research about the 'microcosm' of professional behaviours. The data presented and analyzed in this thesis demonstrate the complexity of the professional task of ethical choice and justification of decision-making. The adage "motives are never unmixed" is amply proven

by the frank discussion of the professionals about their reasons for choosing to breach strict confidentiality. The difficult nature of the professional task and practitioners' acceptance of their moral responsibility and professional accountability are also shown.

The research provides evidence of the way in which individual practitioners' professional choices sometimes serve to reinforce organisational imperatives (such as interprofessional cooperation) and social institutions (such as the family), or the existing social order (e.g. legal responsibilities under the Mental Health Act, 1983), at the expense of individual client's wishes. It also provides evidence of how choice is justified as the correct ethical action based on the particular circumstances unique to that individual case.

The sometimes simplistic rhetoric of the code of ethics implies that the individual client's opinions should always be respected and his choices upheld. The professional literature, particularly that used by those professional schools responsible for training the 'new crop' of practitioners, seldom reflects the reality of work experience, and the fact that the 'client' may not really be the named individual with whom the professional is working (e.g. the mental-health patient being visited by the community psychiatric nurse), but, in actuality, in certain circumstances, could be that person's family, the community in which he lives, or, indeed, in some sense the 'social order'. 'Macro' sociological analysis can show that professions and professionals hold powerful positions in the existing social order and often act in ways which reinforce that order. 'Micro' sociological analysis, can show that, in specific individual circumstances, professional workers sometimes act more as agents of social stability (if not outright social control), than as altruistic concerned individuals who place primacy upon the individual client's best interests.

In my research I asked participants to explain why they made decisions to breach confidentiality, even when the sharing of information was contrary

to the client's explicit request. Respondents' explanations revealed a complex tapestry of conflicting loyalties towards several different potential 'clients' and interprofessional networks, as well as towards themselves as practitioners - loyalties which ultimately led many to disregard the named clients' wishes in favour of some other professional imperative. In addition, the research explores the extent to which participants recognised and actively acknowledged the choices they were making, or 'explained away' their decisions or responsibility. These decisions strike at the heart of the issue of professional accountability, one of the main recurring themes in the academic literature about professions and professionalism. Society demands that professionals and the organisations they work within are accountable for their work decisions and actions (Day and Klein, 1987), but the question remains to whom must they be accountable and how is this to be determined and ensured?

CHAPTER THREE

PROFESSIONAL ETHICS, PROFESSIONAL DEVELOPMENT, AND PROFESSIONAL IDENTITY

This chapter provides additional theoretical background information to the research undertaken for this thesis, and begins the research exercise by examining some codes of ethics (conduct), albeit in a limited way. It contains three main sections. First there is a brief general discussion of the conflict between ethics as representations of belief (or principle) and ethics as rules governing behaviour, and the tension provided through competing theoretical frameworks for ethical choice: deontological 'rules' *versus* utilitarian 'good results'. There follows a brief discussion of professional ethical codes in general and their role in professional development and group identity. Finally, comparison is made between several professional codes of ethics at a theoretical level, showing their similarities and differences and the type of inner inconsistency (conflict between the requirement of one clause with the exhortation of another) commonly found which causes ethical dilemmas and produces risk for practitioners.

This comparison is not intended as a fully comprehensive analysis of <u>all</u> codes of ethics, nor even as an exhaustive analysis of the few codes which have been selected for discussion. A fully comprehensive analysis of "all" professional codes (however defined) would, by itself, be sufficient for a Ph.D. thesis, without proceeding to the further field research about boundaries of confidentiality which was undertaken for this thesis. The comparison is intended simply to aid reader understanding about the complexity of codes of ethics.

ETHICS AS BELIEF AND PRACTICE

Often there is a gap between ethics as belief and ethics as practice; this difference exists because of the differing nature of the two. Belief (or ideology) is based on generalities and is usually expressed in abstract terms. The verbal acceptance of belief does not necessarily imply that the believer will actually follow whatever the tenet is. Belief usually accepts some element of fallibility of mankind in acceding to absolutes.

For example: Christianity includes the concept of forgiveness, which would be unnecessary if everyone always acted 'good' in terms of the values of the Christian doctrines (Libby, 1992). However, there are different interpretations of those doctrines and where there are circumstances which justify 'non good' (e.g. Augustine's concept of free will and divine causation which is inscrutable (Kirwan, 1991) then there is admission of 'non good' and the necessity for forgiveness (e.g. Heywood, 1998). However, 'beliefs' vary in the extent of their forgiveness. We recognize that it can be fairly easy to agree verbally with a 'principle', particularly if you can accept the basic premise which underlies it. But it is difficult to follow it absolutely in practice under all conditions (Davis, 1991).

This holds true for all people, not simply professionals who must follow special ethical guidelines particular to their work. If we consider the principle of 'honesty', we are provided with a simple example. In our society there is a general belief that it is right to be honest and wrong to be dishonest. Yet, from time to time in small specific ways, most moral people still, with equanimity, act dishonestly. They may not feel much (if any) guilt about these actions. The actions may not be illegal; they are merely unethical, and as such would not attract any external sanctions such as a criminal charge. An example of this would be finding something of value. It is quite common. If it is money and of a picayune amount, then one would not go to great lengths to try to return the 'lost' item. One might not even go through a pro forma action. However, if it is a substantial sum of cash, most people would feel they ought to make a real effort to hand it over to some authority (e.g. the lost and found department if it was found in a store); their 'consciences would prick them' if they did not. Yet, in complete contrast with this moral principle, we have a children's saying, frequently invoked in controversy: 'finders keepers' - which also reflects the public mores in our society. Part of our socialisation, from when we are children, leads to our 'internalising' various general principles which guide our actions (Kohlberg, 1971 and 1981). We learn (through a combination of deliberate

teaching and experience) how to apply these principles in real life situations, so that we appreciate the moral dimension to our choices while reconciling ourselves to the differences between the theoretical or abstract principle and the applied standard for everyday circumstances (Stouffer, 1949; Aronfreed, 1968; Kohlberg and Kramer, 1969).

However, people are socialised in different ways with different beliefs. They may hold some principles in common, but not all. Alternatively, some may give more weight to one principle and others place more emphasis on a different aspect of their 'belief' (Bowker, 1994). At the level of folklore and traditional 'wise sayings' or proverbs, there is common recognition of this gap, and of the possibilities for disagreement arising between belief and practice. We see it in such common tags as: 'I agree with you in principle but not in practice' and conversely 'I can accept this in practice but not in principle'. Such phrases encompass mankind's need for compromises from the ideal, living in this world which seldom provides the conditions necessary for the exercise of the ideal (Carr, 1991).

Moreover, although one might agree wholeheartedly with some first general statement of belief, still, as the specific statements of sub-belief or related-belief are added, one might at various points feel it necessary to begin to disagree (or to disagree in certain circumstances; Bowker, 1994). Codes of ethics which have successive clauses, not all of which are held with equally fervent belief, provoke this kind of disagreement amongst professionals. In other words, some 'beliefs' are more expendable than others. Indeed, this is what I have tried to show in the vignettes used for this research, as one after another the complicating variables are added to the initial description of each commonly encountered type of case.

Mankind does not always act as if it is a rational, logical species. And society accommodates to this, while still expecting morally predictable 'good' behaviour. Thus moral codes provide for moral error (Clarke, 1987).

However, professional ethical codes cannot tolerate a high level of 'error' and unpredictable behaviour. They are not intended to be an impossible ideal which has to be compromised regularly and can be departed from readily without guilt or penalty. They are intended to be a guide (often even more - a rule) governing work behaviour which encompasses attitudes, relationships, activities, decisions, judgements and procedures. The ethics of belief may agree that certain activities are ethically acceptable in a service relationship, but the ethics of practice may reject them entirely, or may doubt that they are acceptable given the circumstances of the specific case (Tadd, 1998).

Two major competing frameworks for ethical action exist within moral philosophy and applied ethics, where the difficulty of correct decision-making and the existence of inherent contradictions have long been recognised: deontology and utilitarianism (Thompson, et. al., 1994). The development of codes of ethics falls within the tradition of deontological ethics. The discussions of professional governing bodies about which principles 'must' be included as those inherently correct overriding ethical values which permeate all areas of work, demonstrate a clear legacy of Kantian philosophy and deontological ethical debate (O'Neill, 1991), as is discussed in the next section in this chapter.

Clearly deontological ethics underlie the proscriptive basis of many professional codes of ethics and employers' policies, as well as professional or occupational disciplinary systems which maintain them David, et. al., 1997). Periodic public enquiries into tragedies which produce long lists of recommendations for new policy to regulate professional action also rely, at least in part, on a deontological framework for analyzing 'correct' decision-making. There is a presumption that, by issuing rules or principles intended to govern future professional behaviour and decision-making, somehow correct practice can be determined by a set of objective standards not reliant on the subjective judgement of individuals with their personal bias or the vagaries of chance (Mihill, 1995). However, in addition to this, the

specific tragic set of circumstances which sparked the enquiry also have an impact on the judgement about correct decision-making (Sheppard, 1995). No enquiry would be necessary had there been a 'good result' to begin with. Inquiry is only called for when something has clearly 'gone wrong', and there is a serious question about the quality of service and professional judgement which occurred in a given set of circumstances (Powell, 1998). Thus the forum of the public enquiry provides a crossover between deontological ethics and its competing framework for ethical choice, utilitarianism.

The alternative framework for determining ethical choice provided by utilitarian philosophy focuses on the ultimate 'usefulness' of the decision to help achieve the desired end-result (Pettit, 1991). Simply put: if the action helped to achieve a 'good' result, then it was a 'good' decision which led to the action. If the outcome was tragic then it cannot have been a 'good' decision. Such a philosophy requires that the effective professional has the wisdom (knowledge of alternatives, judgement, experience, etc.) to predict accurately what will be the favourable or unfavourable outcomes of various decisions when faced with situations involving the conflicting values and moral/ethical dilemmas of more than one party (Tadd, 1998). Professional governing bodies tend to argue that one of the hallmarks of the skilled professional practitioner is his ability to accurately apply his esoteric body of knowledge and special experience in order to reliably and predictably choose the 'good result' time and time again, when a lay practitioner could not do this[10]. Utilitarian philosophy provides a theoretical ethical framework for this claim.

The existence of competing frameworks has been acknowledged in much of the

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[10] Similarly, Wall and Rowden (1995) note that N.H.S. managers tend to operate within a utilitarian framework and "may describe their obligation as one of maximising benefits to the greatest number of patients" (p. 29). They go on to indicate that, given recent examples of bad publicity which the N.H.S. management has received, it is important for "managers to state explicitly their adherence to ethical values and ethical behaviour" (p. 32). However, rhetoric aside, the question remains: whose values and behaviour, and following which ethical model?

professional literatures of social work and nursing (Allmark, 1992; Omery, 1989; Webb and McBeath, 1989), but seldom in that of pastoral counselling. Nursing has also begun examination of various models as a method for making ethically correct professional choices. The 'process' approach contained in these models acknowledges the contribution which a deontologically based code of ethics makes to ethical professional choice, but also gives an important role to specific practical circumstances and the desired outcome, and therefore provides for one or more overriding 'rules' for decision-making (Greipp, 1992).

However, it must be recognised that there is a paradox contained in much of this. Nursing has borrowed many of the underlying principles of its code of ethics (autonomy or self-determination, beneficence or doing good, non-maleficence or do-no-harm, justice or fairness, and responsibility or personal accountability) from medicine (Beauchamp and Childress, 1994). This effectively elevates the ultimate outcome of an action such as 'doing good' or 'doing-no-harm' to the level of a deontological rule - a contradiction in terms. Medicine has also noted the tremendous difficulty contained in judging the value or correctness of an intervention, particularly in the human arena, by this standard, given the research problems associated with evaluation and likelihood of multiple outcomes (some good, some bad) to any action (Beauchamp and Childress, 1994). This poses difficult implications for public policy makers in assessing services and promoting professional accountability (McKnight, 1989).

Notwithstanding this inherent problem, the various professional literatures continue to discuss applied ethics in terms related to their own occupations, thus refining their codes with advice on specific behaviours and decisions in work situations exclusive to their profession. Those who favour the deontological framework for making ethical decisions argue that "a thorough understanding of one's code of ethics is the foundation of professionalism" (Anderson, 1992, p. 25). They hold that it is the creation of a code of ethics which marks the beginning of "systematic development" of professional ethics in a given occupation

(Smith and Davis, 1985, p. 335). They consider that "the anticipated consequences of professional acts cannot serve as a valid basis for formulating principles of... ethics" (Levy, 1976, p. 81). They also argue for the importance of a code of ethics as a valued protection for both professional and clients' rights (Hare-Mustin, et. al., 1979). In other words, it is claimed that the professional's knowledge of his occupation's code of ethics will greatly assist the professional worker to make 'correct' decisions when faced with situations involving moral/ethical dilemmas - that amounts to saying that 'the rule' must determine behaviour.

In contrast, the alternative position for professionals suggests that, far from applying some rule to reflect an absolute standard of right or wrong behaviour, "solving ethical dilemmas depends more on the situation than the rules" (Woodruff, 1985, p. 301). Fry believes that practical models have more value in teaching applied clinical ethics to neophyte professionals than rules, since "the student must realize that ethics is not merely the application of a 'formula' of accepted rules, principles, and theories whenever moral conflicts arise in patient care" (Fry, 1989, p. 491). Some professionals also argue that determining the correct course of action involves assessment of the risk of harm (to patient, practitioner and third parties) and assessment of the likely outcome of the intervention (either to prevent harm, or assist a greater good). Review of such factors by the professional should help determine the ethically appropriate response (Fowler, 1989).

Some of the literature on professional practice is beginning to acknowledge that absolute standards of 'right' and 'wrong' cannot exist in all places for all time; a modern professional must accept "the inevitability of living with moral uncertainty" (Hirschfield, 1985, p. 319). Yet accepting this "inevitable moral uncertainty" has implications for any public policy which openly legitimizes professional judgement and discretion (albeit within limitations). This is particularly important since one of the claims which an occupation makes when seeking to gain

recognition for its 'professionalism' involves the consistency, predictability and reliability of a skilled professional's judgement. Similarly, Governments, in authorizing a professional regulating and registering body and legally recognising the exclusive right of certain workers to certain fields of work, also do so on the basis of consistency, predictability and reliability of the skilled workers' judgements[11].

How much autonomy of decision-making is really allowed to the individual practitioner "on the ground"? How much decision-making is reserved for the professional guiding body, the employing agency, and institutions representing the interests of wider society (e.g. the Courts, public enquiries)? Potentially legitimate questions may arise regularly about the basis for worker choice, and the way individual professionals' decisions de facto form policy at a "street level" (Lipsky, 1980). Such policy, in practice, may not conform to the stated written objectives of high-level policy makers, even while the individuals who have implemented it must justify it in those terms. Hudson suggests this is a double-edged sword since:

> ... bureaucracies *require* people to make decisions about other people. Indeed in defence of their activities, organisations will frequently point to the expertise of their members rather than to the success of their endeavours. But once an agency admits that its members have special skills, it also admits to a limitation of the right to define appropriate... behaviour (Hudson, 1993, p. 388).

This tension between the ethical framework for choice provided by the code of ethics (deontology), and the competing ethical framework of looking for the 'good result' (utilitarianism) is one of the pressures carried by individual professionals as they make decisions in day-to-day practice. Exactly how this is resolved, which framework they find more useful, might well affect the decisions professionals make in situations which involve

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[11] For example: Thomas (1995) noted that when drafting the Children Act, 1989, there was a debate about whether or not to place a statutory obligation on social workers to notify police about instances of child abuse, but in the end this was left as "a matter for the social worker's professional judgement" (Thomas, 1995, p. 114).

ethical conflicts, and this should be evident in their analysis of situations and their reasoning to justify the decisions taken. In my research, as respondents discussed in detail how and why they made their decisions information emerged about the framework for ethical decision-making being used. It became apparent whether the respondent was relying upon some 'rule' (code of ethics, policy or law, common procedure of their employer) to determine the correct action because of the intrinsic merit underlying the guiding principle, or whether his choice was guided by the search for the 'good result'. The extent to which participants invoked a deontological framework or relied on their ethical code to justify decisions is discussed in Chapter Ten.

CODES OF ETHICS, PROFESSIONAL DEVELOPMENT AND GROUP NORMS

During this century many paid occupations have been claiming the professional status formerly accorded only to the members of such self-governing and self-employed (fee-for-service) occupations as physician, solicitor or barrister (e.g. Toren, 1972). In counterpoint, many members of the traditional professions have accepted appointments as paid employees (or as quasi-employees paid on approved scales from the public purse. For example: medical doctors paid by the National Health Service). By the 1990s, as the census classifications in all western countries will attest, the number of 'professions' had greatly increased over the number seen at the turn of the century (Wilensky, 1964; Harris, 1996), and academic social scientists for several decades had been studying the effects and implications of the 'professionalization' of the labour force and the autonomy of the professional employed in a salaried setting (Perkin, 1989; Watkins et. al., 1992).

As the members of an occupation organise for recognition as a profession, one of their first activities is to develop a code of ethics (sometimes a code of practice with the ethical clauses included therein). Why? What purpose does a code of ethics serve? Why is it so important as to require intense discussion and considerable controversial professional writing (as was the case with the three professions studied in this thesis, as

described later in this chapter)? Different historical forces may drive the leadership of different occupations and the academics related to it to feel that the specific moral and ethical framework for their work needs to be spelled out and enshrined as a code. Nonetheless, however different their history, they commonly develop codes (e.g. accountancy and medicine, Stewart, 1977; Ramsey, 1988). Why do they place the highest importance on stating categorically what should be the proper moral and ethical framework - governing work behaviour - in their kind of work? What, moreover, persuades them that it is not dysfunctional to insist (thereby limiting the freedom of judgement and activity of their member colleagues) that all who wish to perform that kind of work must observe all the code's imperatives wherever they practice, whether independently or as an employee? Ethical codes are not permissive. They are not the pie-in-the-sky expression of the ideal. They are mandatory, and they are intended to control members' daily work behaviour so that it conforms to accepted orthodoxy (Harris, 1996). Why is this deemed to be necessary and desirable?

Part of the answer to the latter question lies with two kinds of failure (error of commission and error of omission) which professionals might commit in relation to their work, failure which could lead to risk to the other members of the profession and even entail the risk (by association) of bringing the entire group into disrepute (Bayles, 1981). The first may be said to be an 'efficiency risk' - that the individual's work shows evidence of incompetence or neglect, or while once adequate is not now up to the currently expected minimum standard of practice. The second may be said to be a 'moral risk', that the professional's work behaviour has been unethical and thus put the client at risk, and/or that it has been 'unethical' in the sense beyond the normal ethics which govern all in the value system of that society, and/or it is in breach of a specific moral diktat expressed in the code of the profession. Therefore, the unethical individual has been morally unreliable and lacks integrity[12].

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[12] As will be demonstrated later, the concept of "integrity" is common to professional codes of ethics.

One source for the answer to the question of why codes of ethics have been judged to be important, even essential, may be found in the writings of labour and industrial sociologists who study occupations and work settings. One of the earliest of these, Emile Durkheim, analyzing occupational controls concluded:

> There is no form of social activity which can do without the appropriate moral discipline.... It is this discipline which curbs him, that marks the boundaries, that tells him what his relations with his associates should be, where illicit encroachments begin, and what he must pay in current dues toward the maintenance of the community. Since the precise function of this discipline is to confront the individual with aims that are not his own, that are beyond his grasp and exterior to him, the discipline seems to him - and in some ways is so in reality - as something exterior to himself and also dominating him (Durkheim, 1958, pp. 14 - 15).

Thus one major tool for the exercise of "moral discipline" over the members of a professional occupation is its ethical code. These additional constraints, which are not imposed on other workers, are argued as being necessary because of the type of work and the conditions under which it is done. Moreover, while the code is being formulated (and seemingly endlessly thereafter) there is debate on the nature of the 'professionalism' of this type of work and what that professionalism requires ethically (e.g. British Medical Association, 1993). The ethical standards espoused by many professions share certain common characteristics. For example, many require their members to ask themselves such questions as: 'How should this decision be made?' and 'Who should decide?', and 'For whose benefit am I acting?'. And they insist that members analyze issues implicit in such questions not simply in terms of technical expertise but also as value-laden problems (May, 1980).

The underlying basis for ethical codes within many professions (including nursing, social work, and the chaplaincy) lies within the realm of moral philosophy and applied ethics. The questions discussed in the philosophy

of Kant have dominated this field[13]: Do certain concepts contain intrinsic value or does their value depend on derivative factors? Can universally applicable maxims be identified which prescribe appropriate actions? Once one has placed a value on an item by virtue of its intrinsic merit, how does that rank in comparison with another value which also has intrinsic merit? Making a value judgement that something is 'good' or 'bad', or 'better' or 'worse' involves rationally comparing and consciously accepting or discarding (Webb and McBeath, 1989). What criteria should be used in making a specific judgement? How can value judgements be validated? What is the 'best' course of action and how can this be decided? What is a valid 'reason' for justifying a specific course of action? How can one 'reason' be weighed against another? (Baier, 1958).

If conflicts in principles develop how are they to be resolved? In an ideal world any and all the things one morally 'ought' to do can be done. But, patently this is not an ideal world. How can inconsistent and mutually exclusive obligations and the moral dilemmas which spring from them be resolved (Rescher, 1987)? Moral conflicts arise from conflicts in duties; in considering such conflicts which 'duty' is obligatory and absolute, and which is merely desirable (Atkinson, 1969)? Struggles of ethical conscience are: "especially acute when the individual is confronted with the necessity for choosing, as conspicuously as possible, between a strong drive and important values, or among several values crucial to his convictions" (Alishjahbana, 1966, p. 20).

How do value judgements held by individuals become collectively held as social values? "How is agreement possible and why should an agent's actions be guided by social values even when this runs counter to his private interests" (Collingridge, 1982, p. 43)? How are professional and social morality affected by differences between social groups (e.g.

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[13] In the pages that follow I have listed a large number of rhetorical questions. These are drawn from the related literature on ethics and philosophy, which uses this type of grandiose question quite freely, before launching into erudite theoretical discussion (which has not been reproduced herein).

whether one is a member of a particular occupational group, or social class)? How does 'role' determine one's moral position (Ossowska, 1971)? How dependent is the particular judgement, regarding the morality (or ethical value) of a social relationship between two parties, on the roles of the individuals involved (Downie, 1977, p. 121 - 145)?

Philosophers and academics have the luxury of considering all these questions from abstract theoretical perspectives. In professional work they are the fundamental basis of common ethical dilemmas, questions which individual practitioners face as practical choices when making judgements and decisions in real-life situations. However, the issues of moral philosophy are not confined solely to individual conscience. Occupational groups (and indeed other groups[14]) also face them as they relate specifically to the milieu in which the group operates. As the members of the group face these issues and make their value judgements, group norms are identified and develop over time. From these norms ethical codes are developed, and the norms, in turn, further develop and refine ethical codes. Norms constitute:

> ... a scale of values which defines a range of acceptable (and unacceptable) attitudes and behaviours for members of a social unit. Norms specify, more or less precisely, certain rules for how group members should behave and thus are the basis for mutual expectations amongst group members. General norms and norms which refer to peripheral aspects of group life will have wide tolerance, while on issues which are central to the group's existence... the bounds of acceptable behaviour will be quite restrictive (Brown, 1988, pp. 42 and 46 - 47).

Usually, group norms do not develop quickly or easily. Much discussion, negotiation and compromise is necessary before a standard is adopted. Nor are group norms static[15]. They evolve, changing with changed circumstances.

> There is a suggestion according to which one ought to give up the question of how norms come about and ask instead what are

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[14] For Example: Silberbauer (1991) discusses how ethics derive from group norms in "small scale societies".

[15] For example: when Harris (1996) compiled his directory of professional codes he noted many had changed, or were in process of revision.

> their conditions of existence. The rationale of this suggestion is simple and pointed. Norms do not as a rule come into existence at a definite point in time, nor are they the result of a manageable number of identifiable acts. They are, rather, the resultant of complex patterns of a large number of people over a protracted period of time (Ullmann-Margalit, 1977, pp. 7 -8).

In other words, when norms are expressed in terms of statements of expected behaviour it can only be after awareness has been built up of common problems and common decisions regarding behavioral limits. Once established, the group norms act to restrict the behaviour of individuals in the group, but only for those behaviours and attitudes to which moral diktat is attached, and these must accord with the morality espoused by the group ethic.

This concordance is established by a number of mechanisms. First, groups, institutions and organisations *educate* their members (and aspiring members) about what the values, ethics and normal behaviour of the group are (Zander, 1983). For many occupations this begins in the pre-practice training period. At all times neophyte members of a trade or profession are not only inducted into the knowledge base and practice tasks for which the profession has established (or is trying to establish) itself as a monopoly, but neophytes are also socialised into an appropriate mind-set which includes moral/ethical attitudes and values, relationships and behaviours which may be uniquely necessary for the conduct of their professional work. These are not necessarily ascribed to generally in their society (e.g. the 'love ethic' described by Fletcher, 1979).

Second, *conformity* to standards is then encouraged through a system of rewards (Scott, 1987). The first of these, of course, is admission to full status for the professional work itself. Beyond that adherence to group norms allows entry into professional jobs which carry with them high status and above average financial remuneration. Third, overt *non-conformity* to the group's ethical code can be punished. For example, a minor breach of efficiency or ethical standard might require the non-conformist to repeat a training programme (designed to re-impress the norm anew on the recalcitrant member). Repeated failures to comply with the

efficiency or ethical norms might result in exclusion from the group (Zander, 1983). For the fully self-governing professions sanctions include not only suspension or withdrawal of licence, but also other types of censure which can inhibit professional career progress (Abbott, 1983). Fourth, *discussion* of implementation problems (e.g. difficult decisions and dilemmas arising in practice) then refines the general tenets of the ethical and practice codes into a specific formal code of mandatory conduct. Fifth, increasingly, professional organisations require their members to demonstrate continuing compliance with the standards espoused by the code of conduct, including ethical standards (e.g. through continuing education, or a portfolio of practice, etc.), without which the practitioner may be de-registered or have his licence revoked[16]. My research project explored the group norms of behaviour and decision-making for each of my chosen professions and, through practitioners' own acknowledgement of the inherent dilemmas and implementation problems which arose, contributes to the body of academic and professional knowledge which in turn contributes to the refinement of formal codes of conduct.

CODES OF ETHICS COMPARED

The code of ethics (and/or practice) of one profession often bears considerable similarity with that of another profession, even though the circumstances in which the principles are applied are very different. The comparison of codes reveals this. For example, consider the similarity between the following four statements of principle from very different professions:

> Every member shall conduct all his professional affairs faithfully and honourably (Institute of Incorporated Executive Engineers, 1989);
>
> It is incumbent on all members to uphold the highest standards of honesty and integrity in all their dealings (The Chartered Institute of Bankers in Scotland, 1991);
>
> ... a teacher should behave at all times in such a manner as

[16] For example: Nurses are required to submit proof of continuing education and competence and re-register every three years. However, even when professions require this (and not all do), there are problems with ensuring the continued competence of practitioners (Stacey, 1995).

> to demonstrate personal courtesy and integrity... (National Association of Head Teachers, no date);
>
> They shall value integrity, impartiality and respect for persons and evidence and shall seek to establish the highest ethical standards in their work (The British Psychological Society, 1993).

Slightly different language may have been used in each instance, but essentially these different statements all reflect the same values. Similarly, these same four professions, despite their clear differences, all have codes of ethics which express effectively identical principles where confidentiality is concerned:

> Every member... shall have regards to the interest of his employer and maintain the confidentiality of matters entrusted to him (Institute of Incorporated Executive Engineers, 1989);
>
> The concept of banking implies trust of the highest possible order and confidentiality is of paramount importance in the professional conduct of a member (The Chartered Institute of Bankers in Scotland, 1991);
>
> Members of the profession should... respect the confidentiality of information relating to pupils unless its disclosure is either required by law or is in the best interests of a particular pupil (National Association of Head Teachers, no date);
>
> ... they shall take all reasonable steps to preserve the confidentiality of information acquired through their professional practice or research and to protect the privacy of individuals or organizations about whom information is collected or held (The British Psychological Society, 1993).

Once again, these general exhortations about ethical practice sound very similar, even when the application of these principles might be very different given the different kinds of work undertaken by each professional. The type of personal information a banker might need to protect (e.g. about a client's finances), is likely to be very different from the kind of personal information a psychologist may need to protect (e.g. marital problems, propensity to violence, alcohol abuse, anxiety, depression). Nonetheless, the wording of all these codes of conduct clearly presupposes that confidentiality <u>should be</u> and <u>will be</u> maintained as a matter of course.

Another principle which crosses professional boundaries is that involving continuing competence. Consider the codes of ethics of another four professions:

> Members will ensure that they maintain a satisfactory standard of professional competence, such that... their practice is restricted within the limits of their own competence and... further education and training will be undertaken when necessary (British Association of Psychotherapists, no date);
>
> ... therapists are expected to continue to maintain and advance their knowledge and skills throughout their careers. [They] should recognise the limits of their professional competence and, as appropriate, refer clients to other professionals where these limits are exceeded (The College of Speech and Language Therapists, 1991);
>
> Every member shall strive for accurate and increasing knowledge in forestry and related topics to the benefit of society (Institute of Chartered Foresters, 1982);
>
> Members shall take all reasonable steps to maintain their professional competence throughout their working lives and shall comply with the Council's continuing professional development regulations as amended from time to time (The Royal Town Planning Institute, 1994).

Clearly, regardless of the specific details about the kind of work undertaken, occupational associations are concerned that their members are properly qualified, competently produce work of a high quality, and continue to develop their knowledge about their professional work in line with new developments in the field (improvements in techniques, new research, etc).

Another principle which frequently crosses professional boundaries involves the kind of relationship the professional has with his client. Simply put, this principle exhorts the professional to ensure that these relationships are non-exploitative. For example:

> ... the relationship with the patient is maintained on a professional basis and the patient is not in any way exploited by the practitioner (British Association of Psychotherapists, no date).
>
> Customary ethical standards of behaviour must be observed towards clients. Speech and language therapists must not abuse the position of trust given to them by clients.... They should not enter into personal relationships with clients during any part of the period of intervention (The College of

> Speech and Language Therapists, 1991);
>
> ... a member shall not be engaged, concerned or interested in or accept remuneration from any other business or principals, which may influence or appear to influence the member's judgement or which may give rise to any conflict of interests of his said clients or employers. A member in practice shall act at all times in the best interests of his client or employer (as the case may be) as opposed to his own interests (Institute of Chartered Foresters, 1982);
>
> Members shall not... use to the advantage of themselves... information acquired in confidence in the course of their work. Members shall disclose to their employers or clients any discounts, gifts or commissions received from any third parties in connection with their work as professional planners (The Royal Town Planing Institute, 1994).

At first glance, the wording of these different clauses in the codes of ethics for these four very different professions appears quite dissimilar. Yet despite the obvious differences, there is still considerable agreement. Basically, all four of these codes are placing restrictions on the kinds of relationship a professional may have with his clients, and placing the onus on the professional to ensure the proper boundaries are kept. Common to all professions is the need to ensure the relationship does not exploit the vulnerabilities of the client.

In the cases of the psychotherapist and speech therapist, these vulnerabilities could lead to exploitive emotional relationships and so the code of ethics is worded in such a way that this is prohibited. The very different kinds of professional work undertaken by town planners and foresters make financial exploitation or the receipt of bribes from third parties (who do not have the client's best interests at heart) a more typical kind of exploitation, and so it is this which is referred to in the code. Additionally, it appears that the different kinds of work undertaken by the professionals mean that different parties are identified as the 'client' (e.g. an individual child may be the speech therapist's client, while the 'client' of the town planner employed by a Local Government Department is likely to be the collective general public). This in turn affects the type of potential exploitation which is prohibited. However, regardless of the specific differences related to the type of professional work, at the centre of each ethical clause of this type is

the ban on client exploitation.

The codes do not only cover individual personal adherence. Increasingly, codes of ethics (conduct) require professionals to report organisations or other professionals who breach the standards required by the code. For example:

> Any member having evidence of violation of this Code by another shall present such information to Council by means of a letter addressed under confidential cover to the Secretary (Institute of Chartered Foresters, 1982);
>
> It is the duty of every member, subject to any restrictions imposed by law of the courts, to report to the Institute any alleged breach of this Code of which he or she becomes aware and to assist the Institute in its investigations (The Royal Town Planning Institute, 1994).

As yet, not all professional associations specifically require such reporting of fellow members, although a responsibility to inform on fellow professionals whose practice does not meet proper standards, can be inferred from some other clauses in professional codes. For example:

> A Member shall ensure that any student of theirs shall be aware of and comply with the Code of Ethics (British Association of Psychotherapists, no date);
>
> Speech and language therapists must not publicly impugn the character or competence of professional colleagues. Complaints of a professional nature should be made in the proper manner to the College of Speech and Language Therapists or other professional association as appropriate (The College of Speech and Language Therapists, 1991).

One difficulty with the general statements of principle commonly found in codes of ethics (or practice) is that the principles can contain inherent conflicts. The problems which this creates are not restricted to the specific professional group; they cross professional boundaries. Thus, even professions which seemingly bear little similarity to one another, can find that their codes of ethics include inherent conflicts which force them to compromise one principle in favour of another, and this may affect their relations with other professional groups.

For example, the Institution of Incorporated Executive Engineers requires a member to "have regard to the interests of his employer and maintain the confidentiality of matters entrusted to him", while also requiring the member to "at all times take account of the special responsibility of the Executive Engineer toward the general public" (Institution of Incorporated Executive Engineers, 1989, no page). Clearly these two principles would be in direct conflict if the engineer became aware that safety standards were not being maintained and (for example) a bridge was being built which would likely prove unsafe and dangerous. He would need to report this to some inspection or regulating body and this, in turn, might bring him into conflict with some of the other professionals involved in the design and construction of the bridge, as well as the contractors and the officials of the Local Authority who play an approval and inspection role.

Similarly, there are obvious inherent conflicts evident in the code of conduct which the National Association of Head Teachers has adopted, conflicts relating to sharing information about potential problems. For example: this code requires Head Teachers to "keep in confidence discussions with colleagues concerning professional problems", yet also requires them to "respect parental rights to enquiry, consultation and information with regard to the educational development of their children". The potential for conflict is present when there is a "professional problem" which is openly recognised and discussed amongst teaching staff at a school (e.g. arising, say, from declining funding, or from inadequate professional training about a new policy initiative), but which no-one wants to admit openly to the parents.

The banker's code of practice also contains inherent potential conflicts of interest:

> The performance of an individual may be judged by an employer, by a colleague, by the employer's customers and by the public. It is a member's responsibility to make every effort to satisfy all these different groups (The Chartered Institute of Bankers in Scotland, 1991).

Nowhere does this principle acknowledge that the interests of the bank which is employing the professional and the interests of the bank's customer may not be one and the same. Yet banks make profits selling various financial investments, personal loans, mortgages and other services; their motivation in selling these products to customers is one of corporate profit. However, banking customers may have a very different reason for subscribing to these services, and their best interests in securing these loans, investments, etc. may not dovetail with the bank's interests. In such a case the question arises which client's 'best interests' ought to be given priority by the professional who wishes to make a correct ethical choice?

Similarly, the potential for a conflict of interests related to the issue of deciding the priority of one client's needs over another is not really recognised by speech therapists. They are required to:

> ... maintain professional confidentiality with regard to their clients, and must refrain from disclosing information about a client which has been learned directly or indirectly in a professional capacity (The College of Speech an Language Therapists, 1991).

and yet:

> exceptions from strict observance of this rule which may be considered acceptable... where necessarily imparted to a close relative (or appropriate care giver) on the client's behalf and in the client's best interests (The College of Speech and Language Therapists, 1991)

This wording in the speech therapists' code presumes that the best interests of the client will also be the best interests of the care giver, and vice versa, something which individual practitioners know is not always the case. However, the code of ethics does not give any guidance about how to deal with a situation in which the best interests of both parties are not congruent and a judgement has to be made by the practitioner about whose interests must be given primacy.

Conflicts in ethical values or principles often cross professional

boundaries and are common to people in different occupations. This is particularly apparent if workers are employed in similar kinds of work, or work with the same clientele. The result is that the professional literature about dilemmas commonly found in one profession bears considerable similarity to the professional literature about dilemmas facing a different profession. In the next chapter common kinds of dilemmas are discussed further, in specific relation to the three professions chosen as research subjects for this thesis.

SUMMARY

This chapter has presented some of the theory behind the development of codes of ethics. Debate about the part which morals and ethics play in our society lie within the sphere of moral philosophy. There is a difference between the ethics of belief and principle and ethics in practice; this is seen in 'everyday' life, not just in professional work. The dissonance between principle and practice which exists in the wider community serves as a backdrop for understanding the dissonance which is observed in professional judgement.

As they develop, professional associations generally define the norms and standards of practice for their members, enshrining them in mandatory codes. Some of these standards relate to technical competence (e.g. ensuring the nurse knows the correct procedure for, say, administering an injection). However, some group norms relate not to quality of technique, but the quality of the ethical standards of practice (e.g. ensuring the adult social worker does not abuse the vulnerability of a child client by exploiting him). The development of such ethical standards, and the mechanisms the professional group uses to teach and enforce these standards, can serve to reinforce group boundaries and assist an occupational group to gain status, power and recognition as a 'profession'. Codes of ethics owe a large debt to the Kantian ethical philosophy of 'duty' and 'intrinsic right'. Yet, in professional practice there is tension created by this philosophical bases and the framework of utilitarian philosophy which drives the professional to strive for the

'good result'. These concepts have been introduced in this chapter; the extent to which they appear to have affected the decisions of the research respondents in the research, is explored in a Chapter Ten.

The final section of this chapter examined some of the similarities and differences of a few professional codes of ethics (conduct, practice). This was not intended to be a comprehensive or systematic analysis of all codes of ethics, merely an indication that striking similarities are apparent. Some of the codes of ethics discussed are those of 'people' professions whose practitioners might be expected to encounter similar problems to those chosen as subjects for this research (e.g. psychologists, teachers, psychotherapists and speech therapists). Others were codes of ethics covering very different kinds of occupations - clearly not 'people' or 'caring' professions (e.g. bankers, engineers, foresters, town planners). Nonetheless, certain common principles are to be found in all these codes. It was also noted that several of the cited codes contain inherent ambiguities or conflicts which might well, in practice, create ethical dilemmas for the individual practitioner who has to apply the code to specific situations and make decisions about the provision of service. This is a theme which is explored further in the next chapter, in relation to the specific issue of confidentiality which is the focus of this research, and in relation to the three professional groups who provided respondents for research: nurses, social workers, and pastoral care workers.

CHAPTER FOUR

ETHICAL DILEMMAS IN NURSING, SOCIAL WORK AND THE CHAPLAINCY AND BOUNDARIES OF CONFIDENTIALITY

This chapter continues the exploration of the background of professional debate about ethics in practice which underpins my research. In it, initially the codes of ethics for the three professions are discussed[17]. Various examples are discussed of common conflicting ethical requirements encountered in the literature of nursing, social work and pastoral counselling, which were the starting point for my interest in the topic of this thesis - ethical dilemmas requiring professional judgements which, whatever the practitioner decides, might well involve professional risk (i.e. risk of disapproval of the profession or society and sanction to the worker). Finally the issue of limits of confidentiality (the particular principle tested in the research project) and the legal framework surrounding it are discussed briefly.

CODES OF ETHICS FOR NURSES, SOCIAL WORKERS AND CHAPLAINS

This section is not intended to provide an exhaustive analysis of all the similarities and differences between the codes of ethics of the three professions. Nonetheless it needs to be noted that certain principles which were identified as common to many professions (in Chapter Three) also appear in the codes of nurses, social workers and chaplains. For example, honesty and integrity are held to be key principles underpinning the practice of all three professions. The B.A.C.'s code talks about "integrity, impartiality, and respect" (British Association for Counselling, 1994). Formerly B.A.S.W.'s code exhorted the practitioner to "serve these purposes with integrity" (British Association of Social

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[17] There is no one professional association accepted by all social workers. Many do not belong to any professional association. I have used the code of ethics adopted by B.A.S.W. (rather than the Social Care Association), since it is the association which the 'professionally qualified' social workers tend to join, should they join any professional organisation. Equally there is no one professional association accepted by all pastoral care workers or hospital chaplains. Many hospital chaplains do not belong to any professional association. I have used the code of ethics adopted by the British Association for Counselling (B.A.C.) as the 'chaplain's code' in completing this section. It has been chosen because the British Association for the Advancement of Pastoral Care and Counselling has passed responsibility for accreditation of pastoral counsellors on to B.A.C.

Workers, 1986). Although this was removed when the code was revised in 1996, the general 'flavour' of the way other clauses are worded in the current code, implies this duty, even though it is no longer explicitly stated (B.A.S.W., 1996). The U.K.C.C. code reminds nurses they must "justify public trust and confidence" (United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 1992).

Similarly, the need for confidentiality is upheld by all three. Nurses must:

> protect all confidential information concerning patients and clients obtained in the course of professional practice and make disclosures only with consent, where required by the order of a court or where you can justify disclosure in the wider public interest (U.K.C.C., 1992)

Pastoral counsellors must maintain the confidentiality of information obtained in professional practice, and are only permitted to disclose it to others with the client's consent or in very limited circumstances:

> Counsellors treat with confidence personal information about clients, whether obtained directly or indirectly or by inference.... Counsellors should work within the current agreement with their client about confidentiality. (B.A.C., 1994)[18].

In the social worker's code, there is a section which specifies the restrictions about use of personal information obtained about clients in the course of professional practice. Social workers are prohibited from disclosing such information without the express consent of the client, unless "there is clear evidence of serious danger", or in "other circumstances, judged exceptional, on the basis of professional consideration and consultation" (B.A.S.W., 1996). Although there are

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[18] The B.A.C.'s code continues with more detailed advice about when and how confidentiality may be broken without the consent of the client. Included in this are (a) the grounds of exceptional circumstances only such as a likelihood of the client to cause serious harm to himself or others, (b) the pre-requisite that the counsellor has first discussed the proposed breach of confidentiality in supervision, (c) that the breach of confidentiality must be minimised as much as possible, and (d) that the client is informed about the boundaries of confidentiality.

differences in the exact wording of all three codes, it is clear that the intent behind each code diktat is identical.

All three professional associations specifically require their members to demonstrate continuing competence. Once again there are differences in how the codes' clauses about competence are worded, but, the general intent is the same:

> They accept that continuing professional education and training are basic to the practice of social work, and they hold themselves responsible for the standard of service they give (B.A.S.W., 1996);
>
> Counsellors shall take all reasonable steps to monitor and develop their own competence and to work within the limits of that competence (B.A.C., 1994);
>
> ... acknowledge any limitations in your knowledge and competence and decline any duties or responsibilities unless able to perform them in a safe and skilled manner (U.K.C.C., 1992).

Similarly, the principle of non-exploitation, identified as a common value among codes in Chapter Three, exists within the ethical codes of the three professions, albeit expressed somewhat differently in each:

> Counselling is a non-exploitative activity.... All reasonable steps should be taken to ensure the client's safety during counselling (B.A.C., 1994)[19];
>
> ... avoid any abuse of your privileged relationship with patients and clients and of the privileged access allowed to their person, property, residence or workplace (U.K.C.C., 1992);
>
> They will give precedence to their professional responsibility over their own personal interests (B.A.S.W., 1996).

All three of these professional codes specifically require their members to report problems with another worker's practice to the regulatory or disciplinary body:

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[19] This principle is discussed in more detail in its code of practice and guidance documents, which more explicitly discuss the need to set and maintain professional/client relationship boundaries, and the prohibition against exploiting clients financially, emotionally or sexually (B.A.C., 1994).

> ... report to an appropriate person or authority... any circumstances in the environment of care which could jeopardise standards of practice (U.K.C.C., 1992).
>
> Members have a duty to draw such concerns [about misconduct] about individual members to the Association's attention (B.A.S.W., 1996).
>
> If a counsellor suspects misconduct by another counsellor which cannot be resolved or remedied after discussion with the counsellor concerned, they should implement the Complaints Procedure.... (B.A.C., 1994)

As can be seen, the codes of ethics governing the members of the three professions chosen to participate in this research include many of the principles frequently found in professional codes, regardless of discipline. These three professions all work within similar or related areas of service, or with similar clients (if not actually the same clients). This sometimes leads to the development of similar ethical dilemmas shared by them - all of which makes it appropriate to include all three professions in the sample of research participants.

ETHICAL DILEMMAS IN THE THREE PROFESSIONS CHOSEN FOR RESEARCH

Common dilemmas referred to in the professional literature are reviewed here - first those encountered by nurses, then those of social workers and then those of pastoral counsellors. Since all three are bothered by some of the same conflicts, arising from similar situations (even though they play different roles), the similarity is noted.

Nurses:

The nurse's dilemma to influence or not to influence a patient to feed, referred to briefly in Chapter One, is not an uncommon one and in its simplicity may be fairly easy to resolve. But complexity is added by virtue of the patient's age as well as by virtue of the type of illness involved. Suppose the patient is an infant or young toddler. In such a case, the issue of shared ethical responsibility arises - with the parents, and/or with other relatives such as the grandparents or adult siblings. To what degree is it ethical for the nursing staff to influence a family's decision towards what the nurse regards as beneficial for the

child at the expense of the family's specific personal and moral beliefs in what they regard as essential for the child's welfare? There are possible conflicting demands between the professional practice ethics vis a vis the child's welfare and the following - the institution's policy, the family's moral imperative, and the nurse's personal belief and value system. These provide a rich culture for the growth of debate as to whose "right" should prevail. Such a case is described in Pinch and Spielman (1989).

Nurses report that ethical dilemmas sometimes arise from the allocation of scarce resources. For example if the same specialised nursing equipment is needed at the same time by two patients, how should the priority choice of patient be made (Reeder, 1989)? And nurses who provide fertility counselling to H.I.V. positive women also find themselves debating the ethics of providing such counselling and assisting a woman to make her own decisions about pregnancy. There is a conflict between their duty to assist patients to make their own choices and respect these decisions, and their ethical commitment to promote society's wider interests by reducing the number of children at high risk of being born H.I.V. positive, as well as their duty to the "well-being" of the unborn child (Rooks, 1989). Ethical dilemmas can arise when nurses who are dealing with patients who have difficulty communicating (Gadow, 1989). A nurse's obligation to help individual patients can sometimes be in direct conflict with a professional obligation to benefit society, and the framework for determining the correct course of action when this situation exists is not always clear (Fry, 1985).

Similar to this is the conflict between the ethical duty to maintain patient confidentiality *versus* the need to disclose information to others about the potential for contagious disease which would place them at risk if contact continues (Reeder, 1989). The nursing literature openly acknowledges that, despite the public's general perception that nurses hold patient information in a high degree of confidentiality and use such information only in accordance with their 'duty of care' to the individual

patient, in fact "the matter of confidentiality is not as straightforward and clear cut as might be expected" (Jones, 1990, p. 150). For example: a nurse may become aware that a patient is driving despite having a medical condition which leaves him unfit to drive. This poses a danger to others and, therefore, should provoke a report to police - but, the decision to drive or not to drive is not a nursing decision; more than a statement of advice would not be part of her nursing plan, and moreover she specifically is charged with a 'duty of care' to that individual. There are, therefore, many cogent justifications for not reporting to police.

There is another vexatious question that nurses regularly face: What information should be recorded in official files whose contents may be shared with other agencies, confidential information which could thus be disclosed against the client's consent (Pyne, 1992)? In 1988, Thompson et. al. invoked a deontological framework of decision-making to resolve this dilemma:

> The disclosure of information to another health professional involved in his care may be expressly forbidden by a patient. But in certain circumstances, where the patient's safety or welfare is a stake, the nurse may decide, *on principle of beneficence* [my italic], that her duty to care takes precedence over the patient's right to prohibit disclosure of vital facts (Thompson et. al., 1988, p. 131.)

However, in a later edition of the same nursing text, a different approach to the issue was taken:

> Respect for the patient's secrets, his right to privacy, is again complicated by the often over-riding duty to care and to do what is in the best interests of the patient. This may involve the carer in passing on confidential information to another professional in the hope that it will assist in the better care of the patient. Ideally carers have a duty to seek the consent of persons who have confided in them before sharing their secrets, but if it is not possible to get it, then the dilemma arises: which is to take precedence - the patient's right to privacy or the professional's duty to provide the best possible care for the patient? Dilemmas of confidentiality do not arise out of careless disclosures of patient's secrets, but rather when the responsibilities of nurses to their patients, for example, come into conflict with the requirements of team management of patient care or in sharing information with relatives (Thompson et. al.,

1994, p. 80).[20]

Yet the client may be unwilling to accept the professional's decision with which he strongly disagrees, and which is based on the professional belief system that he does not share.

> Professionals are constantly at risk of assuming too readily that the purposes they take to be overriding and to which they have dedicated their careers... are necessarily more rational for all others than conflicting aims. This professional bias has to be taken into account in any decision to override confidentiality on grounds of irrationality and self-harm (Bok, 1984, p. 126).

Conflicts of principle become acute when nursing H.I.V. positive persons:

> If a person is known to be H.I.V. positive, who has the right to know that information? ... Ethically it has been argued that it is justifiable to override confidentiality in the interests of a third party at risk or in 'direct jeopardy'. Sexual partners of an infected person are at risk.... Many people agree that sexual partners should be informed (Grady, 1989, p. 530).

The nursing profession recognises that practitioners have a "right not to engage in practices that violate one's ethical beliefs... so long as the lack of participation does not compromise the safety of the patient" (McElmurray and Zabrocki, 1989, p. 1048). However, in many ways the addition of the latter proviso simply begs the question. What value can be placed on a profession's claim to standards of behaviour which govern <u>all</u> its members, and its claim to possess a firm consistent ethical base for practice and accountability, if the member needs only to claim the pre-eminence of personal ethics in order to violate professional ethics with impunity? And what is the individual practitioner to do if action based on personal ethics does jeopardise the patient or disregards public safety - as might well be claimed in the case of a Catholic who finds himself nursing a woman who is having an abortion, or the Jehovah's

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[20] No matter what the differences are in ethical philosophy, and type of argument, the end result appears to be the same: breach of strict confidentiality is still justified.

Witness who is instructed to give a patient a blood transfusion?

There is a crossover between professional ethics, personal religion and the professional role in relation to spirituality which the nursing literature recognises (Simpson, 1988; Salladay and McDonnell, 1989). However, the conflicts between personal and professional judgement raise many important questions with respect to professional ethical behaviour, particularly when one considers the nature of an ethical code. Is the code merely a desirable set of general principles or is it a set of mandatory instructions governing work behaviour, intended to try to ensure uniformity and predictability of response? If it is merely the first, presumably it is not unique to one kind of work or to work of a professional level of complexity and specialization. Surely all persons in their work would subscribe to the dictum "do no harm"? A professional code is agreed by (and for) a set of workers because it represents a special set of additional constraints to guide their judgement - necessary constraints because of their kind of work. That being the case, the ethical code is perceived by the client and the public as a guarantee that the worker's behaviour will accord to stereotypical, predictably 'standard' behaviour. It is not anticipated that the expected behaviour will be radically changed to conform to the specific worker's religious, political or other beliefs. Since the client is not aware of the personal belief system of the service provider, the degree to which resultant behaviour deviates from the expected stereotype causes uncertainty, lack of confidence and growth of mistrust. Indeed, to the client the professional worker's behaviour may well appear to be unethical.

It is not surprising, therefore, that in the last twenty years nurses have become increasingly concerned about the ethical dimensions of their daily work and disturbed by the discrepancies between their experience and the teaching on nursing ethics they received in qualifying training (Gillon, 1986; Gaul, 1989). Ethical advisory committees and discussion groups have been established in a variety of health and health-related work settings to provide ongoing (post-qualifying) professional development and to

assist nurses in making decisions when ethical dilemmas arise (Murphy, 1989; Scanlon and Fleming, 1989, pp. 984 - 985). Also, the U.K.C.C. has issued advisory papers on areas of practice which commonly provoke controversy and lead to ethical conflicts and distress for practitioners. One such paper systematically addresses the dilemmas related to confidentiality. Its stated purpose is to provide "a framework to assist individual professional judgement" (U.K.C.C., 1987).

Social Workers:

All professionals may, from time to time, face dilemmas arising from owing a 'duty of care' to more than one person, but nowhere does this particular problem seem to be more prevalent or acute than in social work. This was briefly referred to in Chapter One where it was noted that the 'other' persons may be other professionals also trying to serve the client, as well as close family members, the client's colleagues, neighbours and members of the community who may all have a 'need to know'.

For example, if a terminally-ill woman wishes information about her illness to be kept from her family who will nonetheless be affected by it, then the client's "right to confidentiality" has to be balanced against the other family members' "need to know" about serious matters which may well adversely affect their lives, for which they need advance knowledge in order to plan properly (e.g. for the care of children or to make funeral arrangements, Rhodes, 1986, pp. 75-76).

In deciding upon rules for information access, what ethical principle should be paramount? Social workers often use the "need to know" as the practice determinant when assessing how much information ought to be shared. However, the need to know is subject to personal interpretation and is context specific and, therefore, is another 'grey area' where professional judgement will be variable. Ethical dilemmas also arise when a social worker feels he has a 'duty of care' towards more than one person. The 'duty of care' to more than one person (briefly referred to in Chapter One) which may be a simple choice if the other party is another

professional or a close family member (e.g. parent, spouse), is more complex when several other parties are involved and a potential danger to one or all is present.

An example is the case of a social worker attached to a general medical practice who becomes aware that the young dependent son of one patient is regularly visiting another of his patients, a homosexual man with violent tendencies. The social worker must face several questions: Should he disclose his knowledge? And if so, to whom - should he speak only to the young man, only to the older man, to both, or to a third party such as their pastor? Should he warn the mother of the potential danger facing her son, even though this would be a breach of professional/patient confidentiality (Fogarty, 1984)?

Incurable communicable diseases focus ethical dilemmas sharply. Failing to inform others that a client is H.I.V. positive may place someone else at serious risk of infection. Many social workers are highly uncomfortable with the ethical implications of this situation, as Abramson (1990) reported:

> I really feel guilty when I know that someone is H.I.V. positive and that person is living with a woman of childbearing age who doesn't know and I can't tell her that she might have a child who could develop A.I.D.S. (quoted in Abramson, 1990, p. 170).

The H.I.V. positive client whose wife is told of his infection without his consent understandably might be furious at this breach of his personal confidentiality, and consider it highly unprofessional and unethical. So, in keeping with other professions, in recent years social work has recognised that clients need to be informed in advance about the limits of confidentiality. The development of this need has led to the establishment of 'informed consent' counselling. "The concept of informed consent has done much to protect the rights of clients who are served by professionals. Protection is important for social work clients who are vulnerable by virtue of their age, mental or physical capacity, lack of

resources, or other forms of dependency" (Reamer, 1987, p. 428). Unfortunately this concept will not serve all conflict situations and does not free the worker of all risk and the burden of guilt.

Similar to nurses, social workers have reported conflicts respecting client's decisions and autonomy of choice, and a 'duty of care' *to* help and protect the client and those around him. For example, the worker faces a difficult ethical choice when the case involves people who are less than normally capable of making sensible decisions - decisions which, from the worker's standpoint, will serve them best - an example would be an elderly demented person or someone who is disabled (Manger and Oppenheimer, 1989, p. 20; Penhale, 1991). At what point should the professional cease trying to convince the client to accept help voluntarily, and instead impose help on the client in order to prevent suffering and hardship? (Gostin, 1987). Even when social workers acknowledge that their professional role carries with it the necessity and legal authority to coerce, many are reluctant to invoke their power. They believe it should be used rarely and only in the most exceptional cases where failure to act will result in great harm (Henkel, 1985). And, like nurses, social workers have found that society is unlikely to condone their failure to act in cases where, after the fact it became evident that the client posed a certain danger to others.

Balancing the client's wishes against risk to potential 'innocent victims', having available resources to intervene, and the likely effectiveness of action are all factors that lead to a continuum of professionally appropriate ethical decisions. Moreover, decisions must be capable of revisions leading to flexibility in action. The unique factors of a case can alter over time - as was amply demonstrated by Horne's discussion of the progression of the case of Mrs. M. (1987, pp. 47 - 60)[21].

Even in situations where there is real uncertainty about the possible

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[21] This described an elderly client whose living situation and personal abilities were gradually deteriorating leading, over time, to gradually increasing professional intervention, increasing services, and restrictions on personal liberty, as decided by the social worker in charge of the case.

positive outcomes from intervention, if a serious danger to a particularly vulnerable third party might well have been expected to result from the social worker's failure to act, after the fact public disapproval probably would follow even if the feared danger did not emerge[22]. Western societies are increasingly demanding that social workers accept some coercive, overtly controlling, policing function as a normal and regular part of their professional practice - even if practising in this way contravenes their professional ethics (Parry et. al., 1979). This is especially the case if public danger is indubitably present[23]. In Britain, as elsewhere, in recent years social workers have been severely criticised for not acting coercively enough. This is particularly true in two major areas of their work: child protection cases (e.g. Ricki Neave[24]), and the dangerously mentally ill (e.g. Christopher Clunis[25]).

Expectations about intervention are not restricted to situations involving life threatening actions. The case may merely be judged to include a question of 'the public good'. For example: what should the worker do if he becomes aware that a client has lied in order to receive additional benefits to which he is not legally entitled? The social worker faces the

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[22] For example: Muijen (1995) discusses how "moral panics" about professional standards of care have driven law and policy about mental illness in Britain.

[23] Agencies were severely criticised for poor communication between themselves and failure to share records and information (i.e. for maintaining too much confidentiality), in the case of Jason Mitchell. This involved a young man diagnosed with schizophrenia who also had a violent history. He killed three people in December 1993 (Blom-Cooper et. al., 1996; Thompson, 1996).

[24] This refers to the case of Ricki Neave, a child well known to Cambridgeshire Social Services Department. He was on the Child Protection register; his mother warned the department he was at risk of serious injury and asked for him to be taken into care only days before he died. At the mother's trial the Department of Social Services was severely criticised for failing to act.

[25] Christopher Clunis was a former patient at a mental hospital. In 1992, he stabbed and killed Jonathan Zito in an underground station. The resulting public enquiry criticised professionals for failing to share information and failing to coordinate an inter-agency treatment and aftercare plan and made specific recommendations to address these perceived problems in professional judgement and service delivery (Ritchie, et al., 1994; Sheppard, 1996).

ethical dilemma of whether or not to report the client[26]. This is clearly not in the client's best interests (since criminal charges for fraud may be the result) but the alternative is apparently to condone illegal activity, which is not 'good teaching' for the client (something which can be of particular concern if the social worker is dealing with a young person, a case in which this kind of situation is very likely to occur, Thomas, 1995, p. 116), nor one likely to increase respect for the social worker. This is similar to the dilemma which faces the nurse who visits a patient at home and observes stolen property on the premises. Complicating this issue, the worker may be employed by an agency which has a policy of either requiring the worker to report the crime, or restraining him from reporting it, a policy with which he may or may not agree or have strong moral disapproval.[27]

Unlike nursing, the social work profession does not formally recognise that a practitioner's personal principles may, at times, legitimately be in conflict with professional imperatives and take precedence over them. It assumes that whatever constitutes the professionally correct behaviour will coincide with the worker's personal beliefs:

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[26] Thomas (1995) notes that there is no legal obligation on the social worker to report a crime, although there is a common law duty to help the police. This would be left as a matter for professional discretion. The example used (of welfare fraud) involves the added complication that this would not normally be reported to the police, but to the fraud section of the D.S.S.

[27] In a professional teaching text for care workers, Tadd warns that:

> *If staff come into possession of information regarding illegal activities by others they need to be careful not to make promises concerning confidentiality, which they may be unable to keep. If a client admits to a member of staff that they are involved in drug dealing or shoplifting, for instance, staff may have no choice but to report facts to a senior manager. Failure to do this could be seen as condoning criminal activity and even lead to accusations of being an accomplice (Tadd, 1998, p. 71).*

This contrasts with lawyers, who approach this issue very differently. The solicitor has 'privileged communications' with his client; the social worker, nurse and chaplain do not. This means that not only is the lawyer not required to report his client, he would be seriously criticised by his profession and by the Courts if he did so. In this instance the law and the governing profession both recognise that the 'public interest' is being served by the lawyer remaining quiet, just as much as the individual client's personal interests (the Law Society, 1993).

> On the part of the individual practitioner the need for confidentiality will be guided by a personal morality and values acquired during periods of education and training (Thomas, *et. al.*, 1993, p. 23).

Along with nursing, social work has become increasingly aware that its members face ethical dilemmas in their daily practice and that there is need for education in professional ethics to help them cope with difficult decisions. Interest is growing in having such training become an integral part of entry-level qualifying programmes, and advanced-level post-qualifying programmes, and in how most effectively to teach ethics to professionals (C.C.E.T.S.W., 1976, 1991; Mishne, 1981; De Felice, 1982; Butrym, 1983).

Pastoral Counsellors:

For members of this profession the comparable conflicts of client and third party interest, of honouring the client's value system even when it differs from the professional's, of maintaining client confidentiality *versus* condoning or ignoring his actual illegality - these which are shared with the nurses and social workers - are compounded by doubts about the morality of acting as an organised profession at all (Goldner, et. al, 1973). In this country, ever since the formation of the British Association for the Advancement of Pastoral Care and Counselling (A.A.P.C.C.) in the 1970s, there has been resistance to the organisation becoming an exclusive professional association, and resistance to suggestions that all people involved in pastoral care need to undertake training and seek 'proper' professional accreditation.

This raises the fundamental question of whether a 'calling' is paramount to a 'profession', whether intuitive spiritually-based knowledge and understanding can substitute for training-based knowledge and experienced professional judgement. If, for pastoral workers' counselling, the important qualification is recognition by a church of the person's 'calling', then who is to say that specific counselling training must be undertaken before such work can be provided to serve the church's members? Unlike its American counterpart, the A.A.P.C.C. has remained an advisory

and guidance association; it has passed the responsibility for counsellor accreditation to the British Association of Counsellors, which also accredits counsellors who are not clerics or other religious professionals (Foskett, 1992).

Although, traditionally, religious leaders have maintained that a high degree of confidentiality is of utmost importance in their relationship with parishioners, in fact, usually, relatively little training is offered about how this is arranged in practice[28]. Traditionally the Catholic church maintains the absolute sanctity of the confessional, using the classic example of the extreme case, the priest who receives a terrorist's confession of murder. However, in practice, this begs several questions. What, in all conscience, should the religious professional who is not a member of the Catholic faith do, if in a counselling session he is given such information by a Catholic terrorist who assumes that the same confidentiality applies as would apply to a 'confession'? What should the Catholic priest do if he is told about the murder outside of the confessional - should it count as a 'confession'?

This extreme example is also not one which most clerics and religious professionals are likely to encounter in their daily practice. How should they deal with the issue of confidentiality in serious but less extreme examples (such as a distressed person in the midst of a life-crisis, a case involving a child who is being hit by his mother, a case involving antagonism and anti-social behaviour toward a neighbour, a case involving minor criminal behaviour - examples of which are all encountered in the vignettes used in my research)? There is growing recognition that moral problems such as these can cause considerable personal anguish and crises of conscience for religious professionals (Furniss, 1994), however there has been little research about exactly how pastoral workers deal with these problems when they encounter them in professional work.

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[28] Rodgerson's article provides some guidance but does not really assist when ethical dilemmas arise (Rodgerson, 1991).

Moreover, in addition to the issues of appropriate supervision channels, and confidentiality *versus* disclosure, there is the question of good teaching. Training by extreme example, as in the case of the terrorist cited above, is not particularly effective or helpful for the young practitioner. Good teaching materials do not arise from examples the neophyte professional is unlikely ever to meet. Rather, they need materials describing situations involving 'grey areas' where one decision is likely to be as defensible as another, materials which allow for lively discussion and full consideration of the intricacies of a case and analysis of the basic underlying principles. As yet, the body of theological literature for training religious professionals does not fully acknowledge this. It focuses on doctrine, rather than dilemma (e.g. Hick, 1966; Dennett, 1985; Gill, 1985; Soloman, 1994).

However, there is a relatively small but growing discussion within the religious community about the practice dilemmas encountered in pastoral care, particularly in applied work-settings such as chaplaincy within the armed forces, in prisons, hospitals, and colleges (Abercrombie, 1977; Prison Service Chaplaincy, 1984; Hospital Chaplaincies Council, 1987). These debates now acknowledge the value of examining how other professions approach moral dilemmas which affect the ethical behaviour of their members, recognising that many of the principles used (e.g. informed consent) are applicable to pastoral care (Rodgerson, 1991). Guidelines on what constitutes confidentiality, how to keep it, and its limitations on confidentiality in pastoral care are now also being discussed by church organisations (Faith and Order Committee, 1993). There is increasing recognition that pastoral care, in our increasingly secular age, or in times of financial constraint, is not easy and that the conscientious pastoral worker can experience ethical crises in his work (Bradbury, 1989; Taylor, 1983). Pastoral care literature is beginning to discuss the existence of situations causing conflicts of interest and moral ambiguity (Leech, 1990).

However, this body of literature is still very small. In my informal

discussions with the religious professionals who participated in my research (either before or immediately following the semi-structured interview about the vignettes), questions were raised by the chaplains themselves. They speculated about inter-denominational differences: would a Methodist approach the vignettes differently from a Catholic priest (particularly in Vignette One which posed the risk of suicide)? One respondent wondered if his decisions would necessarily agree with those of the lay pastoral care volunteers from his church who also visited patients in hospital. Another felt his disclosure decisions might well differ from those of a consultant psychiatrist he knew. As yet, the body of literature which discusses the kinds of ethical practice dilemmas common to pastoral work is very small. I was unable to locate any professional literature which discusses such matters fully, even for the most common group involved in hospital chaplaincy. On the other hand, literature abounds, both old and new, with discussion of the importance of the pastoral role in religious life (e.g. Fry, 1998; Ward, 1970; Graham, 1990; Davies, 1994; Ball, 1996). However, it does not provide guidance about how to resolve ethical dilemmas. Indeed such dilemmas are not even fully recognised as inherent in pastoral work. The literature merely places pastoral work as central to the ideal of religious life in practice.

LIMITS TO CONFIDENTIALITY:

For all three of the occupations represented in this research, professional discussion of the necessity for, but limitations to, confidentiality has to be considered within the legal framework in which their members operate. In Britain, this is not as simple as it may initially seem. There is, for example, no 'Law of Confidentiality' - no statute passed by Parliament which effectively defines the limits of confidentiality for the professional. Moreover, 'confidentiality' is not a legal concept; it is a professional one.

Hunt (1995) points out that, for medical doctors, the concept dates back to the Hippocratic Oath of 5th century B.C. - pre-dating parliament and

formal written law in this country. 'Trust' is central to 'confidentiality'. However, professional/client trust is not without limits, and there is an unbalanced power relationship inherent in this (Barber, 1983). The reputation of the professional is bound up in the extent to which he is 'trustworthy', and perception of 'untrustworthiness' can have an adverse effect on his ability to do his work (Daniel, 1998).

Related to the issue of the inherent 'trustworthiness' of a practitioner, issues surrounding confidentiality and the ownership or use of personal information about clients, are also of central concern to the professional reputation and task:

> ... confidentiality arises intrinsically from the professional relationship and is a concept in professional conduct and ethics, and is not something imposed on the professions from the outside. It is seen as a matter of keeping private the information which is divulged by individuals in their specific capacity as patients or clients. The professional only has that information because the individual has entered into a narrowly-defined relationship for the purpose of receiving expert assistance. The professional only has that information *qua* professional, and has no right to dispose of it except in so far as it plays a part in discharging that duty of assistance. This implies something else of great importance: the interests of the client are paramount (Hunt, 1995, pp. xxii - xxiii).

Central to the concept of confidentiality is the question of who owns or controls personal information. Beauchamp and Childress explain that: "we necessarily surrender some measure of privacy when we grant others access to our personal histories or bodies, but we also in principle retain some control over information generated about us, at least in diagnostic and therapeutic contexts and in research" (Beauchamp and Childress, 1994, p. 418). It is the principle of confidentiality which allows this. Brown et. al. (1992) suggest that confidentiality is important because personal information is "property", which should be guarded as a "matter of decency, a matter or privacy, and a matter of respecting persons" (p. 102). Nursing and social work texts about ethics and core professional values inevitably discuss confidentiality (e.g. Timms, 1983; Horne, 1987; Tschudin, 1994).

Nonetheless, despite the lack of a 'Law of Confidentiality', whenever issues such as 'ownership' are discussed, 'law' cannot be entirely absent. Certainly laws exist which apply to information use and which affect agencies' and professionals' use of information (e.g. the Data Protection Act, 1984[29], and the Access to Health Records Act, 1990). However, 'law' in modern western societies is complex[30]. It includes a mixture of statute law and common law set by precedent, and these do not always co-exist in complete or self-evident agreement. Within this there is always the difference between academic debate about what a law means, and which aspect of law takes priority in a given situation, and how these questions are argued in a Court which is considering a particular set of circumstances and decisions peculiar to one legal case and reviews them in the light of precedent decisions about comparable cases which are never quite precisely identical[31].

Thus far, social workers, nurses and chaplains have generally not been drawn into Court situations through lawsuits which required them to defend their decisions either to maintain or to breach client confidentiality, but this is increasingly likely to occur in mental health situations. It would, therefore, be useful for nurses, social workers and pastoral counsellors to be aware of the professional and legal experiences of psychiatrists and psychologists with respect to confidentiality.

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[29] Guidance about the implications the Data Protection Act, 1984 has for confidentiality of records is complex (Data Protection Registrar, 1986). The Data Protection Registrar has commented on the difficulties of maintaining confidentiality of information in community care situations given the increased inter-agency contracts and co-working (Data Protection Registrar, 1992 and 1993).

[30] A very thorough discussion of the concept of 'privacy', and various areas of law relating to this, particularly in relation to Social Services, is found in Thomas (1995).

[31] For example: McHale discusses whether or not a nurse who believes a doctor is wrong to withhold information from a patient, would be legally negligent if he raises his concerns with this particular doctor, questioning the doctor's judgement and making it clear he (the nurse) believes it faulty, but ultimately complying with it when ordered. Equally, she discusses the possibility that the nurse might be justified in disclosing information to a patient against doctor's orders. In both instances she notes that legal precedents in this area do not provide clear guidance for either option (McHale, 1995, p. 115 - 116).

In the late 1960s and early 1970s, in the United States, clinicians and legal professionals were involved in a debate about the ramifications of disclosing information without a patient's consent. There was a strong case for 'privileged communications' under law, requiring a doctor or counsellor to maintain absolute confidentiality, giving the doctor/patient relationship the same status as that of lawyer/client, and preventing disclosure (Shah, 1969; Curran, et. al., 1973). After much professional debate, the American Psychiatric Association approved a position statement which allowed disclosure only in the most extreme of cases (A.P.A., 1968 and 1970).

By the 1980s, however, the pendulum of professional opinion had swung away from this position, partly as a result of the Tarasoff decision of 1976[32]. This lawsuit raised the issue of whether or not a professional was legally liable should he fail to disclose information when there was an identifiable danger to an individual or to the public. The deciding principle in that case was: "the public policy favouring protection of the confidential character of the patient-psychotherapist communications must yield to the extent to which disclosure is essential to avert danger to others" (Everstine et. al., 1980). Also in 1976, a similar principle was upheld in Landeros *versus* Flood, when an American court decided that a physician's failure to diagnose and report child abuse, where such failure results in further injury to the abused child, constitutes malpractice (Butz, 1985).

Beck's study of how practice was affected by the Tarasoff decision shows

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[32] In 1969 Tatiana Tarasoff was killed by Prosenjit Poddar. Two months earlier Poddar (a voluntary out-patient) had confided in his psychologist that he intended to kill Miss Tarasoff on her return from holiday. The psychologist consulted with colleagues and decided that Poddar should be committed to hospital for observation. He informed Police of this both by telephone and letter and Police detained Poddar briefly but released him on his promise to stay away from Miss Tarasoff when he appeared rational to the officers involved. The Director of the Hospital then asked Police to return the psychologist's letter and directed that all copies of the letter and of the psychologist's notes should be destroyed, and ordered no action to place Poddar into a 72-hour treatment and evaluation centre. Miss Tarasoff's parents sued asserting that the family should have been warned of the 'grave danger' she was in (reported in Beauchamp and Childress, 1994, pp. 509 - 512).

that psychiatrists have now fully accepted as legitimate the duty to breach confidentiality and warn about potential danger (1982). However, this shift in practice is not as simple as it may initially appear. In contrast with Beck, Pope and Bajt (1988) found that 57 percent of a sample of psychologists in an anonymous survey reported having breached professional ethics and/or laws relating to confidentiality, either by failing to disclose information or by illegally revealing information when they were obliged to maintain confidentiality; and 77 percent of their sample believed that "formal legal and ethical standards should be violated on the basis of patient welfare or other deeper values" (Pope and Bajt, 1988, p. 828). This approach was endorsed by Ansell and Ross (1990) who state "It was clear to us that... [respondents] chose their clients' welfare over mindless obedience to reporting laws" (p. 399). And as late as 1986 Kottow (1986) and Engelhardt (1986) both argued that there could be absolutely no justification for any breach of medical confidentiality without the patient's consent. The dilemma has not disappeared; the 'position' on the limits of the professional is still not clear. The American Psychological Association notes that the fourth most common hearing for breach of professional ethics involves complaints about breach of confidentiality (1988). Similarly, in Britain, allegations about breaches of confidentiality also constitute a substantial proportion of complaints made about doctors (General Medical Council, 1994, p. 16). Research has shown that there is sometimes a gap between the level of confidentiality patients expect and that which medical staff maintain and that patients are anxious about the extent to which their confidentiality has been eroded (Weiss, 1982; Schmidt, 1983; Appelbaum, 1984).

Professional debate about the extent and limitations of confidentiality acknowledges that different circumstances can demand different levels of confidentiality (Plaut, 1974). Beauchamp and Childress's suggested course of action smacks of utilitarian ethics:

> In assessing which risks to others, if any, outweigh the rule of confidentiality, both the probability that a harm will materialize and the magnitude of harm should be balanced against the obligation of confidentiality (Beauchamp and

Childress, 1994, p. 425).

However, despite their neat figure depicting 'probability of harm', cross-tabulated with 'magnitude of harm' (Beauchamp and Childress, 1994, p. 425), ultimately, they do not provide much practical guidance about exactly where to draw the line at maintaining confidentiality. In many cases (certainly when assessing the correct level of shared information between professionals), the "need to know" principle has been endorsed even though it has been pointed out that this can ultimately mean that "confidentiality is diluted by dissemination of information to the extent that the concept is virtually meaningless within the health care team" (Emson, 1988, p. 87). This is echoed by Thomas, in relation to Social Services Departments (Thomas, 1995, p. 62). Professional associations in the areas of health and social services have increasingly become concerned to address, through policy and guidance documents, the extent to which information sharing is acceptable (B.A.S.W., 1983 and 1992; British Medical Association, 1994).

The Tarasoff decision has tended to focus discussions about the issue of confidentiality on the correct moral and professional response to potential violence:

> Although a therapist, a person is still a citizen, and he or she must protect and contribute to the common good. As a private citizen, the person of good conscience will not hesitate to warn an intended victim. That, as far as can be determined, is the meaning of *Tarasoff* (Everstine, et. al., 1980, p. 836).

Yet, in less extreme circumstances (than were evident in the Tarasoff case), professionals often use alternative interventions - ones which do not involve breach of client confidentiality - as the means of dealing with potential danger or harm to others, methods such as hospitalization, enhanced rapport or management of the patients' environment (Lamb, et. al. 1989, p. 41). Denkowski and Denkowski (1982) recommend that professionals develop "contingency plans for dealing with dangerous clients... in consultation with an informed attorney, a local psychiatric hospital, and

area law-enforcement personnel" (p. 374). Part of the difficulty for professionals is the volatility of some situations. "An ethical dilemma is raised for practitioners when clients report behaviours that, although not currently endangering, may become so...." (DePauw, 1986, p. 305). Roth and Meisel advocate that "the psychiatrist's need to act should always be assessed in light of the impact of the proposed intervention on future therapy with the patient and in light of the likelihood of success in preventing violence... the psychiatrist may prefer to rely on the odds and to hope for the best, rather than warning a potential victim or attempting to hospitalize the patient involuntarily" (1977, p. 511).

In a similar vein, Wettstein (1984) notes that psychiatric predictions of dangerousness are notoriously unreliable[33]. Although this is a type of assessment which the profession is endeavouring to improve, predicting 'dangerousness' involves many complex issues and is not as simple or straightforward as it may appear from reading press reports of high-profile incidents (Royal College of Psychiatrists, 1996). Wettstein warns that "therapists will be confronted with the challenge of minimizing the destructive potential of a breach of confidentiality in their attempts to comply with the law" (Wettstein, 1984, p. 312).

Although, in strict legal terms the precedent set by the Tarasoff decision was limited to the United States, in reality it sparked professional and legal discussion in other jurisdictions, and formed part of a gradual change in professional/legal culture and concordance about boundaries of confidentiality. In Australian law an overriding public interest allows disclosure about actual or contemplated crimes (not necessarily violent) or where there is an injury or danger to others (Creyke and Weeks, 1986). In Ontario, Canada, there is a legal obligation upon <u>all</u> knowledgeable persons (not only professionals) to report suspected child abuse. Social work agencies have (at least on paper) <u>mandatory</u> reporting procedures (and

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[33] This complements the work of Foucault (1978) which traces how the concept of a 'dangerous individual' developed in the 19th Century, leading to questions about who should be charged with determining who is 'dangerous', a task which was assumed by the profession of psychiatry.

these sometimes pose a serious dilemma for those working in ethnically-based, voluntary-sector welfare services where the community is strongly opposed to the law and believes the father, as head of the family, has not only the right, but the duty to chastise (Bell, 1993). In Britain, doctors have recognised the classic ethical dilemma contained in the situation when a doctor is aware that "disclosure may be clearly in the interest of public safety, but the patient resolutely refuses to agree to disclosure, and there is neither a statutory nor any other kind of legal obligation upon the doctor to do so" (Havard, 1985, p. 10).

Thus far, case law in Britain and elsewhere supports the professionals' breaching of strict confidentiality even against clients' expressed wishes (McMahon, 1992, p. 14). The anticipated dangerous outcome for the public had strict professional/client confidentiality not been breached was clearly a deciding factor in both W. *versus* Edgell (1989), and R. *versus* Crozier (1990).[34] However, for the most part, although there has been intellectual discussion about the professional and legal principles involved in these situations, notwithstanding two test cases (both of which were decided in favour of the psychiatrists who breached confidentiality), as a less litigation-prone society, Britain has not experienced the same level of legal challenge as the United States. Few professional ethical dilemmas or difficult decisions about confidentiality

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[34] In the case of W. *versus* Edgell (1989), a psychiatrist was instructed by solicitors for a man held involuntarily at Broadmoor Special Hospital. He formed a professional opinion which did not favour W.'s application for a transfer. Without obtaining W.'s consent, the psychiatrist (Dr. Edgell) sent his report to the Hospital Director, Home Secretary and D.H.S.S. W. sued for damages due to this breach of confidentiality. The claim was dismissed. The Court of Appeal indicated that although the law recognises an important public interest in maintaining professional duties of confidence, it treats such duties as liable to be overridden where there is held to be a stronger public interest in disclosure.

In the case of R. *versus* Crozier (1990), a psychiatrist was instructed by a defence solicitor to prepare an assessment in a criminal matter. He arrived at Court late to find the defendant being sentenced without the Court being aware of the serious mental health risk Crozier posed. The doctor showed his report to the Crown Prosecutor, who applied to have the man re-sentenced based on this new information. Crozier appealed the new sentence, submitting that the psychiatrist gave his report to the Crown in breach of his duty of confidentiality. The appeal was dismissed. Once again the argument was accepted that, given the dangers this particular defendant posed, the public interest in disclosure overrode the duty to confidentiality.

reach the court room. Most professionals rely on personal, employer or professional ethical frameworks to provide the basis for their decision to disclose or not, frameworks which are not precise and which only rarely dictate specific actions.

> Professional ethical standards are not absolute in their demand that confidences be respected and the areas of law in which disclosure is either compelled or prohibited are limited. There remains a middle ground in which the worker is left with discretion to respect or divulge the confidences entrusted on him. Both law and ethical standards allow for this grey area (Fox, 1984, p 178).

SUMMARY

This chapter began with a brief comparison of certain aspects of the codes of ethics of nurses, social workers, and pastoral counsellors. Several similarities in principles were identified, common not only to these three professions but also to professions generally (as discussed in Chapter Three).

Ethical dilemmas within the fields of nursing, social work and the chaplaincy were then reviewed. The professional literature of nursing and of social work provide numerous examples of ethical dilemmas which these workers face on a regular basis. Many of the dilemmas result from inherent conflicts in their ethical codes, where two principles clash, with one other. Others result from the inability to fulfil some ideal standard in an imperfect world of scarce resources, or through lack of full information, or through the conflicting and competing needs of more than one client and the dual loyalties practitioners face when they owe responsibility to two or more people simultaneously, or through conflicts between practitioner's personal values and the professional imperatives or employer guidelines they are expected to honour.

It was noted that the professional literature for chaplains has only just begun to identify and analyze such ethical dilemmas. Possibly this is due to tradition - ministers and priests have worked in our society for centuries, while the organisation of chaplains and pastoral care workers

into a recognisable professional group, with close inter-professional links with other professional groups working in the same field, is a relatively new phenomenon. Possibly this is also because the benefits of being professionally organised are still being debated amongst religious professionals.

At the end of the chapter, the professional concept 'confidentiality' and the limits and boundaries of the concept (professionally and legally) were examined. There was a brief discussion of some important court cases which have influenced professional practice in this area and opinion was expressed that legal constraint may well be the road to the future.

CHAPTER FIVE

RESEARCH QUESTIONS AND METHODOLOGY

This chapter reports the methodology used for the study. It briefly discusses the assumptions which underlie the approach to the topic, lists the specific research questions which were addressed, and reviews the directly relevant prior research. The research design is then described, as well as the nature of the instrument created and the type of analysis carried out. There follows a description of the sampling procedure used and the purpose-designed instrument, the pilot study and the actual procedures used in analyzing the research findings.

ASSUMPTIONS

All meaningful human communication rests on certain implicit and/or explicit assumptions. Without them no actual exchange occurs. The assumptions change according to the persons involved, the circumstances and the subject under discussion (i.e. the conditions which may be said to 'carry' the communication). Without some common understanding of the underlying assumptions (not necessarily complete agreement about all of them or of their relative importance) communication fails and misunderstanding arises. In a research report, therefore, it is well for the researcher to try to make the underlying assumptions explicit and precise. Several assumptions underlie the topic and research of this thesis; they are listed below:

1. Professional workers make decisions daily about what actions to take. Most of these decisions are taken without lengthy pondering about the correct course of action. However, in the course of making even the most routine decision workers experience certain actions. Each decision involves a choice to undertake certain activities and procedures and not to pursue others. As the decision is made workers call into play not only technical knowledge and normative behaviour which is unique to their kind of professional and its kind of work, but also knowledge about the policies and procedures of their employing agency and knowledge of the laws of their country. This

professional knowledge provides a general context for decision-making, one which is common to other workers within their profession who also work in the same (or similar) settings.

2. Each time they make work decisions they also use knowledge which is unique to their kind of work. This involves judgement about the relative importance of a number of intervening factors pertinent to a specific decision. Whether self-consciously or not, workers are aware of both the specific duties their role requires them to perform, and also of the limitations their role places on them (i.e. constraining them from certain actions). This also involves an awareness of the point at which their professional responsibility ends (and, in some cases, another worker's begins).

3. Perceived risk is another very important factor involved in each work decision. Workers' training and the technical knowledge specific to their profession equips them to analyze and assess whether or not risk exists, what kind and how serious a risk it is (i.e. what harm and how much damage), how likely it is to happen (i.e. probability) and how immediate the risk is (i.e. timing of risk: within a very brief space of time or in the distant future). Workers assess the level of risk which exists (or may exist at some future time) to a number of people: to the client, themselves, to colleagues and to third parties.

4. There are intervening factors which also help to mould professional workers' decisions. These include the attitudes, beliefs, convictions, and biases to which they were socialised during their pre-practice training. These professional attitudes are often referred to as their underlying 'values' which both reflect their commitment to their field of work and guide their work decisions. These professional values, common to other workers within their professions, interact with workers' personal beliefs and experience, helping to mould their decisions. In the majority of work situations

the worker need not consciously reflect about these underlying values. However, when situations develop where choices are not clear-cut, when indecision, conflict, and crisis may occur and workers may find themselves having to justify a difficult decision to a disagreeing party (either client, colleague, outside professional or reviewing body), these professional values play a crucial role in their decision-making and justifications for the decisions taken.

5. 'Ethics' is an important factor among these more general professional attitudes or values. In other words: the interpretation of the general value into what one might call the specific 'correct ethical behaviour' for the specific situation is an important intervening decision-making factor.

In many work situations the correct ethical behaviour is straightforward and obvious, and work decisions which are 'good and right' involve no ethical conflicts. But there are common work situations in which there is no single 'good and right' decision. Frequently these arouse legitimate concern, making choices difficult among several professional judgements each of which is ethically justifiable.

6. 'Confidentiality' is an extremely value-laden term which incorporates a number of professional imperatives within it (both 'technical' and 'ethical'). These include issues about the importance of records, what information to record, how to record it; issues of 'privacy' and 'ownership' of information (the network of organisations *versus* specific agency *versus* individual worker *versus* client); and of keeping records 'safe' (from people or organisations who should not have access to them). The tension between maintaining 'confidentiality' of client information *versus* the 'need to know' is a most important intervening variable (even sometimes the determining variable) which leads to recurring ethical dilemmas for

professional workers.

7. Finally: my research involves the assumption that workers during in-depth semi-structured interviews will be able to describe their reasoning behind their decisions about ethical dilemmas. A set of case histories can be used as a basis for a discussion which focuses on several common work situations which all involve an ethical dilemma or ethical conflict. By using a set of case scenarios as the basis for extensive discussions about real work situations involving ethical conflicts, it will be possible to have respondents express opinions about, and make hypothetical decisions about, each case and with honesty and candour trace their reasoning in arriving at each decision. By analyzing the rich material of the interviews it will be possible to derive some answers to the research questions investigated for the thesis.

RESEARCH QUESTIONS

As mentioned in Chapter One, this thesis addresses aspects of professionalism - specifically the relationships between the nature of professionalism and the development of degree of integration into a professional network. The research for the thesis considered these relationships by analyzing the hiatus between the ethical codes of practice of three of the 'caring' professions and the practice decisions which a sample of their members made when confronted with dilemmas arising from conflicting ethical imperatives. That is, the research gave forced-choice decision opportunities to a sample of respondents and had them discuss their case decisions and the reasons for them. By use of interviews, apart from interest in the reasoning of respondents as they justify their professional judgements, the research sought evidence of whether a continuum of professions may be said to exist among the three occupations, based on the degree to which the respondents have been 'professionalized' into a cooperative inter-professional network.

The evidence of 'professionalism' is exhibited by the characteristics of

occupations which are 'recognized' or claim to be 'professions' in the related research literature. The three sample occupations used for this research are professions whose members can be expected to demonstrate a 'degree of professionalism' which varies along a continuum.

Of the three sample professions used in this research, nursing is the occupation which has the most clearly monopolistic control of its area of work through legal restrictions on employment, control of training programmes and self-regulation. It is the longest established of these three professional groups. The precepts and principles imbued in nurses throughout their training and professional practice instill an awareness that their work is integrated into a network of professional practice (which includes other types of professionals, such as doctors, social workers, etc. as well as other nurses) and that 'best practice' requires them to cooperate and share tasks and information with a range of other people in order to be effective and 'professional'.

Social work occupies the 'intermediate' position of 'professionalization'; it has less control over training programmes and has not yet become a registered profession with all the monopolistic privileges and power this conveys (although with the advent of the planned General Social Services Council this would be a logical next step in development of the organisational/power structure of social work over the next few years). Pastoral care (as exemplified by a small group of chaplains) is the 'least professionalized' of the three occupations. Many chaplains do not belong to any professional association and there is tremendous debate in the pastoral care literature about the value of 'becoming a profession'. Traditionally, chaplains, particularly those in a health care setting, have been viewed as being outside of the normal inter-professional network and liaison. While nurses and doctors regularly consult with each other, chaplains keep their records and knowledge about the client separate and 'confidential'. Although this has gradually been changing in recent years, due to growing recognition that the spiritual advice and counselling chaplains provide can affect the physical health and mental stability of

clients, nonetheless there is still resistance on both sides to fully accepting chaplains into an inter-professional network which operates a shared information base about each client. Thus chaplains occupy the position of the 'least' professionalized group of workers.

The research focused upon the professional's duty to maintain confidentiality about the client's personal information and respect for client wishes about the use and disclosure of such information. It also explored the question of the professional's responsibility to disclose information to others, even when this may well adversely affect the client and/or is against the client's expressed wishes, because of perceived risk to the individual or to others and/or because of the professional's duty to others.

As has been noted previously in the thesis, statements embodying such conflicting 'duties' are to be found in the tenets of the ethical codes of many professions and in all three under scrutiny in this thesis. Traditionally, in the early writing about the sociology of the professions, the presence of an ethical code containing the imperative of a 'duty of care to the client' was almost a touchstone for the judgement that an occupation was indeed a profession as claimed. Conflicting responsibilities are not exclusive to professional work, but they are present in all such work - otherwise the constraining ethical imperatives of the codes would not be necessary.

Although their work and training differ, common issues and themes arose as nurses, social workers and chaplains discussed the cases presented to them. They described their work in general as well as presenting comparable, even identical, example cases and explaining the factors they would take into account in making decisions about each case, weighing alternatives and defending (justifying) their choices.

There are eight sets of specific research questions that this thesis

addresses[35].

1. Taking the research samples as a whole, and then each professional sub-group separately, what framework for decision-making do respondents use when making ethical choices? To what extent do these respondents refer to their professional ethical codes when discussing the cases presented and when recommending what they regard as the best course of action to take? To what extent do they feel bound by a legal framework? What role do employer policies play in ethical decision-making about boundaries of confidentiality?

The research findings which answer this set of questions are reported in Chapter Ten.

2. If conflict is recognised between the imperatives in the clauses of the formal code and respondents' decision choices in the vignettes, do all use similar justifications for their decisions? Does this vary by professional group? Does this vary more among the three groups than within each one?

This question is addressed in Chapters Seven and Eight.

3. If, within the three groups, there is a difference in the consistency of explanatory factors used to defend the decision to breach confidentiality, can this be explained by the extent to which the respondent's occupation has become 'professionalized' into an integrated network of professionals with divided loyalties, in which the primacy of the individual client's self-interest (supposedly safeguarded by the code of ethics) has been eroded (as alleged by this thesis's proposed continuum of professionalization)?

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[35] Please note that the research does not attempt to examine questions about sex-based differences in approaches to confidentiality, either in terms of the individual respondents (e.g. differences between male social workers *versus* female social workers) or in terms of traditionally male-dominated professions *versus* traditionally female-dominated professions (e.g. chaplains *versus* nurses).

This question is the basis for the analysis described in Chapter Eight.

4. When discussing the cases in the vignettes, do the respondents from the same profession interpret the same information similarly or differently. In other words, do they place greater/lesser importance on specific items of scenario content (and hence on certain variables) found in the situations of their own work? In other words, in practice, does the solution to an ethical dilemma become so context specific as to become a habitual and hence predictable response?

This question is addressed in Chapter Seven.

5. What degree of willingness-to-disclose seems to be present in the discussion material? Does this vary by professional group? Can it be put on a continuum by group? If so, does the degree accord with the thesis's contention of a continuum of professionalization? For example, when informants decide that confidential information will be disclosed, do all those interviewed show a tendency to have the same type of disclosing behaviour? Specifically, to whom do they disclose? Do they disclose more readily to someone they consider a member of another 'caring' profession, and less readily to the non-professional workers of caring professions? Do they disclose more readily to members of 'caring' professions than to people from other 'non-caring' professions? Do they disclose more readily to para-professionals than to non-professional (e.g. family, friends, etc.).

If respondents seem to hold a selective set of reservations and preferences and reveal their specific set (by spontaneously explaining in the interview "I would never discuss a case with.... I would always discuss a case with....) does the justifying language (accepting the need to disclose to some professional workers but not others) imply that the groups whose 'need to know' is being accommodated share the respondent's professional ethical base/value

system? In other words, does the ethical imperative of client confidentiality break down more readily because of the perceived shared ethical base or because of the perceived needs of the complex case? When respondents ponder the decision to disclose (or not) do they seem to differentiate between what may be termed the ethical value systems of the different possible disclosure recipients?

Does there seem to be a hierarchy of groups to whom disclosure is seen as being sometimes both necessary and permissible? If so, what does such a hierarchy seem to rest on: type of information to be transferred or status of information recipient? For those working in the mental health field, are there 'privileged' and 'non privileged' workers? Do respondents seem to perceive some professional groups, involved in some way with their clients' cases, as practising under a quite different set of ethical imperatives, and hence excluded from 'the need to know'? Do the respondents reveal greater acceptance of accommodating the 'need to know' of a professional worker (of any type) than a para- professional or a lay person? Does it make a difference if the lay person is a relative? Does willingness to disclose depend upon the age of the client (e.g. in a case involving a minor).

The analysis reported in Chapter Eight and the second part of Chapter Seven addresses this question.

6. Using the evidence from the interviews, is there a recognizable stage in the development of a case situation at which the confidentiality rule is likely to break down? Does the issue of disclosure arise more readily (earlier) in one of these professions than the others? Does it generally occur earlier (i.e. in all the cases) or only in a certain type of case vignette? Does it occur predictably according to the degree of professionalization suggested earlier, (i.e. in the nurses earliest, social workers next and chaplains latest)? How variable is readiness to disclose according

to work setting? Can it be said that the issue of client confidentiality *versus* disclosure has become so common as to be a matter of routine related to specific case variables and work settings (i.e. that in certain types of practice, disclosure has *de facto* become routine and common practice)? If that seems to be the case, can it be said that disclosure is now routinely decided according to a series of well understood, consistently applied work conventions and constraints rather than the individual's professional judgement of each case (e.g. always to 'a' but never to 'b'; generally to 'a' but only when a certain two recurring conditions are also present). If that seems to be the case, from the evidence of these interviews can a working code of permissible disclosure recipients be drawn up for nurses, social workers and pastoral counsellors whose work involves mental health cases?

Research findings related to this question are discussed in the analysis of Chapter Seven.

7. Professional codes require that workers make considered decisions after carefully considering all their ramifications and that workers accept responsibility for those choices. To what extent did respondents 'face up' to the ethical dilemmas they were facing in the case scenarios, and acknowledge that they involved ethical judgement? To what extent did they blur or obfuscate the choice? How did they rationalize away the ethical dimension to their decisions? What proportion of workers rationalized their decisions?

Research findings related to this question are discussed in Chapter Nine.

8. What conclusions may be drawn from the information gathered in this study with regard to (1) the actual confidentiality of client information in professional practice, and (2) the primacy of the needs and wishes of the client when they are in conflict with the recommended (or even required) sharing of confidential client

information in professional work situations of shared authority and conflicting opinions on the 'need to know'? What contribution can the research for this thesis be held to have made (a) to the common knowledge of the ethical conflicts which members of the caring professions encounter in their daily work; (b) to the adequacy of (or improvement needed in) work routines, common standards of confidentiality/information sharing, and reporting procedures used in agencies employed in the community mental health area; and (c) to the debate on the locus of final authority and accountability in professional work and the hiatus between (and implicit professional risk involved in) ethics as belief and ethics as behaviour involving judgements, decisions, actions and attitudes.

This set of questions is addressed in the final chapter of the thesis.

PREVIOUS RESEARCH

Although in recent years some interest has developed in the ethical conflicts inherent in professional work, there has not yet been much research conducted into ethical decision-making. A general survey by the Children's Legal Centre (1989) about counselling services indicated that they included agencies and practitioners who offered varied levels of confidentiality (ranging from absolute to very limited), but there was much evident confusion about where the boundaries of practice actually lay and there was no scrutiny of the process by which decisions were made.

Aroskar (1989) sent questionnaires to over 1000 community and public health nurses in a survey whose purpose was to identify the ethical problems confronting such workers and to determine how these were dealt with in everyday practice. The research data were discussed in terms of conflicting principles, what the author refers to as "autonomy" *versus* "beneficence"; "truth-telling" *versus* "non-maleficence".

Duncan (1992) also conducted a questionnaire survey designed to identify practice situations which created ethical dilemmas, and to elicit

respondents' emotional response to such situations and learn of their decisions. These were discussed in terms of their implications for training and policy. Recognising that there was confusion about appropriate ethical standards amongst their workers, one social services department conducted a survey to determine what staff would agree should be appropriate standards, using this to develop a set of procedural guidelines (Golding, 1996). The recent surveys documenting the range of existing ethical confusion and the type of moral dilemma experienced in practice in the newer professions follow the research traditions of earlier work on the more established ones (e.g. Noble (1984) on psychologists). Unfortunately none of the research has examined, once the decision has been made to resolve the dilemma, (1) what factors decide the type of decision, (2) how the mix of factors is weighted differently in the same situation by different persons of the same profession, and (3) by the same person in different but similar situations.

Holm (1997) completed research examining the differences between ethical decision-making of doctors and nurses in a hospital setting. However, this was analyzed in terms of (a) the real *versus* perceived ethical differences of nurse and doctors, and (b) whether the organisational culture assisted practitioners to make ethical decisions and reconcile professional differences, rather than in relation to how ethical decisions were made.

There has been some research on decision-making in business that has concentrated on examining how different factors affect workers' professional choices and decisions. Typically these studies concentrate on analyzing how different business structures, company policies, and reward/punishment systems support or undermine decisions which are considered ethically correct. Most of the studies rely on qualitative research techniques involving a quasi-experimental design with a control groups *versus* a group of respondents, or the use of vignettes and structured interviews wherein the respondent makes a choice of branching decisions at each stage of the problem presentation. For example, Trevino and Youngblood (1990) had business students complete a paper in-basket,

decision-making exercise. Newman (1993) examined the linkage between procedural justice, ethics and decision-making in business, using a simulation model of a hypothetical company.

However, although of general interest in the study of professional workers and their practices, such research offers little to assist our understanding of the decisions that mental health workers of various professions, employed in a salaried capacity in bureaucratic structures, make when they encounter ethical conflicts. There is little similarity between the business context and the ethos of profit making firms in which business professional work (such as banking, accounting etc.) is conducted and the normative ethical expectations which are the ethos of the work setting of the caring professions. More importantly, perhaps, the ethical business studies' dilemmas can usually be resolved by reference to the policy of the firm and profitability and costs. The dilemmas in the caring professions' work generally do not present an ethically clear cut 'right' or 'wrong' decision, free from contextual risks and, therefore, judgements have to be made in which ethical trade-offs are debated.

Nevertheless, although the study of ethics in the caring professions is a relatively new field of research there have been some studies which attempt to analyze how these workers make choices to resolve their ethical dilemmas. Holland and Kirkpatrick (1991), for example, held extensive interviews with social workers. Practitioners were asked open-ended questions designed to elicit accounts of their professional experiences. These data were then analyzed in terms of the tensions displayed between three sets of polarities involving moral choices - means *versus* ends; autonomy *versus* mutuality; self-direction *versus* compliance with an external authority. While this research had the advantage of drawing on actual experiences, difficulty was encountered in codifying such diverse experiences for analysis.

Grundstein-Amador (1992) resolved that problem somewhat by using two-phased, semi-structured interviews with 18 doctors and nurses to provide

complementary data. In the first interview respondents discussed their own professional experience; in the second they were asked to consider a hypothetical case and then reply to a standard series of questions. The analysis involved assessing the differences in ethical judgement between the doctors and nurses. The case example contained the dilemma of whether or not to provide medical treatment to a cancer patient. The research concluded that nurses and doctors placed differing emphasis on different factors and values. This led to significantly different types of decision made by members of the two professions which thus created communication gaps between them.

Research projects which describe case studies or practice situations (what in Britain are usually called vignettes and in America scenarios) are becoming increasingly common in studies of professionals' work, opinions, preferences and judgements. Their purpose often is to examine work behaviour and the ethical basis for decisions. But vignettes can equally be used to examine workers' competence and the range of acceptable deviation from standard prescribed procedures and/or workers' reflections upon the possible outcomes of described incompetent practice.

Vignettes may be used in research designs whether the plan is to use quantitative or qualitative analysis (Holloway, 1997). In the former case the described situations are part of a structured questionnaire wherein respondents choose their actions or judgements from a given menu either in an absolute, forced-choice, by rank ordering, or by rating their choices on a likert-type scale (1-5 indicating degree of agreement). In the qualitative research analysis the vignettes act as a lead-in to fairly long discussions with respondents. In such interviews only a few specific questions are asked whose purpose is to 'keep the ball rolling', as the respondent provides rich detail offering opinions, examples, and justifications (McCracken, 1988; Rubin and Rubin, 1995). Research adopting this somewhat free-wheeling use of vignettes is still not common.

Christie et. al. (1989) used vignettes to study ethical judgements in

practice situations. In a mailed survey of British G.P.s. they employed a questionnaire containing six fictional cases as the focus for reactions to ethical problems about (1) how much information to discuss with patients, (2) to what degree the doctor should become involved with the lifestyles of patients, and (3) how to deal with a suspected family problem. Respondents were offered a range of possible decisions and asked to tick the most appropriate one. They were then asked to select from a short list the three most important factors or reasons for their choice. The study concluded that G.P.s tend to use case-by-case analysis to resolve an ethical issue rather than refer to some general principle or theoretical consideration.

Kugelman (1992), also using vignettes, interviewed twenty social workers from two agencies about their perceived role as 'patient advocate' and the ethical position they would take in relation to a series of alternative decisions in a fictional case history. The responses were analyzed as (1) relying upon purely ethical elements as defined by the professional code or (2) referring to non-ethical factors which affected respondents' thinking; and how the type (category) of response affected the decision to act as the patient's advocate or to refrain from taking on this role.

In a similar vein, Waldeen et. al. (1990) used vignettes in a questionnaire to study decisions when the interests of individual clients were pitted against organisational or social imperatives. Their questionnaire described cases of practice dilemmas and asked which action respondents would chose. Respondents found themselves having to endorse one professionally required ethical behaviour at the expense of another. They usually tried to avoid violating their agencies' policies. It was found that the specific details of client behaviour affected respondents' choices, swaying them to a more system-oriented or more client-oriented choice depending upon the degree of deviancy associated with the client's behaviour.

Two fairly recent research studies in Britain used vignettes to examine

the boundaries of confidentiality and risk assessment in practice settings, but neither specifically involved nurses, social workers or chaplains. Roback et. al. 's (1992) six vignettes involving dilemmas in group psychotherapy were intended to test how group leaders dealt with the boundaries of their roles as therapists, and to examine their judgements for action to be taken to deal with the vignette-disclosed problems - whether within the group setting, through individual counselling, or by reporting the problem to an outside authority. Only one of the vignettes involved a client breaching group confidentiality; the remaining five presented situations involved greater or lesser degrees of risk of harm to the patient or to others. Roback et. al. concluded that, when faced with patients' disclosures that had 'psycho-legal issues', the therapists were unlikely to rely solely on group therapy to deal with the problem. The majority elected to supplement group work with counselling and continued to resist breaching confidentiality even in situations involving non-violent criminal activity, unless the patient had made a specific threat to physically harm an identified individual.

Lindenthal and Claudewell (1980) surveyed 439 clinical professionals (internists, psychiatrists and psychologists) using a questionnaire which contained 20 brief vignettes. The purpose was to examine differences between professional groups' response to dilemmas in cases where individual patients' interests were pitted against society's interest - the situations involved shoplifting, reckless driving, alcoholism, pyromania, and rape. The data were analyzed in terms of whether respondents were more 'society-oriented' or 'patient-oriented', and significant differences were found between the three professional groups. The nature of respondents' training, their previous professional experience with threatening or antisocial behaviour, and the predominant approach to treatment were all statistically significantly related to their clinical judgements about confidentiality in the presented cases.

However, the following question arises - How well can research which uses hypothetical case vignettes measure the degrees of confidentiality

dilemmas which arise in practice situations? Ketefian's (1989) review of research on clinical settings noted that 'ethical inquiry' is a subject area difficult to measure. Her analysis of the research on nursing ethics charted the various research techniques used to try to define and measure ethical practice. The majority of them used artificial case histories as the focus for eliciting respondents' decisions.

Abbott and Sapsford (1993) also concluded that:

> Vignettes can be used...to cover a wide range of informants and a wide and systematically constructed range of cases. systematic (perhaps even experimental) manipulation of the stimulus material permits us to explore not just what is done but why it is done, without summoning up the established rhetoric which surrounds all areas of professional decision-making (p.18).

When conducting research in topics that are value-laden (as studies about ethical dilemmas must necessarily be) and yet practical in nature, it is important to use some technique which bridges the gap between generalised principles and theoretical attitudes, and the reality of application of principle in daily work. Bridging this gap is even more important if one is studying professions which have a written code of conduct, the details of which practitioners may be in ignorance. Davis (1991) found that not one of the 21 master's degree nurses participating in a research study even knew the content of their profession's Code of Ethics, although all demonstrated that they had a practical 'code' "derived from a blend of professional values and personal values [which] had developed out of their experiences" (p.1359).

Finch (1987) also points out that:

> Vignettes...allow for features of the context to be specified, so that the respondent is being invited to make normative statements about a set of social circumstances, rather than express his or her 'beliefs' or 'values' in a vacuum. It is a method which...acknowledges...that morality may well be situationally specific (pp. 105 - 106).

RESEARCH DESIGN

The use of vignettes as the basis for interviews focuses discussion with respondents, without imposing unduly restrictive limits. It lends itself to research which tries to document decision choices and assess the reasoning which lies behind them.

By now, for research on the caring professions, vignettes have established another advantage - familiarity to the intended respondents (Sherman and Reid, 1994; Morse and Field, 1996). The professional training of social workers and nurses usually involves the extensive use of fictional case histories as a focus for class discussions. Chaplains are also familiar with the use of 'stories' as a teaching method; after all Jesus taught with parables. So vignettes have a 'comfort value' which sets respondents at ease and creates the reassurance necessary to start them talking freely and frankly.

Therefore, the three primary decisions made about the research design for the thesis were made early and easily: (1) that there would be semi-structured interviews based on a series of case vignettes but with few forced choices to elicit preferences and decisions, so that most of the time could be spent in rather free-wheeling discussions which would follow the lead of the respondent; (2) since much of the information gathered would be in the form of recounted experience containing rich anecdotal detail, the appropriate documentary analysis would have to be qualitative in nature but some descriptive statistical data showing frequency of response might be presented and, therefore, the design of the research instrument must take that into account; and (3) since the intention was to compare the response of more than one professional group, while the sample of respondents would not be chosen to indicate national representativeness, each group should be sufficiently large to ensure that many varied examples would be gathered about professional experiences spontaneously recounted.

THE SAMPLE AND THE INTERVIEWS

Originally the intention was to interview and compare the responses of a group of social workers with a group of community psychiatric nurses. A small group of hospital chaplains was added when discussions with practitioners (during the pilot study) and the research literature review revealed that parallel ethical dilemmas were commonly being faced by pastoral care workers and that hospital chaplains were increasingly becoming 'professionalised' as, in their work, they were drawn into counselling and a network of clinical relationships.

Since the intention was not to conduct a large survey but to try to gain deep understanding from a relatively small group of participants, generalizability would not be claimed. However, since general rather than idiosyncratic information was desired and would be sought, the choice of sample was not unimportant, nor was sample size, given the time and resource limitations of a doctoral student. It must be sufficiently large to lend substance to the analysis and presentation of the research findings, and be sufficiently small to enable the student to personally conduct lengthy, one-to-one interviews. The decision was made, therefore, to have all respondents randomly chosen from one geographical service area. Leeds Community and Mental Health N.H.S. Trust provided a list of names of community psychiatric nurses employed in the Leeds area, whom the Trust management believed might be willing to participate in my research[36]. Initially Leeds Department of Social Services was approached for permission to interview social workers employed in mental health services in the Leeds area. However, Leeds declined to participate in the research project and so Wakefield Social Services Department was approached as an alternative source for practising social workers. Wakefield Social Services Department agreed to participate in the project and kindly provided a similar list of social services workers employed in mental

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[36] The Trust sent an initial memo to all Community Psychiatric Nurses employed by them in Leeds explaining about the research and asking them to say whether or not they wanted their names included on a list given to me. The names of those people who agreed were then given to me. I was never informed by the Trust what proportion of names of all the Community Psychiatric Nurses employed in Leeds were sent to me.

health work in the Wakefield district. A list of the health care chaplains who were working in the same districts was also later developed.

I envisaged interviewing approximately 25 nurses and 25 social workers, with a smaller number of chaplains (since fewer people work as chaplains). The initial two lists contained a total of 68 names, 37 nurses and 31 social workers. Given the small size of the total group I decided to try to interview as many as possible within the time constraints of my research (I allotted six months for interviews), achieving as much as humanly possible, a 'total' sample.

Respondents were initially told about the research study through memos sent by their employer, introducing me to them and asking them to cooperate with the study. I then attempted to contact each possible respondent by telephone to explain further about the research and ask if they were willing to be interviewed. The research was described; the approximate length of time the taped interview would take, the respondents' role and the nature of their contribution were explained; and the person was asked to cooperate. Respondents were assured that all the taped material would be transcribed anonymously so that, if a respondent was actually quoted in the thesis, he would only be identified by an occupational description (e.g., a nurse said...); that the interviewee might read and amend the transcribed tape if he wished (none took up the offer), that he was free to decline to answer any question, decline to discuss any vignette and decide to end the interview at any time (none made any of these choices); that a copy of the vignettes would be provided ahead of the interview upon request (only two so wished and one revealed, at the interview, that he had not had time to look at the vignettes prior to our meeting); and that the interviews would be held on a date, at a time and in a place to be decided at the convenience of the interviewee.

The cooperation received was truly exceptional. I had explained that the interview would take about an hour and a half, however, many took considerably longer (the longest transcribed to fifty-one typed pages).

Although not all the nurses could be contacted (e.g. some had left the job or proved to be on leave), and some felt unable to participate in the research due to pressures of their work schedules, I quickly put together the desired nurses' sample and had more than half the social workers lined up when I carried out the pilot study (described below). In all 27 nurses were interviewed. Meanwhile, not all social workers felt able to participate in the research and so only 21 interviews could be completed.

When it was decided to include hospital chaplains in the study, it was thought that a sample of 10 might be satisfactory, but a list of ten chaplains in the Leeds area could not be obtained. I was given the names of two hospital chaplains (who it was felt might be interested in the research) by the university chaplain. They provided further names, and as I interviewed those people, I also gathered other names of chaplains. They agreed to be interviewed making a total of seven; thus bringing the total number of completed interviews to 55. As in most interview-based research, arranging the last few of the desired number of respondents was difficult; although respondents were willing to participate in the study, telephone call-backs trying to arrange a convenient time and place were time-consuming, so closure had to be pronounced.

The interviews were taped. Before each began an introductory statement was read to the respondent (see page one of the instrument in Appendix One) and he was given a copy of the interview schedule to follow, as I also referred to a copy. This had the advantage of reassuring respondents that there were no unexpected or trick questions and they could take as long as they wished to read and ponder on the case described in each vignette. Most interviews took place in the respondent's place of work. All answered all questions, even those requesting personal information. All discussed the vignettes thoroughly, providing examples from their experience of similar ethical problems and how they were resolved.

Not much interview time was spent reading the vignettes or answering the few specific questions in the interview schedule. Most of it was taken up

with discussion of each case vignette, referring these circumstances to comparable cases with similar, or even more complex, complications, justifying possible hypothetical decisions with details of actual ethical decisions. Typed transcripts ran from twenty-two to fifty-one pages.

The four vignettes presented during the interview were designed to reflect conflict between the principles of maintaining confidentiality and respecting clients' wishes, and different types of risk of harm and conflicting duties of care to other parties. Each was presented in two typed pages and had the same structure. On the first page the basic situation was described. The recording machine was turned off while the respondent read the case. Then the tape was re-started and a series of standard questions were asked specifically directing the participant to consider whether or not to disclose information which the clients had declared they wished to be held confidential; to whom they would disclose and why. On the second page the same vignette was varied by a series of small changes in the circumstances of the case, and after each variation the respondents were asked to consider again whether they would disclose any information against the client's express wishes, to whom they would disclose and why.

All participants were given the same vignettes and variations. Since the sample was confined to the Leeds area, and a relatively small number of respondents from each profession would be interviewed, it was not feasible to give sub-groups of each profession different sets of case vignettes (which would have been an alternative means of examining how slightly changing various factors might alter a professional worker's judgement). Moreover, as the complexity of the vignettes in the interview instrument increased, the number of different cases which could be discussed without exhausting the goodwill of participants had to be limited. Thus the breadth of experience which might have been revealed through a greater number of vignettes was sacrificed in favour of the detail and depth of discussion of a few cases - which, happily, in practice were greatly increased by the examples provided by respondents.

None of the vignettes describes an actual case. However, all were written to reflect 'real life' work situations familiar in the professional literature of nursing and social work. The first two show relatively negative situations and the second two relatively positive ones, but all four describe non-emergency, middle-of-the-road situations designed to stimulate discussion about the 'grey areas' of ethical practice, rather than obviously 'right' or 'wrong' choices. In the preamble to the interview the respondent was assured that there is no right or wrong decision in these cases. Just as in their daily work there are compromises. There are decisions with which colleagues might not agree and situations they might handle in a different way[37]. Many decisions might be the best which could be made given the difficult circumstances. Respondents had been told all this when the study was described to them during the initial telephone contact, but it was necessary to reiterate the assurance that this interview was in no way a 'test'; there was no 'score' being given. Spontaneous comments made by several respondents during the interviews indicated that, despite the fictitious nature of the cases described, nonetheless, they found the vignettes very 'true-to-life'.

'Risk of harm' is often a central factor in situations which involve ethical dilemmas. The extent to which professionals assess a set of circumstances as posing risk to a client, others, or themselves can affect their decisions. This risk management is seen as an appropriate part of their professional role (Carson, 1994; N.H.S. Executive, 1994). Therefore the level of 'risk of harm' was varied within each vignette. Generally the more risky circumstances are shown in the final vignette, although this is not always the case. I was careful to ensure that none of the vignettes included a case which would necessarily be included on the Supervision

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[37] This is not uncommon. For example, in the Tyra Henry Inquiry, there was disagreement about what information should properly be shared at a case conference (London Borough of Lambeth, 1987). The Tyra Henry case involved a very extreme child protection case, and yet even in this circumstance, the police disagreed amongst themselves. All the scenarios used in my research involved far less extreme or obviously risky examples.

Register developed under the Mental Health (Patients in the Community) Act, 1995 (National Health Service Management Executive, 1994)[38].

The type of relationship the possible recipient of information has with the named client is also an important factor in decision-making. Firstly, the issue of disclosure to professional *versus* para-professional *versus* non-professional is central to the research questions. However, additionally, in certain circumstances, there is a legal *requirement* for professionals to breach strict confidentiality by discussing the client's circumstances with his closest relative (involuntary admission to hospital under the Mental Health Act, 1983; Rashid, et. al., 1996). Although none of these vignettes includes a case where it is very clear that the specific legal clauses which would require this would become relevant, nonetheless, many of the participants[39] in the research project would have been aware that there are times when they are obliged to discuss confidential information with the client's "nearest relative" (Ball, 1992, p. 105), regardless of his wishes. Thus the vignettes were designed so that the respondents were forced to consider whether or not to disclose to different people with varying degrees of relationship with the named client.

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[38] Vignette Two borders on this, due to the diagnosis of paranoid schizophrenia, and (in the later variations) information about past violence. However, the respondents were also told that Jim had been living in the community and functioning well for a considerable period of time, without need for any lengthy hospital admission. None of the information suggested he was not cooperative with treatment, or had been involuntarily admitted to hospital in the past, all of which are factors which could be expected contribute to including a patient's name on the register. Moreover, I was completing my interviews in 1994, before the legislation was enacted which brought in Supervision Orders (although those people interviewed certainly were aware of the forthcoming legislation). Jim is a client, however, who potentially could be subject to the Care Programme Approach which mandates systematic assessment of care needs, an agreed care plan, allocation of a key worker, and periodic reviews - in short, close inter-agency cooperation and inter-professional liaison - although all this is supposed to be on a voluntary basis with the client's agreement (Department of Health, 1990).

[39] Many, but not necessarily all. Chaplains, particularly those who are employed part-time as chaplains, and who spend the majority of their time as parish ministers, would not necessarily know this. In addition, not all of the non-qualified social workers would be aware of this, because the nature of their training and day-to-day work would preclude them ever being in the position of making decisions about involuntary admission to a mental hospital. However, the most of qualified social workers (whether or not they were also Approved Social Workers) and nurses who participated in this research would have been aware of this legal requirement.

When developing the vignettes, care was taken to identify the precise key issue being examined through the specific case factors, and how each factor affected respondents' decisions. This also had the advantage of enabling respondents to reflect and comment on how they felt about their quandary (to disclose or not) after each change in the case was brought forward. Inevitably there is some repetition of key issues throughout the vignettes; this was deliberate. The structure of the variations for each vignette in relation to each topic can be depicted as follows:

Vignette One:

> Case Topic: Cathy is a young woman who has suffered multiple bereavements which have left her very vulnerable. She is depressed and now homeless. As the vignette is varied additional information suggests she may be at increased risk of harming herself, although the exact level of risk is never made very clear.[40]

Issue: Varying Level of Risk of Harm to Self

Simple Case	Complicating Factor	Added Complication
Basic Story	Self-mutilation	Suicidal
(Low)	(Medium)	(High)

Issue: Varying Degree of Relationship

Doctor/Staff	Mother	Friend
(Professional)	(Related)	(Non-related)

Issue: Varying Level of Risk of Harm to Self and/or Others

Healthy Mother or Friend	Frail Mother	Depressed Friend
(Low)	(Medium)	(High)

[40] The vignette incorporates factors which research has shown are associated with increased risk of suicide, such as homelessness, being widowed, childhood bereavement, unemployment, etc. (Ryan, 1996; Morgan, 1994).

Vignette Two:

Case Topic: Jim has a long-standing diagnosis of schizophrenia (mildly paranoid). He has generally lived in the community in stable circumstances with his condition well managed by medication. However, although he is still taking his medication, recently he has become increasingly agitated about people around him. As the vignette is varied increasing information is given about the potential for anti-social behaviour on the part of Jim, although the exact level of risk is never made very clear.[41]

Issue: Varying Level of Risk of Harm to Others (History of Acting Out)

Simple Case	Complicating Factor	Added Complication
Basic Story (Low)	Nuisance (Medium)	Violence (High)

Issue: Varying Level of Risk of Harm to Others (Living Situation)

Neighbour Target Lives w. Family (Low)	Neighbour Target Lives Alone (Medium)	Family Target Lives w. Family (High)

Issue: Varying Degree of Relationship

Doctors (Professional)	Parents (Related)	Neighbour (Non-related)

Vignette Three:

Case Topic: Mark is a young learning-disabled man who is attending a workshop training programme. He has recently been shoplifting alcohol and bringing it to work. In later variations he shares the alcohol with other clients and his living circumstances change.[42]

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[41] Factors associated with an increased risk of anti-social and violent behaviour from mental patients, such as type of diagnosis, length of illness, past history of anti-social behaviour, degree of relationship with potential victims, etc. have been incorporated into this vignette (Crichton, 1995; Estroff and Zimmer, 1994; Ryan, 1996).

[42] Some of the same elements which can be seen in the training case studies about learning disabled people developed by Kemshall and Pritchard (1996) were incorporated into this vignette, although it must be noted that the vignette does not use the kind of extreme examples used in this training literature.

Issue: Varying Level of Risk to Self

Simple Case	Complicating Factor
Age 26 (Low)	Age 16 (High)

Issue: Varying Level of Risk to Self or Others

Self Only	Providing to Alcohol to Others
(Low)	(High)

Issue: Varying Degree of Relationship

Workshop & Resid. Staff (Professional)	Parents (Related)	Police, Shopkeeper Other Group Members (Non-related or no duty of care)

Vignette Four:

Case Topic: Mary is a single parent of two pre-school children; she is receiving help to combat her dependence on prescription medication. She is stressed and sometimes feels she cannot cope. Variations of the case increase risk of harm to the children through physical chastisement and health problems.[43]

Issue: Varying Level of Risk to Others

Simple Case	Complicating Factor	Added Complication
Basic Story (Low)	Bruising (Medium)	Health Problems & History (High)

Issue: Varying Degree of Relationship

Doctor, Child Protection (Professional)	Supportive Husband (Close Relative)	Estranged Husband (Non-relative)

[43] Factors such as drug misuse, acceptance of physical chastisement, chronic health problems, young age of child, etc. have been associated with increased risk of child abuse (Stone, 1993; Corby, 1996).

THE PILOT STUDY

Before engaging in the research study itself it was necessary to test the interview conditions and the instrument and its vignettes, in a pilot study. The cases had been devised for, and the pilot was carried out with nurses and social workers, since that had been the original sample decision. But it was agreed that the types of case would be familiar to members of any of the caring professions. It was necessary to test the interview procedures and the vignettes for clarity, relevance and face validity. Moreover, apart from orthodox research procedure, it is reassuring to actually conduct a set of 'rehearsals'.

This pilot study involved two steps. First, two nurses and two social workers who would not be participants in the study, who are personally known to the researcher agreed to take part. Interviews were held with each, the vignettes were reviewed and these interviews differed only from the 'research' ones in that at the end the process, the cases and all aspects of the instrument were discussed, were frankly appraised for relevance and typicality, and suggestions were made for small improvements. These appraisals focused on whether the questions asked were appropriate and sufficiently factual and the language used in the cases and by the interviewer was 'neutral' (i.e. did not, in any way, guide or influence the respondent). There was also much discussion as to whether the vignette cases were 'true-to-life' involving grey area decisions, not traumatic or extreme situations where the decision to disclose would be obvious. The pilot respondents were also asked to comment on whether the structure of the vignettes accurately conveyed issues of 'risk' and of complicated relationships and conflicting loyalties. The pilot study did not include any chaplains. However the design of the vignettes was discussed with one chaplain before the research interviews were undertaken, and his advice sought about the same issues as those discussed with pilot respondents.

A second step was added to the pilot study in order to obtain an expert outsider's view of an experienced social science academic researcher. She

was sent a copy of the vignettes and asked to critique their contents to assess whether each modification to a case added sufficient 'weight' of difficulty to the disclosure decision as to be regarded as a real decision point and whether it made a difference that some vignettes had what I considered to be four decision points and others only two. The ensuing discussion about what I felt each complication represented and how it was proposed to analyze the interview information clarified my thinking about the vignettes.

In summary, the pilot research exercise led to minor adjustments of wording in the instrument, the preamble to the interviews and the research procedures, and reduced the number of vignettes from five to four. It also helped me clarify my notion of how the information which emerged during the interviews might be analyzed, but by and large no real change was made to the research design, the instrument or the intended procedures. All were found to be satisfactory.

THE ANALYSIS

The recommended process for analyzing qualitative research findings in the social sciences (gathered by detailed unstructured or semi-structured interviews and comparable techniques) are well defined in research methodology literature (Riley, 1990; Bryman and Burgess, 1994; Coffey and Atkinson, 1996; Mason, 1996). This study involved the following steps:

1. Shortly after each taped interview the tape was transcribed and entered on the computer, each interview being treated as a file. The file was labelled by codes which identified the respondent by profession and the characteristics provided during the interview.

2. The codes, comparable to those used in statistical data computer entry, enabled respondents to be tabulated on these factors sufficiently to describe the distributions in the sample. They would also protect respondent anonymity and ensure research accountability whenever a respondent's words were directly quoted or a lengthy descriptive

paraphrase used for illustration. Source could then be cited by code which would inform the reader about the characteristics of the speaker. (The characteristics of the research respondents are described in Chapter Six). For example a quoted respondent might be identified as "a nurse with five years experience in mental health work and another ten of more varied nursing duties cited a similar case she encountered where she...." The coding of the stages of each vignette allowed me to indicate points at which agreement to disclose was reached and relate these to the characteristics of each participant.

3. Each interview transcription was read several times to ensure that, at each decision point in a vignette, the words of the respondent could be weighed carefully and classified as a "yes", "no", "maybe", "rationalization". This permitted fairly easy recognition of the incidence of agreements and refusals to disclose for most of the decisions and the unclear or tentative ones could each be considered individually as, on balance, a "yes" or a "no". However, the rigour of statistical analysis was not intended.

4. After these rather mechanical research steps the interviews were again read and re-read to isolate wording which would indicate the major themes to be found throughout all the interview material, and those unique only to sub-groups of participants. Noted also were the factors which seemed to trigger the disclosure decision, phrases which revealed consistency or inconsistency of response, words which suggested indecision and/or conflicting loyalties which made compromise decisions difficult, and the justifications used to account for respondents' decisions on each case and how these changed as a circumstances in the vignette changed. Such phrases were colour coded by use of highlighter pens, so that examples could be found quickly and quoted verbatim for use throughout the research report. All data analysis was done manually. Although computer programmes are now being developed for qualitative data analysis, I did not feel any were satisfactory for this project.

In analyzing verbal information there is always the danger of analyst bias. In a large study using many research assistants, to overcome such bias and strive for inter-analyst reliability, as the classification categories are created from the respondents' phrases, more than one analyst reads all transcripts until there is consensus that the categories capture all the variations voiced by the participants. When there is but one analyst the danger of inconsistency of analyst interpretation of the transcript copy is nullified, but the problem of potential bias still persists. This problem has to be acknowledged as a potential difficulty with this kind of Ph.D. research project. The curb on bias is provided by the challenge of the student's thesis supervisors as they receive progress reports and read drafts of manuscript chapters.

Research neutrality was made evident by having all participants interviewed in the location of their choice which, for most, was at work. In addition to the vignettes, all respondents were asked the same questions about their professional qualifications and experience as well as the type of work they were currently doing. At the end of the interview they were also asked general questions about their knowledge of law, policy, a professional guidelines which might affect boundaries of confidentiality.

Before agreeing to participate respondents were assured that the information and opinions they provided would be used for the research purpose of my doctoral thesis only and any quotations would be anonymously reported or paraphrased in my report. They were invited, if they so wished, to review their interview transcript to correct any inaccuracies, but none took up the offer.

CHAPTER SIX

PROFESSIONAL BACKGROUND OF RESPONDENTS

For this chapter participants' self-described characteristics and their decisions were classified and tabulated so that comparisons of the sample's sub groups might be shown. Before beginning discussion about the vignettes, all people interviewed were asked a few standard questions about their personal and professional background. These results are discussed below. A total of fifty-five people were interviewed for the research. Twenty-seven were Nurses. Twenty-one worked for Social Services; of these eleven were professionally qualified Social Workers, while ten were employed in an auxiliary capacity (Social Work Assistant, Community Mental Health Worker, Case Manager). Only seven Chaplains were interviewed. The following tables provide some information about the background or 'profile' of the people who participated in this research.

A caveat must be entered: The statistical distributions describe the special respondent population of this research study and compare groups within the sample and their disclosure decisions about the four case vignettes they were asked to address, but this is not intended to imply that a claim as to the representative character of the numbers is being made. Statistics have been used merely because they help to sharpen the picture being painted of the members of the sample and the decisions they reported they would have made if faced with practice situations like those in the cases described in the vignettes. All of the percentages need to be treated with caution due to the low numbers of respondents.

SAMPLE CHARACTERISTICS

Information about the respondents racial or ethnic origin (self-description) was collected. All were of White/British Isles extraction.

Age

Comparison of the three sub groups of the sample is shown in Table One. There was a considerable age gap between the oldest (62 years) and youngest (27) person interviewed, however this reflects only the extremes.

The bulk of the sample ranged in age between the mid-twenties and mid-forties. By comparing the sample's percentage figures on the right of the table with those of each professional group, it may be seen that the nurses who participated in the study were younger than the respondents from the other two professions (more than half were between 25 and 35 v almost half the social workers being aged 36 to 45, and 4 of the 7 chaplains older than 46). One might reasonably describe this sample as young middle-aged and, by this indicator, they would probably be at the mid-career stage.

TABLE 1

Age Distribution of Respondents by Profession

	NURSES #	%	S.W. #	%	CHAPLAINS #	%	TOTAL #	%
26 - 35	14	52	6	28			20	36
36 - 45	9	33	10	48	3	43	22	40
OVER 46	4	15	5	24	4	57	13	24
TOTAL	27	100	21	100	7	100	55	100

Sex

The distribution of the respondents by sex is shown in Table Two. For the sample as a whole there was an unintended, fairly even split, male:female of 53 percent:47 percent. However, while this ensures that in this study the views of both sexes were well represented, in terms of employment in the three professions combined, the number of males participating in the study created a sample bias.

The names of 37 nurses were provided to me as potential interviewees; 15 of them were male, and 22 were female. This means that the total sample of nurses from which I drew people to interview had a male:female ratio of 40 percent:60 percent. The sample of nurses who were interviewed had a male:female ratio of 44 percent:56 percent. This meant a slight over-representation of the views of male nurses, but, given the small numbers involved, probably this is not significant.

However, the same cannot be said of the social workers. The names of 31 social workers were provided to me as potential interviewees; 11 of them were male, and 20 were female. This means that the total sample of social workers from which I drew people to interview had a male:female ratio of 35 percent:65 percent. However, the sample of social workers who were interviewed had a male:female ratio of 48 percent:52 percent. This meant that the views of male social workers were significantly over-represented, because a higher proportion of male social workers agreed to be interviewed than did female workers.

Only the names of male chaplains were provided to me as potential interviewees. It appears there are no female chaplains in Leeds.

The considerable over representation of males is sufficient to skew the sample as a whole and provide undue importance to the male point of view. However, since it was not the intention for this thesis to carry out a representative quantitative survey, nor to assess the relative willingness of male and female professionals to disclose confidential client information, it is sufficient if the reader is warned of the possible presence of systematic bias.

TABLE 2

Sex Distribution of Respondents by Profession

	NURSES		S.W.		CHAPLAINS		TOTAL	
	#	%	#	%	#	%	#	%
MALE	12	44	10	48	7	100	29	53
FEMALE	15	56	11	52			26	47
TOTAL	27	100	21	100	7	100	55	100

Qualifications

Respondents were asked for both their professional and academic qualifications. these are shown in Tables Three and Four. As expected of any sample of professional workers, these respondents proved to be well educated both academically and technically. Over half of them (53 percent)

hold university degrees; the rest have no academic qualification beyond secondary school level, but all have had some professional training and almost all had the formal, basic, entry-level qualification of their profession.

As a licensed profession, the nurses were the most uniformly qualified. All had completed the R.M.N. (or equivalent) which is required for registration. All the chaplains had completed the seminary course required of their religious denominations to be ordained as a priest or minister. The technical qualifications of the social workers were more varied. Five of them had only had in-service training and another five (making altogether almost half of the sub group) had formal training only to the certificate level (apart from additional in-service training).

Social services departments typically employ many kinds of worker to provide front-line services to people with mental health problems. The ten respondents referred to above would not be considered professionally qualified by the social work profession. Such workers are colloquially referred to as 'unqualified personnel', but this can be something of a misnomer since they may possess appropriate, recognised qualifications not accepted as standard professional social work qualifications in the UK. This was the case with five of the members of this sample who had completed accredited vocational or professional courses related to their current work. For example, as a group, they had completed the following: the R.M.N., the City and Guilds - Nursing Assistant course, B.T.E.C. - Mental and Physical Disabilities course, City and Guilds - Community Care course, a two-year Diploma in Social Care.

Three-quarters of the nurses and sizeable minorities of the other two professions held additional accredited or advanced professional qualifications which involved specialist training. For example: the nurses had completed courses (ranging in length from nine months to two years part-time study) leading to one or more of the following: the Diploma in Community Psychiatric Nursing, Advanced Diploma in Counselling, H.E.

Diploma in Community Health, Diploma in Family Therapy, Diploma in Psychosocial Intervention, the Health Education Certificate. One chaplains with additional training was a qualified Youth Worker (two-year full-time course) while two had completed the Certificate in Counselling (minimum one-year full-time course).

Only 11 of the 21 social workers in the sample would be recognised as having the full professional qualification desired of a social worker in this country - the C.Q.S.W. or the Dip.S.W. Eight of them had also taken advanced formal training which conferred upon them a specialist status. The most common of these was Approved Social Worker training, a three-month, full-time course, completion of which qualifies the recipient to undertake special responsibilities under the Mental Health Act, 1983. Other types of certification of advanced training also mentioned were: the Post-Qualifying Diploma in Social Work, Certificate of Management Studies, Certificate of Advanced Counselling and Psychotherapy, and the Certificate in Handicap Studies.

Table Three reads as follows: all the nurses hold the basic qualification; for 7 of them that is the highest professional qualification; 20 also hold some advanced diploma or certificate - sometimes more than one but this is not recorded in the table; there is no double counting.

TABLE 3

Professional Qualifications of Respondents Distributed by Profession

	NURSES		S.W.		CHAPLAINS		TOTAL	
	#	%	#	%	#	%	#	%
IN-SERVICE			5	24			5	9
RELATED			5	24			5	9
BASIC	7	26	3	14	4	57	14	25
ADVANCED	20	74	8	38	3	43	31	56
TOTAL	27	100	21	100	7	100	55	100

In-Service = Training Courses provided by the Employer (past or current).
Related = Training Courses which are related to the field of work, not provided by an Employer, and not one of the recognised professional qualifications.
Basic = Entry-level Professional Qualifications.
Advanced = Professional Qualifications additional to the Basic level.

There appears to be little difference among the three professions represented in the sample in terms of the percentage who held academic degrees. 53 percent of the sample report having (or just completing) one or more academic degrees, and the comparable figures for the subgroups were: nurses, 52 percent; social workers, 57 percent; and chaplains, 53 percent. Nine percent of the sample held (or were just completing) post graduate (Master's level) degrees, and the comparable figures for subgroups were: nurses, 11 percent; social workers, 9 percent and chaplains, 0. However, the degrees are not necessarily directly related to the respondents' professional work. Some had obtained a degree before taking their professional training. Some obtained a degree while studying concurrently for some professional qualification. Others studied for the degree part-time while working in their profession. A few mentioned taking leave from work to complete a degree.

TABLE 4

Degree Qualification of Respondents Distributed by Profession

	NURSES		S.W.		CHAPLAINS		TOTAL	
	#	%*	#	%*	#	%*	#	%*
B.A/B.Sc.	11	41	10	48	3	43	24	44
MASTERS	3	11	2	9			5	9
TOTAL WITH	14	52	12	57	3	43	29	53
TOTAL NOT	13	48	9	43	4	57	26	47

* Percentages shown are the percentage of total sample of each professional group, not percentage of those who had degrees.

The types of academic qualifications are diverse. Among the nurses, for example, the largest number had a B.Sc.N. or a B.Sc. (nursing), but one had a degree in chemistry, two had B.A.s in Psychology, and one was finishing an M.Sc. in geriatric care. Similarly, among the social workers many different degrees had been obtained, but most were in the social sciences. For example: two had baccalaureates in Social Studies, two had B.Sc.s in Behavioural Science and Psychology, one had an M.A. in Crime, Deviance and Social Policy. However, some of the respondents' academic interests were surprising. One of the social workers had a B.A. in English

Literature; one of the chaplains was studying for a B.Sc in Physics. The other degrees of the chaplains, predictably, were (completed or completing) in theology.

Relevant Work Experience

It was expected that, when confronted with the problems exhibited in the case vignettes, respondents would comment and make decisions based on their general professional knowledge and training, and on the insightful wisdom gained from their total professional work experience and, in particular, their experience in the particular setting of their present jobs. Therefore, two questions were asked about experience: the total in that kind of work and the time in the present setting. It was expected that work experience knowledge and judgement would be filtered by information about the current employer's policies, procedures and preferences (all the intangibles which make up the ethos of a particular workplace) discounted by similar knowledge of other comparable work settings. If the respondent's experience was long and varied and the present employment of short duration, it was expected that respondents would use such phrases as: "This is the way I always decide about...." , rather than, "In this hospital (agency etc.) we always ....".[44]

Initially the instrument contained only one question about experience - total experience. However, during the pilot study it became evident that professionals in employment situations often find their long experience at odds with the procedures of their current employer. The possibility of ethical dilemmas arising in such situations is high. It was thought that if two experience questions were asked and the distributions were different, this might indicate a source of ethical tension in daily practice. Comparison of the figures in Tables Five and Six do indeed present some sharp contrasts.

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[44] In the end, with the exception of the analysis presented in Chapter Ten, the data were not analyzed in this way. Much of the specific detail about career paths gathered in the interviews simply was not used in the thesis. However, this was the original reasoning behind asking two related questions about work experience, rather than simply asking one.

TABLE 5

Past Years of Experience Distributed by Profession*

	NURSES #	%	S.W. #	%	CHAPLAINS #	%	TOTAL #	%
UNDER 2	1	4	2	9			3	5
2 - 5+	10	37	4	19	1	14	15	27
6 - 9+	7	26	9	43	2	28	18	33
10 & OVER	9	33	6	28	4	57	19	35
TOTAL	27	100	21	100	7	100	55	100

* Past experience does not include those years spent in professional training.

TABLE 6

Number of Years in Current Post Distributed by Profession

	NURSES #	%	S.W. #	%	CHAPLAINS #	%	TOTAL #	%
UNDER 2	12	44	9	43			21	38
2 - 5+	10	37	11	52	5	71	26	47
6 - 9+	3	11	1	5	1	14	5	9
TEN & OVER	2	7			1	14	3	5
TOTAL	27	100	21	100	7	100	55	100

As the data on age and qualification would suggest, most members of this sample are at the mid-career stage and they bring considerable relevant experience to their work. This was revealed in the discussions during the interviews, and confirmed by tabulations of the participants' statistics. Only three respondents (5 percent of the total sample) might be classified as neophytes, and for none was this the first year of professional work. The prior work experience figures of Table Five do not include years of work which were part of a professional training programme. However, they do include years in which the work may have been both full-time and part-time, with the latter not discounted into full-time equivalents. Of the 27 nurses in the sample, 59 percent had 6 or more years professional work experience; the comparable proportions for the social workers and chaplains were 71 and 68.

In view of their long years of related professional work experience, it is interesting to note how many of the respondents were fairly new in the current job. The overwhelming majority of them (47 out of 55, 85 percent) had held their current position for fewer than six years, and 21 of that total (38 percent of the sample) when they were interviewed had been less than two years in their present position.

Overall differences between the professional groups were slight, and, due to the small numbers, must be treated with some scepticism. However, it would appear that the chaplains as a group held the greatest degree of past professional experience and the nurses the least. This is not surprising given that the age distribution of the respondents shows that the chaplains were generally slightly older, and nurses, as a group, were generally slightly younger than social workers.

SUMMARY

Before discussing the vignettes, respondents were asked for some basic information about their personal and professional backgrounds. These findings have been classified and tabulated so that a comparison of the sample's sub-groups is shown. Apart from this, however, the data have been presented without much analysis or discussion. They are intended merely to provide information, something of a 'profile' of the people who participated in this research. They included roughly equal numbers of men and women. Generally the respondents were a fairly well-educated group of people. They might generally be classed as 'young middle-aged' who were often at a mid-career stage in their professional lives, with considerable past work experience. However, these statistics and the 'profile' of the respondents that they present are based on small numbers and it would be inappropriate to try to extrapolate wide-ranging or comprehensive conclusions based on these data. No claim is being made to generalize the findings of the thesis to the whole membership of the professions involved.

CHAPTER SEVEN

CONSISTENCY

In this chapter the concept 'consistency' is used to analyze the interview materials of the thesis research. The presence or absence of consistency is examined in various ways. The chapter consists of five sub-sections.

In the first sub-section, participants' disclosure decisions are analyzed to note when they made the decision to breach client confidence. The differences between the three professional groups are discussed, both in terms of whether they would disclose information, and whether these decisions were consistent within each professional group and/or consistent across professional groups, and in terms of when (at which point in each vignette) they would breach strict confidentiality.

In the second sub-section the data are analyzed in relation to the issue of who to tell. Once again there is discussion about the similarities and differences in the choices of the three professional groups, and the consistency of their choices of the appropriate recipient of confidential client information.

The third sub-section in this chapter discusses in terms of consistency, those respondents who, for a case vignette, first made a decision to disclose and then changed to a refusal to disclose position, as well as those who at first would have disclosed to a given person (or type of worker) and later revoked that decision to disclose to a different person.

The fourth sub-section deals with consistency in oneself, what herein is termed 'self prediction'. This occurs when, early in the case discussion, the participants reveal that they would have disclosed the information "if..." (some circumstance or complication had been present) and then, when that variation did occur later in the story, they decided not to disclose.

Finally, each vignette was analyzed for consistency of interpretation of

the case to see whether there was present a predisposition of these professionals to "see" a case in terms unique to their group, thus "interpreting" the same facts differently by stressing different aspects of the context and environment of the problem. This is reported in the fifth sub-section of this chapter. Respondents' choices were dependent on their interpretation of the information presented to them in the individual vignettes. All those interviewed were presented with the same vignettes, but people do not always interpret a given set of information in identical ways. During the interviews, differences in interpretation led on occasion to radically different (if not opposite) disclosure decisions being made for different reasons.

One of the claims both the occupations represented here and their employers often make is that the specialised advanced formal training and guided professional practice available both through qualifying programmes and during subsequent practice (as well as additional post-qualifying specialist training) ensure that workers within a given 'profession' can be relied on to interpret facts in a consistent way - relied on to make good and consistent judgements in which, given the same set of facts, one worker would generally agree with another's decision. That is one of the attributes of 'professionalism' - one member of the profession, having been socialized into the group's unique way of thinking and acting, will generally agree that, given the known facts in a case, they would make the same decision and act in the same manner (or, if not make precisely the same decision, agree that both their's and the other workers' decisions are equally appropriate, valid and professionally correct).

Potentially, however, if the members of a single occupational group do not act thus, it can have serious implications for the employer, for professional disciplinary bodies, the Courts, or a public enquiry, any of whom might find themselves subsequently reviewing the individual worker's decision in the event of a complaint or problem. In the 1990s most professional workers are expected to be accountable for their practice decisions, and employers are also often expected to be accountable (or at

the very least, to ensure that they have employed a worker whose judgement can be relied upon and take appropriate steps to redress this should they discover otherwise). This kind of consistency to ensure accountability pre-supposes that there is an accepted standard or group norm against which any given judgement can be measured. Thus, it was important to analyze the respondents' choices about when to disclose and to whom to disclose to determine if such a consistent and stable 'standard' could be detected.

In addition, workers in the caring professions are increasingly being are integrated into close-knit networks of persons who share the same clients. For example, mental health social workers no longer operate relatively independently in their jobs. Increasingly they liaise closely with other professionals (who also visit the same clients) about the tasks they, as social workers, are performing, and how well, in their view, the client is functioning. The same is true of nurses, and to a lesser extent, is becoming true of chaplains. Thus it was important, in this research, to examine exactly at which points in each vignette respondents made decisions to disclose, and the extent to which participants from the three different professionals agreed or disagreed with each other about the importance of sharing information regardless of the client's wishes.

The varying decisions professionals take about 'whom to tell' might well reflect serious differences between occupational groups. It was expected that respondents who belong to the more highly 'professionalized' occupations (in the sense of being more closely involved within an integrated professional service network which has expectations about 'normal' sharing of information) would be more likely to disclose confidential information at earlier stages and more consistently disclose only to certain persons or agencies, so that there would be greater predictability of their decisions. In contrast it was expected that those who act more autonomously and work within a less recognized role, having a less visible professional network, would show greater autonomy of decision-making and less consistently articulated professional support for

their decisions, decisions, in turn, which would appear to be idiosyncratic and unpredictable. Thus it was expected the nurses would disclose more often and earlier than would the social workers, and the chaplains would be least likely to disclose. The decisions of the latter would be the least predictable, least identical to each other, least disposed to disclose, and would breach confidentiality later in the story only as a last resort, since they would have no clear reference figure in whom they habitually confide.

More subtle issues of consistency also arose as the transcripts were read and re-read. Respondents' decision choices obviously depend upon their interpretation of the information provided. All interviewees were presented with the same vignettes. But, it was expected that they would not 'read' the facts in identical ways. However, one alleged attribute of 'professionalism' is that all the members of the special group (the 'elect' one might say) have a unique body of work/practice information which leads to common understanding expressed in their common 'professional language'. They take the same meaning from terms (jargon) common to their community. Such unanimity is achieved by their long professional conditioning process. Differences of interpretation ought to be minimal. This leads to similarity and predictability of response to the needs of the typical cases in everyday practice. However, in the interview transcripts, it quickly became evident that differences in interpretation of the same vignette material were occurring and, on occasion, these had led to radically different decisions being made. Since this has serious implications for professional disciplinary bodies, it was appropriate to document its presence and extent, and discuss the reasons for its occurrence.

WHEN TO DISCLOSE

Vignette One:

A significant proportion of all respondents, over one quarter (27 percent), said they would disclose information about Cathy at the earliest stage in this vignette. This increased by a further 18 percent when the

risk factor of self-mutilation was added, and increased again when a past history of suicide attempts was added to the case information. By this point the large majority (81 percent) of all respondents had decided, against Cathy's wishes, to disclose information to somebody. Generally the nurses would more readily disclose information at earlier stages than would either social workers or chaplains.

TABLE 7

Distribution of the Points of Disclosure (Version 1, 2, 3, etc.) of Vignette One by Professional Group (Number and Percentage)

	1	2	3	4	5	6	None	Tot
N	10 37%	5 19%	10 37%	2 7%				27 100%
SW	5 24%	5 24%	8 38%	1 5%	1 5%		1 5%	21 100%
Ch			2 29%	1 14%			4 57%	7 100%
Tot	15 27%	10 18%	20 36%	4 7%	1 2%		5 9%	55 100%

However, this combined figure masks the differences between the three professional groups. Clearly there was considerable congruence between the decisions made by social workers and nurses in this vignette. All nurses eventually disclosed and only one social worker did not. However, generally the nurses would disclose more quickly. 37 percent of nurses said they would disclose at the initial version of the vignette, compared with 24 percent of the social workers. By version three of the vignette, 93 percent of the nurses had decided to disclose while only 86 percent of social workers had made the same decision.

For this vignette chaplains were the group least likely to disclose. None decided to breach confidentiality in the earlier versions of the vignette; it was only when a past history of suicide attempts was added (at the point when a substantial majority of nurses and social workers had already committed themselves to breaching confidentiality) that some chaplains decided they must discuss the situation with a third party. In the end,

57 percent of the chaplains opted to maintain confidentiality throughout the discussion of Vignette One. This position was in marked contrast to the members of the other two professional groups.

It may be said, therefore, that in the case of Vignette One there was some consistency of response to the question of disclosure apparent between the nurses and social workers, which the chaplains in this sample did not share.

However, what of the consistency within each group of its members' disclosure decisions? After the initial version of the first vignette the nurses were 10 to 17 in favour of breaching confidentiality - not a high level of congruence. At the second decision point they were 15 to 12 in favour; and by the third (when there were two other possible complicating factors still to be revealed), they were unanimous. So it might be said that, given a case with several risk factors readily apparent, nurses will likely agree that a breach of confidentiality is both necessary and desirable. In the initial stages of such a case, when few of the risk details are known, disagreement about the proper decision will be substantial.

Initially, in this vignette, the social workers showed slightly less uniformity of decision-making on the issue of disclosure, but they too, by the third decision point, were showing remarkable consistency, agreeing that it was necessary to breach confidentiality. After the first version of Cathy's story, they were only 5 to 16 in favour of disclosure; at the second decision point they were roughly in balance (10 to 11), and by the third were 18 to 3 in favour of disclosure. So one might draw much the same conclusion for the social workers as for the nurses in terms of congruence of decision-making, except perhaps to recognize a more conservative initial stance revealed by a reluctance to breach client confidentiality in cases where there is only small evidence of risk.

As for the chaplains, they exhibited little group unanimity except a very

strong reluctance to take the decision to breach confidentiality. This might be termed a consistently conservative negative position. All began by refusing to disclose and held to that decision until the third version of the story, but based on reasoning which was idiosyncratic and individualistic. After two additional risk factors had been revealed, 2 out of 7 decided to disclose, and when another factor was added the total became 3 to 4. This remained unchanged to the end of the story although two more decision points were faced.

Vignette Two:

TABLE 8

Distribution of the Points of Disclosure (version 1, 2, 3, etc.) of Vignette Two By Professional Group (Number and Percentage)

	1	2	3	4	5	None	Tot
N	12 44%	7 26%	8 30%				27 100%
SW	8 38%	5 24%	6 29%	1 5%	1 5%		21 100%
Ch			1 14%	1 14%	3 43%	2 29%	7 100%
Tot	20 36%	12 22%	15 27%	2 4%	4 7%	2 4%	55 100%

A higher number of respondents decided to breach confidentiality from the outset of this vignette than for any other. This was expected since it had been designed to present the highest risk situation of all four scenarios. Twenty of the 55 respondents started the interview discussions with a willingness to disclose confidential information (regardless of Jim's refusal to consent). By the second decision point, when Jim's history of 'nuisance' behaviour was introduced, the original 36 percent in favour of disclosure had increased to 58 percent, and by the third, when his previous convictions for assault were added, 85 percent of the respondent sample were prepared to breach confidentiality.

Once again the table shows greater convergence between the case decisions of the nurses and social workers than between the chaplains and the rest. A substantial minority of participants (44 percent for nurses and 38

percent for social workers) were prepared to disclose on the information divulged in the original case description. By the third version all the nurses were willing to breach confidentiality and all but two of the social workers, and even these two eventually disclosed. In contrast only at the third decision point did one of the seven chaplains decide that disclosure was necessary; and to the end of discussion on Vignette Two, two chaplains held out, refusing to breach confidentiality. Clearly for a case like Jim's, there is no consistency between the chaplains' approach to decision-making regarding client confidentiality and that of nurses and social workers.

For Vignette Two the pattern of consistency of the disclosure decision within each professional group was similar to that found for the first vignette. At the outset of Jim's case, with the minimum information available, the nurses decided 12 to 15 that, in the described circumstances, confidential information would have to be passed on to a third party. With one additional complicating factor added, the ratio rose to 19 to 8 for disclosure and by the third decision point, the decision to breach confidentiality was unanimous.

The social workers also arrived at unanimity to breach, but only by the fifth decision point. On the original case material the ratio of positive to negative disclosure decisions was 8 to 13; when the second decision had to be made it had reversed to 13 to 8; and by the third point it was 19 to 2.

None of the seven chaplains disclosed information about Jim until the third decision point, after which the ratio on the disclosure decision was 1 to 7. The chaplains changed their minds but slowly, and only after much reasoning back and forth expressing disapproval and doubts, and two remained unconvinced to the end that a breach of confidentiality was necessary. These figures reinforce the impression gained by analysis of the first vignette's responses. If there can be said to be consistency in the chaplains's behaviour it is a negative - to 'let well enough alone'

and 'try to deal with the situation oneself'. With the other two groups, the professional who is well-integrated into a service network, is driven to act, to do something to try to solve the problem, even if only to discuss it in confidential detail with another professional. The chaplains' preferred behaviour seems to be more passive. Each seemed aware that he was acting quite independently, with no strong professional guidelines to support him (or it must also be recognised, to constrain and direct him).

Vignette Three:

TABLE NINE

Distribution of the Points of Disclosure (Version 1, 2, 3, etc.) of Vignette Three by Professional Group (Number and Percentage)

	1	2	3	4	None	Tot
N		9 33%	8 30%		10 37%	27 100%
SW		6 29%	6 29%		9 43%	21 100%
Ch		2 29%			5 71%	7 100%
Tot		17 31%	14 25%		24 44%	55 100%

This vignette contained the least blatantly risky complicating circumstances, and no respondent was willing to breach confidentiality at the outset of the case. This was expected, since it had been designed to present the lowest risk situation of the four case scenarios. However, in the second version, when the information was added that Mark was providing alcohol to other clients at the workshop (thus placing other people at risk as well as himself), some members of all three groups showed unmistakeable consistency in judging that now confidentiality must be breached. At this second decision point almost a third of each group's members were willing to disclose. In this case vignette, if respondents were willing to disclose at all, they had made up their minds by the third decision point. Beyond that, they held firm to their original negative decision.

The familiar pattern has become apparent. More nurses disclose than social workers and they tend to disclose earlier in the saga. The chaplains disclose reluctantly and for this vignette only 2 of the 7 make that decision. Once again, there were greater differences in the chaplains' approaches to disclosure and between them and the members of the other two occupations.

In terms of consistency of decision-making within the groups' membership, the evidence of discussions on this vignette would support the contention that the long education and conditioning process which professional workers undergo before they are allowed to practice produces a fairly high degree of unanimity and consistency of judgement, decision and professional action. On the basis of the original case description none of the sample agreed that disclosure was necessary. For the nurses there seem to have been two 'camps'. In the first, about half its members reacted to breach confidentiality after the first complication was added and the rest after another set of risk circumstances was revealed. Combined the first camp represent two-thirds of the nurses (17 out of 27). Right to the end of discussions on Vignette Three, there was a minority camp which maintained its initial decision not to disclose. So one might say there was an evident consistency of decision-making within the nurses' group, but within one of two interpretations of what professional action this case required.

The members of the social work group, after initial negative disclosure unanimity, also showed consistency within two fairly equally held opinions about the need to disclose. The unanimity at the first decision point, by the second had broken down to a 6 to 15 ratio for disclose/maintain confidentiality; by the third, opinion was fixed at 12 to 9 in favour of breaching and thereafter did not shift.

By Vignette Three, the chaplains' generally conservative reluctance to intervene by reference to a third party was well established. They show the highest group consistency; it breaks only gradually. The question must

be asked, however, whether this apparent consistency arises from a uniform professional 'cast of mind' about chaplaincy practice, or from the general theological role of a confessor giving comfort and advice, whose confidentiality is almost never breached even under very stressful circumstances. In other words, whether the chaplains' consistency of decision-making arises from a sense of professional identity functioning within the prescribed parameters of their role as chaplains within the health trust, or from their sense of 'calling' and 'ministry' due to their religious ordination with the latter's role concepts and imperatives being much more strongly committed to the importance of the individual troubled person against all others' needs, than is encompassed by the concept of 'professional service'. Such strong commitment would have been less likely eroded by the circumstances of Vignette Three, which presented quite a low risk scenario.

Vignette Four:

TABLE TEN

Distribution of the Points of Disclosure (Version 1, 2, 3, etc.) of Vignette Four by Professional Group (Number and Percentage

	1	2	3	4	5	None	Tot
N	1 4%		6 22%	10 37%	4 15%	6 22%	27 100%
SW	5 24%		8 38%	3 14%	3 14%	2 10%	21 100%
Ch			3 43%	3 43%		1 14%	7 100%
Tot	6 11%		17 31%	16 29%	7 13%	9 16%	55 100%

Response to the final vignette appears to have been the exception which proves the rule; the pattern of decisions to disclose does not conform to the distributions already discussed. The nurses had the lowest, rather than the highest, disclosure rate of the three professionals groups (78 percent), and in this case there was greater congruence between chaplains and social workers than between nurses and social workers. In general, the social workers disclosed at an earlier stage than the others. Five (24 percent) were willing to share some information with third parties from

the outset of the story, and by the end 19 of the 21 would have breached client confidentiality. In comparison, none of the chaplains had decided to disclose until the third decision point in the vignette and only one of the nurses. However, by version three, 62 percent of social workers and 43 percent of the chaplains were prepared to disclose information against Mary's own wishes, compared with only 26 percent of the nurses. It was not until the fourth version of the case, when information about the child's ill-health was added, that a large percentage of nurses decided to disclose (37 percent).

Explanation for the pattern of decision-making revealed by the figures of this table may lie in the content of the vignette. The different training, roles and experiences of nurses, social workers and chaplains undoubtedly lead them to place special emphasis upon different aspects of the specific risks introduced into the four vignettes. This is explored further in the second section of this chapter when the varying interpretations (revealed in participants' discussion of the cases) put on each vignette are explored. It will suffice to point out here that specific training about situations that might indicate child abuse (or that at least might not be 'healthy' for a child) forms only a small part of the basic pre-entry-to-practice, formal professional education of a nurse. Therefore, these nurses might not be strongly impressed by case notes that suggest that a style of child-rearing which might include hitting the child is probably present, but they would be alerted to its possible importance when other information about the child's chronic medical problem is later added.

In contrast all social workers, regardless of their specialist area of work, are required to have taken programme modules specific to child protection as a part of their entry-level professional qualification. Similarly, the parish work of clerics often involves work with stressed families. They visit the homes of their parishioners and their training includes advice on parental counselling. Two of the chaplains in the interview specifically mentioned that counselling anxious mothers and trying to help parents who are frustrated with their children's bad

behaviour are common themes in pastoral work. Certainly, before social work was firmly established as one of the main family and child care professions (early in this century) and as the one profession holding primary legal responsibility for dealing with child abuse (post World War II), it was religious ministers and priests who were the prime source of help and/or social control for families with problems (hugman, 1991). On reflection, therefore, it ought to have been expected that participants from these two professional groups would disclose earlier in Vignette Four than would their nursing counterparts. In all likelihood, this merely reflects their greater expertise and 'professionalism' within the area of practice which was the subject of the case.

What consistency of decision-making existed within each professional group for this case? The nurses showed fairly consistent reluctance to disclose (7 to 20) until the point in the story when a possible threat to health was introduced. Then the ratio abruptly changed to 17 to 10. But by the end of the case there was still no unanimity; their disclosure/maintain confidentiality decision ratio overall was 21 to 6.

Among the social workers, despite a general alertness or sensitivity to the possible presence of child abuse, after the original version of the case was read, the ratio stood only at 5 to 16 to disclose. By the third decision point, however, it was 13 to 8, and by the end of the story 19 to 2, which suggests a fairly high level of decision-making consistency within the group provided certain types of risk factor are present and known.

Similarly, among chaplains, after the original version of the case was read, no-one chose to disclose, showing a completely unanimous negative response. By the third decision point (when information about the mother hitting the child was introduced), 3 out of 7 decided to breach confidentiality. Near unanimity within the chaplain's group was again achieved again by the fourth decision point, with 6 out of 7 opting to disclose.

WHOM TO TELL

The concept 'consistency', as used for analysis in this research, has several dimensions. It was important to learn not only whether there was some agreement across all the professions included in the sample as to whether, and when, respondents would make the decision to disclose, and how this varied according to the type of case and client being discussed. It was also equally important to learn what agreement there was in the decision to disclose confidential information only to certain types of recipient and what divergence exists on this dimension. It may be argued, and from the interview discussions it became evident, that "disclosure" in certain circumstances would not be considered <u>really</u> a breach of client confidence because "X" <u>ought</u> to have full knowledge of the case. In addition, it was also important to learn not only who, generally, would be given confidential information about the professional's cases but (1) why (the reasons given, the justifications), and (2) how this relates to the workers' understanding of the four cases (their interpretations of the vignettes - the essence of each case). The justifications for disclosure are reported in Chapter Eight under the rubric "Conflicting Loyalties". The issue of how the research participants interpreted the information given in the vignettes is discussed later section in this chapter.

Below is reported the incidence of disclosure to various kinds of persons. Altogether eighteen categories are shown in the four tables of this section; information recipients were either specific types of people or agencies/figures/offices spontaneously cited by respondents or ones named in reply to a question of the interviewer ("In a case like this or in a situation like this, would you have discussed this with...?" If no discussion follows, use prompt, "How about a ... or a ...?")

Information recipients have been classified as appropriate for each vignette. For the first vignette this was as follows: the original source which referred the case to the respondent, the client's G.P., a psychiatrist, the respondent's supervisor, one of the respondent's team colleagues, referral to another agency or another type of professional,

a residential worker, a member of the client's family, one of the client's friends. It was expected that:

1. Given the different content of the vignettes, the range of recipients of confidential client information would vary from case to case, but that they could be categorized without distorting the information;
2. That there would be some common referents for all cases;
3. That the referents commonly used by the respondents might well vary among the three professional groups but the respondents of a group would be inclined all to use the same type of referent; and
4. That a respondent would consistently use the same type of referent for all four cases described in the vignette and at all stages of decision within a developing case.

In other words, it was expected that analysis of the transcripts would reveal a high level of consistency of referent use - consistency of the individual, of the members within each group, and across the three groups. However, as is shown by the tables below, one of the most striking things about respondents' decisions about whom to disclose information to was their lack of consistency. No one person or figure was cited in a majority of instances as the usual person this sample of professionals would contact as a general rule - not for the four cases as a whole and not for any one of them, not for any of the professional groups, and not even for the individuals of each group. In reality, no 'general rule' about the appropriate person with whom confidential case information is discussed could be established from the interview transcripts which record the respondents' decisions and their discussions about them.

It should be noted that a respondent might disclose to more than one person when worried about a case. For this research, if the respondent reported information to two individuals of the same kind (e.g. two psychiatrists, two kinds of doctor one of whom was the G.P., two different

nursing colleagues), it was counted as two recipients. Because, in some vignettes, some of the respondents did not breach client confidence and some revealed client information to more than one confident, the totals on the right of the tables below do not sum to the total number of members in the sample.

Vignette One:

TABLE 11

Distribution of the Recipients of Information in Vignette One by Professional Group (Number and Percentage)

	A	B	C	D	E	F	G	H	I	T
N	2 6%	9 26%	2 6%	6 18%	1 3%	1 3%	5 15%	6 18%	2 6%	34 100%
SW		5 19%	1 4%	3 11%	2 7%	5 19%	6 22%	5 19%		27 100%
Ch		2 50%		1 25%				1 25%		4 100%
T	2 3%	16 25%	3 5%	10 15%	3 5%	6 9%	11 17%	12 18%	2 3%	65 100%

A = Original Source of Referral
B = Client's G.P.
C = Psychiatrist
D = Respondent's Supervisor
E = Team Colleagues
F = Refer to Another Agency or Professional
G = Residential Workers
H = Client's Family
I = Client's Friend
T = Total

The individual most commonly cited overall in this research, as the recipient of confidential client information, was the client's G.P. In Vignette One this was also the case, but this category accounts for only 25 percent of the 65 recipients. The 50 participants who breached confidence after listening to Vignette One varied greatly as to whom they consulted; recipients ranged from 2 (3 percent of the total) consulting the person who had originally referred the client to the respondent, and 2 who discussed confidential information with the client's friend, to 16 (25 percent) who disclosed to the client's G.P.

As expected respondents who are professionals proved to be more willing to reveal client confidential information to other professionals than to

para-professionals, non-professional workers or lay persons. When the different types of professional are combined (columns A,B,C,D,E,F) they represent 40 (62 percent) of the 65 recipients whom respondents would have consulted about Cathy's case, revealing information she had intended only her case worker to know. There would have been only 11 disclosures to residence workers (17 percent of the total), and 12 to Cathy's family (18 percent). However, as will be discussed in Chapter Eight, there is an issue about the extent to which family can be co-opted into a quasi-professional role, which was recognised by some respondents when they explained why they made decisions to disclose to family. It might, therefore, be argued that in some cases the disclosure to family was equivalent to disclosure to a para-professional co-worker with a formal statutory 'duty of care' to the named client. If one adopts this model, then the combined percentage of disclosures to para-professionals-plus-family rises to more than one-third (35 percent) of the total.

This was the result expected by the research hypothesis, which postulated that respondents would disclose most readily to other professionals, that some would disclose to para-professionals who, they felt, also had a 'duty of care', or to close family who shared this type of concern or role. However, it was expected that there would be great reluctance to involve others who were not closely related and who did not have a clearly established working relationship with the client and/or the professional, and these data support this conclusion.

There was little difference among the three professional groups in the number of recipients used for consultation on Vignette One. The 27 nurses, all of whom disclosed, breached confidentiality by having discussions with 34 recipients, an average of one and a quarter per nurse. The comparable figures for the social workers were: 20 (of 21) disclosed to a total of 27 persons, an average of one and a third per respondent; for the chaplains, 3 (of 7) disclosed to a total of 4 persons, an average of one and a quarter persons.

Nor was there much difference among the professional groups in terms of their four main recipients, although the relative frequency of use of specific recipients varied somewhat. The prime recipient for the nurses was the client's G.P. (26 percent of the total) followed by their supervisor and the client's family (each 18 percent) and then residential workers (15 percent). Two of the chaplains' four confidantes were the G.P. and the others were the respondent's supervisor and the client's family. Unlike the nurses and pastors, in this vignette the social workers' chief confidantes were the residential workers who are their para-professional colleagues (6, 22 percent, of their total), followed equally frequently by the client's G.P., some professional in another agency, or the client's family (5 each, 19 percent of the total). Much less frequently than the nurses did the social workers disclose to their supervisors. This was probably a function of the difference in work setting, the social workers being more isolated and accustomed to be the leaders of a team which includes para-professionals and, therefore, themselves the decisive recipient for difficult decisions. The nurses seem to have the widest recipient group, and this was also apparent in the figures for the other vignettes (which can quickly be seen by noting the blank spaces in tables twelve, thirteen, and fourteen). It is also interesting to note that, in Vignette One, the only disclosures to a friend of the client would have been made by nurses.

Vignette Two:

In this case there was even less overall agreement on what single type of person or agency would be the appropriate recipient of confidential client information. The 53 respondents who disclosed confidential information in this case consulted 74 persons. None of the four highest categories of recipients - the client's family (19 percent of the total), the G.P., or a psychiatrist (each 18 percent), the respondent's supervisor (15 percent) - was chosen as frequently as 20 percent of the times. However, although no 'general rule' seems to be present about who is the best person to discuss the confidential case information of Vignette Two with, the preference for a fellow professional over all others was unmistakeable,

even more marked than in the first case. The professionals (of all types) combined, represented 73 percent of the total and, if one includes "the hospital" as a surrogate for medical and allied health personnel, the total becomes over 80 percent.

TABLE 12

Distribution of the Recipients of Information in Vignette Two by Professional Group (Number and Percentage)

	A	B	C	D	E	F	G	H	I	T
N	5 13%	7 18%	7 18%	5 13%	2 5%		4 11%	7 18%	1 3%	38 100%
SW	1 4%	5 17%	5 17%	5 17%	3 10%	3 10%	2 7%	5 17%		29 100%
Ch		1 14%	1 14%	1 14%		2 29%		2 29%		7 100%
T	6 8%	13 18%	13 18%	11 15%	5 7%	5 7%	6 8%	14 19%	1 1%	74 100%

A = Original Source of Referral
B = Client's G.P.
C = Psychiatrist
D = Respondent's Supervisor
E = Team Colleagues
F = Refer to Another Agency or Professional
G = Hospital
H = Client's Family
I = Client's Neighbour
T = Total

Once again the differences of the three professional groups' choices of confidants were slight. The overwhelming majority of the nurses' disclosure recipients (78 percent) were professionals. The comparable figures for the social workers and chaplains were 82 percent and 71 percent. The most common categories of recipients consulted by the nurses were: the client's G.P., a psychiatrist, or the client's family (18 percent each), or the respondent's supervisor, or the original source of the referral (13 percent each). The social workers' preferences were almost identical: client's G.P., a psychiatrist, the respondent's supervisor, or the client's family (17 percent). The chaplains differed - only 5 breached client confidentiality, making all told 7 consultations, 2 of which were references to another agency and to speak with the client's family.

Vignette Three:

TABLE 13

Distribution of the Recipients of Information in Vignette Three by Professional Group (Number and Percentage)

	A	B	C	D	E	F	G	H	T
N		3 16%	4 21%	4 21%	1 5%	6 32%	1 5%		19 100%
SW		5 33%	2 13%	2 13%	1 7%	5 33%			15 100%
Ch		1 50%	1 50%						2 100%
T		9 25%	7 19%	6 17%	2 6%	11 31%	1 3%		36 100%

A = Original Source of Referral
B = Workshop Staff
C = Respondent's Supervisor
D = Residential Workers
E = Police
F = Parents
G = Social Skills Group
H = Shopkeeper

It will be remembered that this was the case for which respondents were least willing to disclose confidential information; only 31 of the 55 members of the sample decided to disclose, and they discussed the case with 36 persons. Interestingly, their choice of confidantes shows somewhat more consistency than those for the two cases already reviewed. However, consistency did not reach a level of agreement that could be characterized as a 'common response' or a 'general rule'. In Vignette Three some member of the client's family (parent) became the chosen confidante more frequently than in any of the other cases; they form the largest group consulted (11 of the total of 36, 31 percent). This is the highest proportion of references to any one category of information recipient, in any of the four vignettes.

However, while this is sufficiently high to suggest that a parent would normally be one of the people automatically *considered* as a possible recipient for disclosure in a case like this one if the professional dealing with it had concerns about the situation, it is not a sufficiently frequent reference to establish any sense of imperative that nurses, social workers and chaplains agree that a parent 'ought' to be told. For

the consistency of a 'general rule' to be established, the reference should amount to more than half the total. The level of reference to a parent or the workshop staff (25 percent) was not high enough to suggest that, in a case like this, either should always be 'kept in the picture', but it was sufficient to warrant that they are 'worthy of consideration'.

Another interesting feature of the overall distribution seen in this table is that no-one suggested disclosing to the person who originally referred the client to the programme, no-one suggested informing the shopkeeper from whom the alcohol had been stolen, only two respondents would have informed the police and only one respondent would have informed the other members of the social skills group. The latter two responses were sufficiently infrequent as to prompt the specific question: "Would you inform the...?" These two small recipient categories and the blank cells in the table, already referred to, represent the most consistent decision responses offered in the discussion of the vignettes. However, the consistency was negative; there was agreement at to what the respondents would not do, rather than what they would do. (There is another example of this negative consistency in Vignette Four which is alluded to below.)

It was not as simple to analyze the responses to Vignette Three in terms of professionals *versus* para-professionals *versus* non-professionals, as it had been for the other three vignettes. Firstly, the workshop staff might include professionals and/or para-professionals. Should the police be considered 'professionals', 'para-professionals' or, perhaps, non-related 'non-professionals', since in this case they did not have a clear 'duty of care' to the named client but represented the wider interests of 'the public'? Effectively the neat, perhaps slightly artificial distinctions of the postulated model did not match the reality of who would normally be involved in the kind of situation described in this vignette.

Therefore, when analyzing these responses, I grouped as 'professionals' and 'para-professionals' (combined) all those who had an identifiable duty

of care towards the client, Mark (i.e. the workshop staff, supervisor, and residential staff). Included together, for comparison, were all those who clearly did not share a duty of care to Mark (the police, social skills group and the shopkeeper). This left the parents as non-professional, close family. Overall the members of the combined 'professional-plus' category were the recipients of 61 percent of the disclosures; 31 percent of the consultations involved the parents, while approximately 9 percent of the breaches of confidentiality were made to the combined group of people who did not share a duty of care for Mark. This distribution roughly corresponds with the expected findings of the research hypothesis.

Once again, in Vignette Three, no great difference was found between recipients of the nurses', social workers' and chaplains' confidences: 58 percent of the nurses', 59 percent of the social workers', and all the chaplains' disclosures were to professionals. However, since there were only two chaplain disclosures in this case, their figures have to be discounted. The proportion of disclosures to parents by the nurses and social workers were very similar (32 percent and 33 percent respectively). Altogether, it is evident that this vignette produced a remarkable consistency in the choice of confidantes who received confidential client information.

Vignette Four:

For this vignette, also, no clear pattern emerged about which person or agency 'ought normally' to be informed if the respondent, as case worker, had some concerns given the circumstances of a case. The 46 respondents who were willing to breach confidentiality would have disclosed case details to 52 persons or agencies. Most of the disclosures (54 percent) would have been to someone employed in specialist work with families and child care. But no preference emerged whether this should be a Social Services Department or other child care agency (e.g. N.S.P.C.C., children's nursery, etc). Since the information in the vignette pointed to potential areas of concern relating to child behaviour and/or child care, the fact that over half the disclosures were to an agency involved

with children's services is not remarkable. It would be more remarkable if these had not been the preferred confidantes. The next most frequent consultant was the client's G.P. (21 percent), followed by the respondent's supervisor (13 percent). No disclosure was made to the estranged husband of the named client, who was the father of the children in the family[45].

TABLE 14

Distribution of the Recipients of Information in Vignette Four by Professional Group (Number and Percentage)

	A	B	C	D	E	F	G	T
N	2 8%	6 24%	5 20%	8 32%	3 12%	1 4%		25 100%
SW		2 10%	9 43%	3 14%	4 19%	3 14%		21 100%
Ch		3 50%		3 50%				6 100%
T	2 4%	11 21%	14 27%	14 27%	7 13%	4 8%		52 100%

A = Original Source of Referral
B = Client's G.P.
C = Social Services (child protection)
D = Other Child Care Services
E = Respondent's Supervisor
F = Team Colleagues
G = Client's Husband
T = Total

At first glance there seems to have been considerable similarity between nurses and social workers' disclosures in this case (to some type of child care agency). However, closer examination of the precise, preferred confidantes reveals that the nurses choices of the appropriate person for disclosure were more dispersed than those of the other two professional groups. The social workers were far more likely to disclose to a Department of Social Services than were the nurses' (43 percent *versus* 28

[45] This is noteworthy given that the concerns in this case involve the children's well-being. The Children Act, 1989 places a legal onus on Social Services Departments involved with the family to work cooperatively with the parents of children, when they identify child care problems ("children in need", and "children at risk"). One would expect that the social workers who participated in the research, at the least, would have been aware of this due to their professional training. Yet, conspicuously, no respondent mentioned this when discussing Vignette Four, despite being specifically asked to consider whether or not to discuss the situation with the children's father.

percent) or chaplains (none). And, while the nurses were more likely than the social workers to disclose to some other child care agency (32 percent *versus* 14 percent), the three (of six) chaplains who opted to disclose did so to some agency other than Social Services. Also, the nurses disclosed more frequently to the family G.P. than did the social workers (24 percent *versus* 10 percent), and none of the disclosing chaplains consulted him.

These differences between the type of confidante chosen by the three groups of respondents probably reflect their different work environments. All the nurses in this study worked in a community health trust (i.e. a health/medical setting); all the social workers were employed by a local authority Social Services Department in a mental health setting (rather than an office which carried responsibility for services to children and families). All the chaplains were hospital-based.

CHANGING THEIR MINDS

Decision-points were not always quite as clear-cut as the tables in this chapter might imply. Eventually, for each case, each respondent was categorized as a "yes disclose" or a "no". But the tabulation does not mirror the 'journey' of explanation and justification which sometimes preceded the decision. For some respondents the decision was clear cut, unequivocal, and quick. For most there was some dialogue and debate with themselves, but not what could be considered dithering or extreme inconsistency. For a small group some of the case decisions about whether and when to disclose were really difficult to make. First we consider five respondents who showed considerable indecision about when to disclose. Typically, as the interview progressed, the respondent realised that he had made an assumption about some fact in the earlier version of the story, which he realized was incorrect when he read a later version of the vignette. Now, with that realization evident, the earlier decision looked suspect. For example, one person commented:

> Vignette One (variation 3): I think I need to change my decision about telling the hostel workers....If she isn't suicidal then I don't think I'd be saying too much to them. I was thinking she was suicidal.... (nurse 11).

Alternatively, a respondent might change his mind about the appropriate person to disclose the confidential client information to. There were four respondents who betrayed this kind of indecision. For example, one person effectively changed his mind about an earlier decision:

> Vignette Three (variation 3): I guess if I'm going to tell the residential workers at this point, because they are acting in loco parentis, then I should have told his parents earlier (non-qualified social worker 52).

Such inconsistencies are not startling, nor should they suggest that the professionals in question did not know how to deal with the given situations. The vignettes describe fairly complex situations and problems, which the respondents had not read about before the interviews (even though they were given the opportunity). Within a short space of time, they had to consider, judge and make decisions about four cases which developed increasing complications as their stories were reiterated. Normally in casework with an individual client, the worker would have considerably less pressure to make a decision 'now' - particularly since all the vignettes described relatively non-urgent situations, not ones of immediate urgency and great risk. In real work life the workers would be able to take some time, even a day or two, to ponder the possible outcomes of various decisions, to reflect on the various factors, before facing the decision to disclose or not. This luxury was not present in the interview situation which involved immediate choices of action. Thus it is not surprising that some inconsistency of the kind described was encountered. What was not expected is that there were so few examples of it.

SELF-PREDICTION

On several occasions, during the interviews, when asked the disclosure question, a respondent would say, in effect, "not now". That is, at the initial or early stages of the vignette, they would either explicitly or implicitly side step the question by saying "if the conditions were different..., then...." and they would anticipate some complication which in fact arose later in that story. Some would even say that, if a given

expected variation of the case (which later was added) were present then they would breach confidentiality. Or at the later stage of the story, when the complication was added, they would comment that had it been presented at the outset, then there would have been no question but that they would disclose (when they had initially not disclosed). For example:

Vignette Three (basic vignette):

> I think perhaps Mark might want to but they're not. He's not putting them at risk. Unless he's taking them with him, you know, as things get complicated. I'd forgotten about the next page. You get to dread the next page (nurse 23);

Vignette Four (basic vignette):

> No I would want to get her agreement before I spoke with anyone. She's obviously under a lot of stress but really I see this as a very positive situation. Look at all she has achieved since her marriage ended. I'd be wanting to help her and talking to someone she didn't want wouldn't help. If the situation were different, say if the children were being abused, that might be different, but not with what you're saying here. But I bet when I turn over you'll be telling me she's been hitting the boy! (chaplain 66).

However, respondents were not always able to predict their own decisions with consistency. On occasion, when discussing the decision required for the early stage of a vignette, some would say that they would disclose if some factor were different, only to change their minds (and decide not to disclose) when it was incorporated in the later version of the vignette. For example:

1. Vignette One:

> No I would respect Cathy's wishes because I'd be wanting to develop that trust. It's not as if she's suicidal - then I might have to look at it differently (version one - social worker 40);
>
> She's saying it's something she's considering, so I'm concerned about suicide. But she's asking me for help, she's being open and I wouldn't want to break her trust, because it's so important she feels she's in control of what is happening, so she can feel she'll get over this, instead of me taking that away from her so she feels there's nothing she can do and that nobody trusts her. I think her telling me is a good sign and I'd be more worried she'd really do something if she weren't talking about it. So I think I'd try to negotiate with her and let me tell people... rather than tell people without getting her agreement (version three - social worker 40).

2. Vignette Two:

> If he was violent it might be different (version one - chaplain 63);
>
> No - because that's his past. He's not saying he's going to hit his neighbour now (version three - chaplain 63).

3. Vignette Three:

> His age makes the difference. He's only sixteen, so he's the responsibility of his parents. If he was older maybe I'd not tell them, but at sixteen they need to know (version one - nurse 5);
>
> No (version four - nurse 5).

4. Vignette Four:

> There's no reason to tell anyone. Basically she's a good loving mother, she's just very stressed and who wouldn't be with all she's facing. She deserves to be supported, not have her decisions questioned. Maybe I would if you were telling me she was hitting the children or wasn't coping so well as she is but the children aren't being abused or anything like that, so I don't see the need (version one - nurse 22);
>
> No. I'm concerned she feels so stressed, but I'd be wanting to support her so she isn't so hard on herself. I'd help her see that lots of mothers hit their children at some time and feel guilty about it so she shouldn't be so hard on herself. It's very normal (version three - nurse 22).

It was not possible to analyze in detail the response information, comparing the professions or vignettes in a systematic way to show (assess) subjects' ability to predict their own decisions. In the discussion on how they arrived at their decisions about disclosure, many interviewees did not comment much after only the initial version of a vignette about what factors might influence their later decisions if they were they to occur in the subsequent versions of the vignettes. Clear cut 'predictions' about their future behaviour or decision-making were only given in a minority of the interviews. Comments on the initial case often were quite brief.[46] As the complexity of each case progressed the discussions about alternatives and justifications lengthened.

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[46] Fifty-five people were interviewed and each person discussed four different vignettes. In theory this would allow the possibility for 220 'predictions' about future decisions, if one were to assume each person made at least one prediction during the initial version of each vignette. However, in fact, only twenty-four clear-cut, openly stated 'predictions' were made. This should not be taken to suggest that other respondents had no idea how they would react if future conditions changed. Simply: they did not openly state in advance what factor might change their decision.

The majority (17 out of 24) of these 'predictions' were accurate. In other words, generally, if a respondent said he would make a certain decision if some particular factor were evident, and that factor turned up in the later version, the respondent then acted as he had predicted he would. Predictions were 'accurate' 71 percent of the time. However, all of the vignettes included at least one example of someone making a false 'prediction' about his own decision, and respondents from all three professions made such inconsistent statements - although there were only seven false predictions in total. This was too small a number to warrant more detailed analysis. Nonetheless, the fact that 29 percent of the self-predictions were 'inaccurate' is a finding which cannot be entirely ignored. Professionals' judgements, at least in theory, are supposed to be consistent and predictable within the norms of their profession's standards. One should, therefore, be able to expect that a professional can accurately predict his own response to a given set of circumstances. It is of concern that any of these predictions showed professional workers being indecisive and inconsistent.

INTERPRETING THE VIGNETTES

Decisions about whether to disclose were affected by the respondents' interpretation of the information supplied in the case history. Several times interviewees commented that they were making decisions based on relatively little information about each client and his or her circumstances. However, in comparison with many vignettes used in social science and policy research, the ones used in this project were extremely detailed. Nonetheless there is a practical limit to how much information can be included and there is a limit to how much detail a participant can be expected to absorb in a single interview (even if it is a fairly long one) before interview 'turn off' emerges.

In reality, any worker who has been involved with a client over several months (even years) would likely have a great deal more detailed information on a client - his personal and professional relationships, abilities and resources, life history and current circumstances - than

could be included in the few paragraphs of a brief vignette. This meant that interviewees had to interpret the information included in the vignette in the light of their own professional experiences which might supplement the bare 'facts' the scenario provided. These differences in interpretation, in turn, could well lead to different decisions about what actions to take. Thus even though each interviewee read the same basic information, not all interpreted it in precisely the same way. Different emphasis and different interpretations of the same basic facts were revealed in the discussions about each case.

Vignette One:

The first vignette revealed inconsistencies in the way respondents viewed residential staff. Some regarded them as professional colleagues; others clearly did not accord them this status. For example:

> Well it depends on what the hostel is like and what kind of staff it has, because if they're just there to open the door then I wouldn't tell them anything but if they actually work with the residents to help them deal with problems then maybe they should know more. So I don't know if I'd tell them (nurse 3);
>
> They may be nice people who want to help but they aren't professionals (nurse 8);
>
> Obviously they are an important part of the professional network that's there to help Cathy (social worker 30);
>
> Very few hostel workers have the qualifications or experience necessary to really understand that kind of information and I'd be concerned how they'd deal with it (social worker 39).

Comparable examples were found for each profession - respondents who accepted residential workers as part of the professional network, and ones who did not.[47]

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[47] Lipscombe (1997) recommends that when dealing with homeless people who are mentally ill the "multidisciplinary team should include mental health and social care practitioners, *including housing workers*" [my italic] (p. 145). She goes on to point out that:

> *Most specialist mental health teams are located within the statutory sector, whilst many single homeless people rely on the voluntary sector for their essential provision. Specialist teams should provide a bridge between the two sectors, creating positive working relationships and good communication (Lipscombe, 1997, p. 145).*

The relationship Cathy had with her mother was also subject to different interpretations, and respondents indicated this could affect their decisions about disclosure. The vignette deliberately presented the information about the mother neutrally. Initially respondents were simply told Cathy's mother was 'unable' to offer help; no reason for this inability was given. In a subsequent variation Cathy was described as living with her mother who had frail health. Some respondents expressed frustration about the limitations of the information about the mother. As provided, it could be interpreted to mean that Cathy had a good relationship with her mother, or that the two were not close. Many interviewee responses showed that there was awareness of both possibilities and suggest that the degree of closeness in the relationship was a variable affecting whether the professional would want to discuss personal information about Cathy with her mother. For example:

> I'd want to know why she can't help. It's difficult because if this was my case I would know, but here I can only speculate. Maybe Cathy and her mother don't get on. But maybe they are close and then I'd be wanting to help Cathy feel she could reach out - could talk to her mum - because that's one of her main supports. But I just don't know (non-qualified social worker 59);
>
> I'd guess they don't have a very good relationship, because if they did then why would the mother be asking me when she'd already know this from Cathy. So, no, I wouldn't tell her anything (nurse 6);
>
> There's been a lot of grief in this family; they've been through so much together that I'd want to help Cathy and her mother talk with each other and support each other through what was happening, and that may mean talking to the mother about what Cathy is going through (chaplain 64).

The degree of risk of suicide was also subject to different interpretations, even among respondents of the same profession who share the same professional knowledge base and expertise. All participants had a different store of experience to recall and this is evident from their speculative discussions. Some considered this possible risk from the

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This suggests that those respondents who were wary of accepting residential workers as fellow professionals were out-of-step with current thinking in professional practice in this area.

beginning stages of the vignette; others considered it only after being told about the history of suicide attempts. There was also considerable variation in interpreting the seriousness of the suicide risk, even after the information about previous attempts was given. For example:

> She's going through a pretty traumatic time and I'd have to ask myself if she's going to try to kill herself (version one - nurse 9);
>
> It's a downward spiral and I'd be concerned but there's no indication she's likely to try harm herself so I'd respect her decision if she said no (version one - nurse 13);
>
> You can't ignore what she's saying but I'd see it more as a cry for help. I mean she's tried it twice but each time she got help, and she's telling me this now so she's warning me so I know and can watch out for her. I'm not saying there isn't a problem or that it couldn't happen, especially since its paracetamol and that can kill you because its more dangerous than people realise. But equally people who try it with pills aren't always really serious, its more that they want help and want people to notice (version three - social worker 35);
>
> I think we have to take what she's saying very seriously. If something isn't done quickly to help she could kill herself (version three - social worker 34).

Vignette Two:

Vignette Two revealed differences in the way respondents interpreted information about the doctor and the patient's medication. Their responses were indicative of different assumptions about the client's doctor and the situation. For example:

> G.P.'s often don't know a great deal about these medications and so I'd want to get his psychiatrist involved (nurse 24);
>
> Probably the psychiatrist hasn't seen him recently so he doesn't really know what is happening; in my experience psychiatrists don't have the time to see their patients for very long and they rely on me to give them information about what is happening. So I wouldn't just accept this but I'd be coming back to the doctor again to ask for a review (nurse 10);
>
> It's very difficult because the doctor's supposed to be the expert about this and he's the one who prescribes, but I'd have to question if there really is nothing that can be done, because sometimes a change can make a real difference. I've seen it before (social worker 31);
>
> People often think that if you change the medication it will solve everything but psychiatrists can only do so much and then there are just problems in living. So really I don't see the point in going back to the doctor, even if he were willing to talk with me which probably he wouldn't be (non-qualified social worker 55).

These differences may be less reflective of 'inconsistencies' than of genuinely different views of the circumstances as reflected by the individual professional's experience and role. When considering the vignettes, respondents obviously had to 'interpret' the case and they did so in the light of their own professional past. The nurses were all currently employed as Community Psychiatric Nurses, but they all had worked in other settings, and often had received referrals or been allocated patients in different ways. Thus one nurse respondent would regularly liaise with G.P.s and see the consultant psychiatrist rarely, while another would have little contact with a patient's G.P. but regularly liaise with his psychiatrist. The same is also true of the social workers and chaplains who participated in this research. Nonetheless, the different responses and discussions suggest that the same information was being viewed very differently by workers from the same profession, and by those from the three different professions, and this leads them to offer different decisions about how to deal with the case situation and how they justified or rationalized the decision.

Similarly, the issue of Jim's mental state and whether his condition was relatively stable, or unstable and deteriorating, was a key issue which affected the respondents' assessments of risk (and hence the decision whether or not to disclose). The same information was interpreted differently with many variations. For example:

> He's never really spent much time in hospital - he's only been in three times and then only for two weeks which is no time at all really. So he's doing quite well and I see this as just a minor problem. You don't want to overreact just because he's a bit upset at the moment. I mean maybe he's right and the neighbour has been complaining about him. You can't just assume that because he's agitated he's unwell. He might be perfectly justified to be upset at the neighbour (version one - social worker 32);
>
> I'd have to talk with someone because he's getting ill (version one - non-qualified social worker 51);
>
> I mean if the doctor is saying Jim's mental health is deteriorating then I'd have to monitor the situation more carefully, but really compared with other people I work with he's doing fine. He's managing on his own and I wouldn't want to disrupt that. The difficulty is that people always think all mental patients are dangerous, when that's not true (version one - nurse 27);

> I'm concerned about the agitation and paranoia because that's something I'd be watching for as a sign he's getting unwell. I think we need to deal with the problem in its early stages - I mean it's in the early stages now and we don't want to let it get any worse because then he'd have to go into hospital (version one - nurse 10);
>
> Obviously I'd be worried if he becomes unwell but I think we need to be careful not to jump to any conclusions. There could be a perfectly simple explanation for all this (version three - chaplain 67);
>
> I guess he isn't very well at the moment and the convictions are very worrying so it's a lot more risky but I'm still not sure about my role in telling anyone without Jim's permission (version three - chaplain 64).

As these examples show clearly, differences and inconsistencies in interpretation of the vignette were found between workers belonging to the same profession as well as across the professional boundaries. Similar inconsistencies were found in the way some workers interpreted information about Jim's anxiety focusing on his family. For example:

> In some ways I wouldn't be as worried if he's upset with his family because they are used to him, whereas a neighbour would be less tolerant or willing to cope and might report it all to housing or the police which could cause Jim trouble (social worker 36);
>
> Well you see it's more worrying if he's angry at his family (social worker 34);
>
> Families deal with an awful lot. They are more likely to bear the brunt of his anger than anyone else and I have to be concerned for their safety as well as Jim (nurse 1);
>
> No I think the risks are the same whether it's his neighbour he's upset at or his family (nurse 26).

Vignette Three:

When discussing their decisions in Vignette Three quite a number of interviewees (24, 44 percent) mentioned the client's age as an important factor behind their decisions. This suggests that some respondents felt that their professional decisions should change with the age of the client. This happened in the final version of this vignette, but contrary to expectation, it had little effect. The actual decisions about whether to disclose did not really change when the age was raised from sixteen to twenty-six, although the rationale behind these decisions was affected.

The following are typical examples of this:

> I guess the age - he's sixteen so he's under-age, got some adult responsibilities but he's got learning problems so he's not fully able to... So I'd speak with Mark and then I think his parents or maybe the workshop staff, they'd need to know (version one - nurse 25);
>
> Yes it does - he's twenty-six, so he's more responsible. But he's been giving alcohol to the others so the staff still need to know (version four -nurse 25).

Vignette Four:

Vignette Four revealed an interesting comparison in respondents' perceptions and attitudes toward Child Protection Services. When this was connected to workers' desire to act in ways which would achieve a 'good result' it affected whether or not they referred Mary and her children to Social Services for child welfare/protection reasons. In some instances respondents' assessment was that Mary needed help with child care. However, clearly they also felt that Child Protection Services were not a good source for that help. For example:

> Well she's beginning to crack slightly but I wouldn't wish to throw her over the edge by involving Child Protection. I would feel furthermore that she should be encouraged to seek help to take away the pressure of the children, to try and give her a break. This is what she wants, she loves the children but it's nice to get away from them occasionally. So I would try to involve agencies that would try to help her (nurse 14);
>
> He's a child that's ill to start with and he doesn't want to be afraid of his mum as well. I really would encourage her to talk to her G.P. who could help (nurse 17);
>
> Not Child Protection because she's probably already afraid she could lose her children and that would just make her even more afraid (chaplain 62);
>
> She could probably benefit from some help with the children but I don't think that's a matter for Child Protection (non-qualified social worker 54).

In contrast, some respondents clearly discussed Child Protection Services in a way which indicated they saw them as having a wider remit for general preventive help rather than simply a narrow investigative function if a

child was being physically abused[48]. In these instances, even though ultimately they left the decision about disclosure to the client, respondents were more likely to want to involve Child Protection with Mary at an earlier stage in the vignette (albeit with Mary's agreement), since they expected the involvement would probably lead to a beneficial outcome. For example:

> I'd want to get Mary to agree to my contacting them because she could get support for the dealing with the boy, but if she said no then I'd have to respect that (social worker 38).

CONCLUSION

When one considers two issues the findings reported in this chapter have serious implications. The first concerns theories about the process of 'professionalization' of individual workers. These suggest that, through their professional education and training and shared work experiences, they gradually learn how to interpret practice information in a standard or consistent way. In other words, they learn to conform to a 'norm'. Thus, in theory, one should be able to expect that respondents in the same profession would share an identical, or almost identical, interpretation of the meaning inherent in the same basic information, they would consider the same facts as significant and discount others and would give the same weight, in the transcript material, to the same factors and issues and disregard others. If the theories are tenable, one should see the professionals (at least by group) agree about exactly when the presence of certain 'facts' means that they will agree, in each vignette, that information needs to be disclosed to a third party. In theory, it might even be possible to identify, not only the 'triggering' fact and the case stage, but also the appropriate person (or office) to whom information should be disclosed, and in what detail this should be done (i.e. who

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[48] Related to this issue is the extent to which workers recognised that the complications added into the variations of vignette four introduced mild child protection elements. Professional literature has recognised that some of the difficulties of inter-agency collaboration in areas such as child protection arise because of conflicting definitions of the same situation. What one profession sees as normal chastisement, another views as physical abuse (McFarlane, 1993). This is a factor which resurfaces in the next chapter on Conflicting Loyalties.

'needs to know' and what they 'need to know'). Thus, in theory, if fact 'A' appears in the case history at stage two it will trigger an almost uniform response from the members of a group of nurses (social workers, chaplains). However this level of professional consistency is not present in these data. Instead, there is considerable variation in the interpretations of the basic case information provided. This was true for each vignette.

More congruence of interpretation was found between the nurses and social workers as well as similarity in the decisions they made, than was evident between the chaplains and either other professional group. As expected, the nurses disclosed more readily than did social workers, and chaplains disclosed least. This pattern held true for all but Vignette Four where nurses held the lowest disclosure rate. These differences may be reflective of the responding groups' different professional experiences and expertise about family stress and dysfunction and child protection.

The transcript were analyzed according to the recipient of disclosure in order to determine whether breaches of strict confidentiality involved certain people as a general rule. However, this could not be established for any vignette. On this factor there was remarkably little difference between the three professional groups. As expected, all three would disclose information more readily to fellow professionals than to para-professionals or family. The lowest frequency of disclosure was to non-professionals who were not related (or did not share some form of 'duty of care') to the client.

Although many of the professionals interviewed were able to predict, at the early stages of a case, their future decisions about disclosure, this was not uniformly so. A small number thought they would disclose if a certain circumstance developed in the future, only to maintain confidentiality when the vignette later provided for that possibility. In other instances a small number of respondents changed their minds at the mid-point or late in the vignette discussion, referring back to alter the

decisions made at an earlier stage. There were also great differences in the way respondents interpreted the various aspects of each vignette - their comments reveal that what appeared to be a serious situation or complication to one respondent was judged to be very much less serious by another.

The second implication concerns the authority and responsibility of professional discipline bodies, particularly the licensed or registered occupations, where the practitioner can be de-licensed if he fails to comply with the professions' accepted behavioral 'norms' and 'standards of competence'. The analysis of the interview transcripts demonstrates that there is no clear cut 'standard' or 'norm' to indicate <u>when</u> it is permissible (even desirable) to disclose against a client's wishes. Nor is there a clear taboo or cutting line to indicate that <u>before</u> 'this' stage in a case, disclosure should never be made and <u>after</u> disclosure should always be made. Nor, for that matter, is there a clear agreement and common practice about to whom disclosure should generally be made. Within each professional group interviewed there were considerable differences of judgements on these matters.

Such findings suggest that, if an individual practitioner's judgement were questioned and it had to be defended before a professional disciplining body, this defence might well be very difficult. The colleagues reviewing the case, after the fact, might not only not agree with the defendant, they would not necessarily agree with each other! However, having recognized that, it should be remembered that these research findings demonstrate a noticeable tendency to favour disclosure over non-disclosure, and a decided bias for disclosing confidential information to professionals of one's own kind as well as other kinds of professionals, as distinct from disclosure to para-professionals, and even more reluctantly to non-professionals.

CHAPTER EIGHT

CONFLICTING LOYALTIES

In this chapter the concept 'loyalty' is used to analyze the material of the interviews carried out during the thesis research. Apart from a brief introduction and conclusion, the chapter is divided into two main sections reporting the reasoning of those respondents who did not breach confidentiality and those who decided to disclose. The latter is a long section, discussing material in the transcripts classified in four main categories as described below.

The issue of loyalties which professionals may have to a variety of clients is well established in literature on the professions. In short, in many situations, a professional may have more than one 'client'. It then becomes crucial for the worker to manage his 'duty of care' towards each client so as to maximise benefits for all clients without obviously sacrificing the interests of any one person. In situations where this ideal cannot be realised, the professional may wish to divest himself of one or more client, thus avoiding conflicting loyalties. However there are times when practical considerations make this impossible[49]. Even in situations where a professional actively identifies only one person as his client, there may be other wider loyalties or expectations which conflict with an individual client's interests (e.g. self-interest, the interests of the professional group, the 'public' interest).

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[49] One person discussed this issue in relation to Vignette Two as follows:

> *Some of it is helping them for their own needs and some of it is helping them so that they can help Jim better. I think that there may be instances when another person could provide that help for a relative, so I would say I'm sorry because of my involvement with your son, your daughter, your husband or your wife, it's very awkward for me to speak to you but I've got a colleague who I could ask to come out and speak to you. So that's maybe another way of dealing with it but very often there are difficulties in doing that. The work is often working alone and not being able to call on colleagues. I do see situations with relatives where I would suggest they see someone on their own. There are instances now where I am working that that goes on. Or where I get other workers to work with the client and I work with the relatives. But sometimes it isn't possible to have more than one worker involved, and the relative needs much more counselling, maybe more skilled help, so you can't just not work with them. So it could be either way (social worker 35).*

During interviews, when examining respondents' decisions about whether or not to disclose information (regardless of their clients' wishes), the tension created by these competing loyalties was evident. It underlay many of the reasons given for disclosing or not disclosing. This was apparent from the respondents' description of attempts to reconcile or avoid conflicting loyalties and their reasoning in justifying decisions to disclose. It was expected that respondents who identified with their individual clients' wishes would be unlikely to decide to disclose and would cite loyalty to the client as their justification for this. However, it was also expected that, once the respondent identified competing loyalties, the loyalties themselves would become justification for disclosure. This indeed happened in many cases. In the discussion which follows, greater attention is paid to the reasons respondents gave for disclosing information (rather than maintaining confidentiality), because they were more varied and urgently 'argued'[50]. Moreover, they represent the views of the bulk of the respondents. Each Vignette is analyzed separately.

An interesting revelation of the analysis of the decision to maintain or not maintain confidentiality was the emergence of a theme which might be termed 'professional paternalism'. Loyalty to the clients' interests was used both to justify maintaining confidentiality and to justify disclosure against the clients' wishes.

It should be kept in mind that respondents cooperating with this research study had as many as 20 possible opportunities to decide (responding to a specific question) whether in the cases described they would have maintained client confidentiality or disclosed information. There were 6 decision points in the first vignette, 5 in the second, 4 in the third and 5 in the fourth. However, since many of the disclosure decisions were made

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[50] This is not surprising. The codes of ethics of the three professional groups presume confidentiality will be maintained unless there is good reason otherwise. Therefore a decision to maintain confidentiality, from the position of maintaining the code of ethics, would not require as much discussion or justification because of the bias against disclosure.

well before the end of the vignette, effectively most respondents made fewer than the possible maximum. During each interview the issue of confidentiality was mentioned many times, because in discussing the vignettes it was quite usual for respondents to 'worry' their decision, going over it in different words and approaching the issue from different positions, with examples from their own experience - this led to numerous iterations of their 'decision' and their 'reasons'.

The methodology chapter (Chapter Five) included a description of how the transcripts of the interviews were read and re-read to decide upon their major themes. The reasons having been thus categorized there remained the problem of how they should be tabulated. Although the reasons would be described and discussed verbally, it seemed desirable to provide a tabulation to indicate roughly the 'weight' of different reasons in terms of the number of respondents voicing them, albeit in different phrases and terms. It is recognized that the reasons behind professional work decisions are complex and have many strands, but in the interview transcripts, for the most part, it is possible to discern the prime reason being given for the decision, and the interview tapes reveal the emphasis and emotion accorded to it.

There were a number of ways the reasons might be used to illustrate the frequency of their appearance, but a set of rules had to be devised as to which reasoning phrases would be 'counted' as <u>the</u> reason for a given decision at a specific decision-point in a vignette. How should the particular reason be recognized as the <u>main</u> or determining reason for the decision? The intention, when discussing disclosure reasons by profession was to see whether the different professions relied upon one kind of justification more than another. The intention when discussing disclosure by type of case was to see whether respondents tended to use one kind of justification for decisions in one vignette and a different kind in another.

Therefore, for the purpose of preparing the tables in this chapter, it was

proposed that the rules used had to pass the tests of 'reasonableness' and 'utility' - in other words: that they would result in distributions of reasons by category that a third party who had read all the transcripts would agree accurately reflect the recorded conversations; and they had to make a complex task manageable. It is recognized that classifying and tabulating verbal material involves a level of arbitrariness, but this is reduced by liberally quoting examples from the interview transcripts. Where a respondent mentioned only one reason to justify the decision, it was a simple matter to categorize it. The rules used to identify the main reason, when several reasons were recorded at a decision point in a vignette, were as follows:

1. When, from the discussion, an overwhelming main reason could be clearly identified, either by the length of time devoted to it, by the emphatic language used, or the emotion of the voice, it was counted and the secondary reasons were ignored in tabulations.

2. It was noted that most respondents gave more than one reason for a decision but that the first often received more elaboration, took up more interview time. Therefore, when neither emphasis nor elaboration were present and a clear picture of the respondent's main reason was not apparent, the reason given at the earliest point of discussion of disclosure was counted as the main one - provided that the same person was receiving the information.

DECISIONS TO MAINTAIN CONFIDENTIALITY

It will be remembered that, while no respondent consistently refused to disclose at every point for all the vignettes, many decided to maintain confidentiality when the early versions of the cases were presented, before a number of complications were added, and some refused to disclose even at the end of the vignette. Altogether, 40 final decisions not to disclose were made during the interviews. They varied as to the vignette and by the professional group of the respondent, as may be seen in Table 15. As noted in Chapter Seven, when the interview materials were analyzed in terms of the consistency of disclosure/non-disclosure decisions, the

third vignette was the case in which the greatest persistency in maintaining client confidentiality was found, and the chaplains were the group least inclined to breach it. There were 16 final and unchanged decisions to maintain confidentiality made by the nurses, only 40 percent of such decisions although that group formed 49 percent of the interview sample. The comparable figures for the social workers 12, 30 percent and 38 percent, and for the chaplains 12, 30 percent and 13 percent. Vignette One accounted for 12 percent of the total decisions not to breach confidentiality, Vignette Two for 5 percent, Vignette Three 60 percent and Vignette Four 23 percent.

TABLE 15

Distribution of Decisions to Maintain Confidentiality by Vignette and Professional Group

	Vign. 1	Vign. 2	Vign. 3	Vign. 4	Total
Nurses	0 0%	0 0%	10 42%	6 67%	16 40%
S.W.	1 20%	0 0%	9 37%	2 22%	12 30%
Chap.	4 80%	2 100%	5 21%	1 11%	12 30%
Total	5 100%	2 100%	24 100%	9 100%	40 100%

It was not surprising that the most common justification for maintaining confidentiality was that this decision would protect the client's best interests. However, the 'best interest of the client' could be invoked in a number of ways. Commonly used were concepts of 'honouring client trust' and 'respect for the individual'. Of the 40 non-disclosure final decisions some 27 (68 percent) might be said to have been justified by such phrases. Examples are:

1. Vignette One:
Cathy is my client. She is my primary concern. It's not respecting her to divulge to others.... (chaplain 65);

I think you've always got to be open with your client, tell them everything you feel you want to do or discuss with other people.... Let them know that they can trust you and that you will not do anything behind their back like talking to anybody (non-qualified social worker 52);

It would be in order to maintain a therapeutic relationship with her (nurse 13)[51].

2. Vignette Two:

If I did that he wouldn't trust me ever again (nurse 6)[52];

I think you've got to respect the fact he's been coping pretty well and that he has a right to make his own decisions (social worker 30)[53];

He is telling me this because he trusts me and I have no reason to betray that trust (chaplain 64).

3. Vignette Three:

Because I think if we do that you'd immediately lose his trust; it would be the authoritarian figures that were not on his side (nurse 16);

I want to work with him about the consequences of his actions and making the right choices.... I couldn't do that if I took the choice away from him and didn't respect his decisions (chaplain 61);

Too many people don't respect the fact that disabled people can make their own decisions (non-qualified social worker 50).

4. Vignette Four:

I'd be respecting her judgement not to tell anybody else; I think again that builds a relationship which I think is very important (social worker 36);

It wouldn't be showing respect for her if I told anyone when she didn't want me to (chaplain 64);

I have to trust that she knows what is best (nurse 18).

On a few occasions respondents who maintained confidentiality did not put forward the concepts 'trust' or 'respect' as their reason. In these cases it became clear that they, as professionals, had made independent judgements that maintaining confidentiality was desirable and possible - one might almost call these 'efficiency' judgements rather than 'ethical' judgements. It was fortunate for the client that the professional judgements concurred with the clients' wishes. It was apparent that if this had not been the case, disclosure might well have followed anyway:

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[51] Ultimately, this person disclosed. This response was given at an early stage when the decision was still to maintain confidentiality.

[52] Ultimately, this person disclosed. This response was given at an early stage when the decision was still to maintain confidentiality.

[53] Ultimately this person disclosed. This response was given at an early stage when the decision was still to maintain confidentiality.

1. Vignette One:

> Sometimes hostel workers get very nervous about the idea someone could harm themselves and they don't really know how to deal with this. I'd be afraid they could make things worse. She'd feel she was being watched, or they might ask her to leave, and that wouldn't help her (nurse 21);
>
> That's a guaranteed way to get involved with all sorts of games. I don't see that as being beneficial for anybody (chaplain 61).

2. Vignette Two:

> It wouldn't help anybody if I were to talk to them (social worker 30);
>
> Talking to the family won't help Jim (chaplain 66).

3. Vignette Three:

> Mark's told me because he trusts me. If I go and tell someone else he will just hide it next time, which will make things worse (chaplain 62);
>
> Telling the police would only cause more problems - I'm there to help Mark, not cause problems for him (nurse 25).

4. Vignette Four:

> I want to do something to help Mary and the children and I can only do that if she cooperates. Otherwise she'll just feel it's more pressure on her and she already has a lot, so it would make it worse (nurse 10);
>
> No... because if I told him [Mary's husband] it could cause more problems between them and that would just add to problems and not get us anywhere (chaplain 66);
>
> It doesn't look like he [Mary's husband] could be much help (social worker 35).

Two points are interesting about these decisions. Firstly: in these particular cases the professional decision may have concurred with the client's wishes, but it was not made out of respect for that individual. The worker's professional reasons for the decision are paramount. Therefore, implicit in this situation is the prospect that had the professional judgement differed from the client's, then the decision might have been made to disclose[54]. Secondly, the decision which was made was justified on the basis of the expected outcome. The worker was pursuing

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[54] One respondent described a situation he had encountered where he believed he had breached his profession's Code of Ethics by maintaining confidentiality, thereby failing to prevent a client's suicide. This worker mentioned having respect for the individual but acknowledged his decision was made partly because he agreed with the decision. He admitted that in different circumstances, where he disagreed with the client's own assessment he had breached confidentiality in order to prevent suicide.

a 'good result', and used that to justify his decision to maintain confidentiality. As will be seen later in this chapter, other respondents used the same 'outcome' reasoning to justify their decisions to disclose. This demonstrates that such distinctions are not simply academic issues; they are key factors which play an important role in professional decisions. This is discussed more fully below when the disclosure reasons are analyzed.

Finally, there was a third group of non-disclosing respondents who, at times, in the case discussions, revealed that they judged disclosure in the face of client objection to be unjustified because it would not substantially affect the risks involved. Therefore, on balance, it would be as well to maintain client confidentiality. Examples of these positions were:

1. Vignette One:

   This doesn't seem to significantly increase the risk to Cathy and so, there's nothing in there that makes me think oh yes, it would improve Cathy's safety if I was to talk with this person (nurse 25);

   Telling the staff wouldn't make her less likely to do it. If she really wants to die she'll find a way anyway. And if she felt she couldn't trust me that would only make things worse for her (social worker 34).

2. Vignette Two:

   No... because if Jim is fixed on this neighbour then it wouldn't help to talk to the neighbour - he'd only get more paranoid (nurse 2);

   If Jim felt everything he told me went to someone else then that would just increase his feelings of paranoia and make him more anxious (chaplain 63);

3. Vignette Three:

   There's no point to telling the shopkeeper because Mark could get it from somewhere else (nurse 12);

   It wouldn't change anything if I told the group. It's none of their business and telling them wouldn't stop Mark drinking. What I want to be doing is talking with Mark about the risks he's running so he understands it better (chaplain 65).

4. Vignette Four:

   She could do with some help with the children, practical things. But I couldn't do it without her agreeing. I mean it doesn't make any sense because she'd have to be involved with taking the kids there, and picking them up, and if she didn't want to go then she just wouldn't (nurse 14);

> Telling the husband wouldn't make her less likely to shout at the kids, because he's not around when it happens, and anyway, if they got into an argument about it she'd just be under more stress and feel more overwhelmed (nurse 19).

DECISIONS TO DISCLOSE

The length at which respondents discussed their reasons for disclosing information was evidence of their concern. They did not choose lightly or without careful thought about the impact of their decision and likely implications of their actions. It is for this reason that about three-quarters of this chapter has been devoted to analysis of the explanations respondents gave for why they decided to breach strict boundaries of confidentiality. Their reasons can be classified in many ways. For this thesis they have been put into four major groups according to their view of the overriding loyalty which must be recognized:

1. Reasons which imply prime, undisputed or unswerving loyalty to what is perceived as the client's best interests;
2. Reasons which imply, on balance, prime or equal loyalty to third parties;
3. Reasons which imply prime or equal loyalty to other professionals; and
4. Reasons which imply prime or equal loyalty to one's self.

Not surprisingly, the frequency with which these different reasons were cited varied depending on the vignette being considered and the professional group making the decision. Different circumstances led to different rationales for decisions. However, the variance in reasoning behind the decisions to disclose should not blind us to the general research finding that, overwhelmingly, most respondents opted for some form of disclosure at some point during each vignette, and quite vigorously justified these decisions.

It cannot be emphasized too strongly that the interviews for this research were extended reflective discussions. Unhampered by interviewer questions, each respondent had the opportunity to report and discuss a decision to

maintain/disclose on a case vignette. Then, if it was wished, they were free to re-consider it, reiterate it, confirm it with supporting examples, go back over their reasoning and review it several times, or change it. It was not uncommon to consider a vignette, make decisions about it and then refer back to it comparing its dilemma and decision with those revealed in a subsequent vignette. Respondents could (and did) give multiple reasons for decisions. The reader should keep in mind that 50 of the 55 respondents decided to disclose by the end of the different versions of Vignette One, and the comparable figures for the other three vignettes were 53, 31, and 46, and each respondent had 20 opportunities to give reasons for the disclosure decision (as well as taking advantage of re-considering decisions to re-state their original reasons and add to them). Therefore, although only the main reasons were tabulated for the tables of this chapter, all reasons were classified and all could be fitted into the four categories used for the analysis. Although not included for tabulation, sometimes the pithy wording of a second 'reason' provided an excellent illustration of some point being made in the text, and they were quoted.

It should be noted that, because of the many opportunities to state reasons for disclosure decisions, all but one of the vertical totals in Table 16 and all the horizontal ones exceed the number of respondents in the sample. In addition, the reader is warned that all the horizontal percentages should be treated with caution, not only because the classification of verbal material into a few categories involves simplification (and hence the danger of over-simplification) but also because, when comparisons are made between the professional groups, very small numbers are involved (particularly of the chaplains).

The purpose of classifying and tabulating the reasons given for disclosure decisions was to provide rough comparisons of the frequency that different types of reason were advanced to justify or explain the disclosure decision, and also to note the variance in reasons given by the respondents from the three professions. However, numbers such as these can

only be considered as indicators. They should not be read in absolute terms. First, the categories could not be made entirely mutually exclusive. Second, respondents were not asked to confine themselves to one reason, nor to rank order the ones mentioned, nor to name their prime reason. This would not have accorded with the style of the interviews and the free atmosphere which was established. Respondents were not being forced to make structured choices. It was acknowledged by both parties in the discussions that decisions in professional work are made only after a thorough review of the alternatives appropriate to a complex set of circumstances. Pains were taken to ensure that respondents did not feel that the decision points of the vignette cases in any way represented 'tests' for 'right' and 'wrong' decisions. If the respondent's reasoning contradicted something previously said, this was not pointed out.

Respondents not only frequently had more than one reason for a disclosure decision, they might also have different reasons for providing confidential information to different people at the same point in a vignette. For example, in Vignette Three one respondent decided to discuss information with the parents because they had a 'right to know', and later also decided to disclose confidential information to the workshop staff because of standard inter-professional working relationships. In this case, applying the rule mentioned above, the first reason was tabulated (it had also been given the greater emphasis) and is counted in Tables 16 and 17. Alternatively there might well be valid different reasons for providing information to the same person at different points in a vignette. An example from a discussion of Vignette Two : the respondent who would discuss information with the G.P. at the initial stage of the case, because of standard inter-professional working relationships, later also said he would have disclosed to the G.P. because of concern for the safety of third parties.

The point must be made here that presentation of a different reason for the disclosure decision at a late stage of a vignette does not necessarily nullify or invalidate an earlier reason for disclosure (nor vice versa).

Nonetheless, analyzing the disclosure decisions in terms of competing 'loyalties' and assigning each mentioned reason to one of the four categories allowed the 'weight' of the different types of reason to be judged, and permitted all the reasons voiced to be searched for quotations which provided good examples of respondents' views. Since some respondents gave many more reasons for their decisions than others, to tabulate for comparison using only the prime or main reason seemed a useful means of showing fairly accurate comparisons. However, for analysis, to classify all reasons using one set of categories also enabled examples to be shown of how different disclosure decisions can be made for the same reason, in the same situation, and, alternatively, how the same decision in a given set of circumstances can be made, based on different underlying reasoning which illustrates motives and purposes.

It must be admitted that the type of analysis employed here may have the unintended effect of over-simplifying some of the decisions which respondents made, by making it appear as if each decision had only one underlying reason. Remarks made during the free-flowing discussions showed that respondents recognized this and, therefore, their reasoning has been extensively quoted verbatim in this chapter, using main and subordinate reasons. A verbatim excerpt from the transcript of one interview has been included in the Appendix Two to illustrate the complexity of the discussions.

TABLE 16

Distribution of Reasons Given for Disclosure by Professional Group

	Client Best Interest	Third Party Loyalty	Other Profess. Loyalty	Self-Interest	Total
Nurses	44 25%	57 33%	54 31%	20 11%	175 100%
S.W.	30 22%	54 40%	37 27%	15 11%	136 100%
Chap.	9 41%	9 41%	2 9%	2 9%	22 100%
Total	83 25%	120 36%	93 28%	37 11%	333 100%

From the figures of Table 16, there appears to be considerable similarity in the reasons for disclosure chosen by all three professional groups. In all groups loyalty to third parties was the most frequently advanced reason for disclosure. The social workers and chaplains do seem to have been slightly more likely to cite this reason for disclosure than were the nurses; but overall, well over one third (36 percent) of all the prime reasons given for disclosure fall within this category. The second most frequent reason category justified disclosure on grounds (i.e. expressed in words describing) of loyalty to fellow professionals.

TABLE 17

Distribution of the Frequency of Main Reasons to Disclose by Vignette

	Client Best Interest	Third Party Loyalty	Other Profess. Loyalty	Self-Interest	Total
Vig. 1	34 34%	25 25%	36 36%	6 6%	101 100%
Vig. 2	24 18%	52 40%	36 28%	18 14%	130 100%
Vig. 3	7 16%	12 29%	16 38%	7 17%	42 100%
Vig. 4	18 30%	31 52%	5 8%	6 10%	60 100%
Total	83 25%	120 36%	93 28%	37 11%	333 100%

As expected, four different mental health cases led to quite different <u>main</u> emphases in the justifications for disclosure. Thus in Table 17 we note that in Vignettes One and Three disclosure was most often justified as necessary by reason of loyalty to other professionals (36 percent and 38 percent of the total for these cases), while in Vignettes Two and Four the paramount reasons for disclosure could be defined as 'third party loyalty' (given 40 percent and 52 percent of the totals). That is not to say that prime disclosure reasons which might be defined as 'in the client's best interests' were not also frequently voiced. They were the main reasons in a large number of cases in certain vignettes, notably One (34 percent) and Four (30 percent). In the rest of this chapter examples of respondents' disclosure reasoning are reviewed, separately, according to the four categories shown in the table above and then as they were voiced for one vignette after another.

The Client's Best Interests

Loyalty to the client's best interests, as defined by the worker rather than the client himself, could sometimes be used to justify breaching strict boundaries of confidentiality and disclosing information to other professionals or third parties. In these cases clearly the workers were substituting their own professional judgements for that of the individual client about what really constituted the individual's 'best interests'. The existence of this kind of decision is well-known within social work. For instance, Payne (1996) says that "usually, workers' definitions of clients' interests control which material is confidential rather than the clients' wishes" (p. 4).

Judgement about expected outcomes resulting from the workers' choices played a part in decisions of this kind. Workers wanted to have a positive effect on the situation (or at least no negative impact which might make matters worse). In these cases respondents did not make their choice based on the intrinsic value or good of some principle (regardless of end result), but because they hoped their decision would help or lead to a 'good result'. The following are examples of this position:

> If I thought it was something her mother could help her with... but if it's something I thought would not work, Oh no, I wouldn't tell her mum (vignette one - social worker 32).
>
> It's to do with making sure she gets the right sort of help (vignette four - social worker 31).
>
> ... so that they could support him effectively and so that he's actually getting what he needs (vignette two - nurse 14).
>
> It's to see that she gets the best deal from Housing, from my colleagues or from the doctor (vignette one - nurse 12).
>
> to allow the friend to see another side of it and consequently to be of more support to Cathy (vignette one - nurse 17).
>
> to get the help he'd need (vignette two - unqualified social worker 58).
>
> I guess it would be if it would benefit Mark. It would have to be of some benefit to Mark (vignette three - social worker 40).

The extent to which professionals used their own independent assessment (rather than simply accepting the clients') and sought the 'good result' which they felt was in the client's best interests became evident when they perceived there was a risk of harm to the client, either directly or indirectly, if the clients' wishes were followed. The intensity of this perception varied with the circumstances of the described case.

VIGNETTE ONE:

In Vignette One, risk of serious harm to the named client was perhaps most immediately evident (self-harm and suicide). It was therefore expected that disclosure in the 'best interests' of the client would be more common in Vignette One than in any other scenario, and this expectation was supported by the research data. 34 percent of the reasons respondents gave for disclosure in Vignette One were for the best interests of the client. The following are some typical examples of this:

> Because if she's got plans I'd have no question then I would definitely divulge that information. If she's so seriously depressed and is considering suicide I couldn't just leave her... (nurse 1).
>
> I'd tell the G.P. that I had serious concerns that Cathy was likely to take her own life (chaplain 61).
>
> You've got to report that. Even if they don't want you to. You've got to do it to try and save that person's life (social worker 37).

VIGNETTE TWO:

In this vignette there was relatively little danger of bodily harm to the client; more immediate concern was for the (possibly threatened) neighbour and family. A few respondents justified disclosing information in Vignette Two on the basis of preventing harm to the client, or the client's best interests. However, not surprisingly, this rationale was markedly less common in Vignette Two, than were other reasons for disclosure. Only 18 percent of the reasons given fell into this category, even though the total number of disclosure reasons given for the vignette was high (130). Nonetheless, 18 percent of such a large total (24 reasons) makes the Vignette Two 'yield' of the 'client best interest' argument a not insubstantial share of the total number of times this justification was

used as a main reason (29 percent). For Vignette Two, many other disclosure reasons were also used, both as the main justification and additional arguments. A couple of examples of the 'client interest' justification are listed below:

> I'd talk to the neighbour - I think to try and prevent the neighbour from retaliating (nurse 20).
>
> To prevent the violence from happening and ensuring safety - both his family's and his as well (social worker 38).

VIGNETTE THREE:

This vignette also included some risk of harm to the individual client (criminal charges and/or accidental injury). Thus, potentially, respondents could use loyalty to the client's best interests as a reason for disclosure. However, this Vignette had also been designed to show a generally 'low risk' situation (in comparison to the other Vignettes), and so it was not expected this reason would be cited as often in this case, as it was in the earlier Vignettes. This expectation was fulfilled. Only 7 respondents gave reasons for disclosure which could be classified as loyalty to the client's best interests. They represent 16 percent of the reasons for disclosure, but it must be remembered that this was the vignette for which there was, overall, the lowest number of decisions to disclose. Examples of the use of the client interest argument in Vignette Three are given below:

> You've got to break that confidentiality because of the client's safety (non-qualified social worker 59).
>
> Because if he's working with machinery he might injure himself - but it would depend on what he's had and I would hope the workshop supervisor would notice anyway without my having to tell him (social worker 33).

VIGNETTE FOUR:

The frequency with which respondents cited issues relating to loyalty to the client's best interests as the reason for disclosure in Vignette Four was unexpected. Risk to the primary client in this case (Mary), was less obvious than risk to her children, albeit the latter risks were not introduced at the beginning of the vignette. Nevertheless, 30 percent of

the reasons given for disclosure in Vignette Four were due to concern for client's best interests, and this was the second most common reason given as the main justification for disclosure (the 18 examples represent almost 22 percent of the 83 times this reason was used for disclosure during the interviews). Interestingly, the answers showed respondents associated potential risk to the children or the need to get help for them with harm to or help needed for the primary client, their mother. Several examples are quoted here:

> I know enough about them [Child Protection Services] to know the kids won't get dragged into care or anything like that. I mean, it's getting the fact it happened registered and acknowledged by someone who should be able to help - it's getting help for Mary (nurse 23).
>
> We'd also talk to her doctor because I think this is a sign that she was not able to cope, that our intervention isn't enough. It's about getting to the bottom of the problem, whatever it is. Is she depressed? I wouldn't want her to feel she's the worst mother in the world (nurse 4).
>
> I would want to be helping Mary to be more in control of her feelings because she doesn't want to hit him either (social worker 30).
>
> If Mary's saying she's afraid then yes, I would have to report it because Mary is basically asking for help (non-qualified social worker 56).
>
> She needs practical help and I'd be wanting to help her find this. If she gets it then the situation may never arise again. She obviously feels awful about what happened and that won't be helping her (chaplain 61).

Loyalty to Third Parties

The professional codes for nurses, social workers and chaplains all recognise in principle that situations can exist in which one client's best interests directly contravene another's. The existence of multiple clients is not exclusive to community based work, but it is particularly common in this setting. One of the prompts used during interviews played on this by suggesting that as the worker arrived at the client's home, he was met by the client's mother (neighbour, friend, etc.), who asked to speak with him about the client. During their discussion, respondents often acknowledged the very real existence of this scenario, sometimes illuminating discussion with anecdotes about how they had dealt with it in the past. For example:

> This is very difficult because I see people in their homes and quite often there are members of the family around. The difficulty I have is actually getting them on their own, you know, rather than listening to what the relatives are saying is the problem (vignette two - nurse 3).
>
> Oh my God the 'nosy neighbour from hell'. Yes I've been trapped that way before (vignette two - social worker 33).
>
> I always hate this sort of thing because sometimes they [family] are more difficult than the client you're working with. But I'd just have to be firm and stand my ground on that, 'more than my job's worth' (vignette two - non-qualified social worker 50).

Each vignette identified the obvious or primary client by name, but several other potential 'clients' appear in the stories, each with a different degree of relationship to the primary client. Thus in Vignette One, Cathy's mother and friend can be identified as other possible clients. In Vignette Two, Jim's family is mentioned. Vignette Three includes Mark's parents as well as other members of the social skills group, while in Vignette Four Mary's children are potentially additional or alternative clients. Some of the Vignettes also include people who represent the 'public'. For example: in discussing Vignette Two respondents were asked to consider whether they would disclose information to Jim's neighbour, and in Vignette Three the shopkeeper was mentioned. Having to reconcile multiple differing interests is the essence of professional care work with complex cases, and in the interviews third party 'rights' to consideration and protection led many respondents to decide they must disclose information. In various of the described situations, members of all three professions interviewed would disclose information to third parties. Their responses show varying degrees of recognition that they accept the need to do so because the third parties either must be considered as potential 'clients' or at least as persons towards whom they have some responsibility. This category contains 120 examples; a few for each scenario are quoted below.

VIGNETTE ONE:

> It [disclosure] would be related to mum's ability to accept that information at that particular time, and if that causes mum severe problems due to illness. Again it's a responsibility to mum, to mum's health, but it's also that it might help mum (social worker 38).

> It's difficult isn't it? The reality is that fantasy is sometimes a lot more frightening than reality. So it may be that her mother is actually exaggerating what's going on and imagining that things are a lot worse than they actually may be. So clear information sometimes can actually be advantageous (nurse 21).
>
> You're not only with Cathy, you're working with mum, because you're relieving mum. In my job it's an hour a week so mum can have a rest from that. It's not much but it is a little bit of a rest... I think you've got to give her a little bit. Cathy's obviously in a depressed state. Her mum's having to deal with her anyway, put up with her mood swings and her depression and all that. So mum needs help with Cathy, mum needs a relief from Cathy (non-qualified social worker 57).
>
> I'd have to try and strike some sort of balance to keep her mum reasonably content that she's been helped but not to be letting out Cathy's innermost feelings when she doesn't want anybody else to know. So you've got to be very careful. I should still want to keep the mum's confidence and respect but above all keep Cathy's confidence (social worker 51).
>
> I could be the family minister as well (chaplain 67).

Respondents recognised family and friends were sometimes carers. In such cases disclosure to the carers might contain elements of both a responsibility to them as potential clients as well as a responsibility to them as sources of help for the client (help which would be more effective if they had more information about the situation):

> [I need to] ... get to the problem and say this is how we solve it. So her mum would have things like phone numbers, and so that she didn't feel alone but that people were around to help (nurse 15).
>
> I think the same applies to anyone she's living with, if there is a great risk. I'd be suggesting to her that the friend has to cope... I'd want to be able to approach the friend. I'd work with her here and now, what's important now and what the risks are now (nurse 23).
>
> I'd be providing her mother with information in a carer's group to support her (nurse 24).

One respondent described an actual situation he had encountered where concern for third parties affected his decision to disclose information to residential staff:

> I'd told them that the person was in fact attempting to burn themselves to death which would have put other residents at risk as well (nurse 25).

Altogether, concern for the well-being (interests, needs, rights, etc.) of third parties was cited in various phrases 25 times during discussions of this vignette as a reason to disclose; 25 percent of the justifications for disclosure in Vignette One, and 20 percent of the times such reasons were presented during the interviews.

VIGNETTE TWO:

Once again, members of all three professions disclosed information to third parties because of concerns for their rights or well-being. The 52 prime reasons in the category represent 40 percent of the reasons given for disclosure in this vignette, and 43 percent of the total citations of disclosure because of the interests of third parties. Similar to Vignette One, these responses show ambivalent evaluation of the client's family. Sometimes the family members were considered virtually as alternative 'clients' toward whom the professionals felt a 'duty of care'. Sometimes they were regarded virtually as 'carers' who could be more effective sources of help if brought within the circle of shared information. Examples of these attitudes are:

> I would just say to the family that if you've got any worries about Jim I'm here for you as well as him (nurse 15).
>
> My hope would be that the family would be very involved in the care anyway so would be involved with him living there, that I would be treating him as part of a family system and my care would have been, from the beginning, directed towards helping the family as a whole care for Jim (nurse 6).
>
> I would have to say to Jim, you know, I'm sorry but I need to speak to your family about this. If I thought they were at risk, if I felt that they were becoming very distressed and were asking to speak to me because they were at their wits end and didn't know what to do about Jim (social worker 32).
>
> That's in order to try and support them living with the situation because I actually feel that relatives very often feel that they're left out and deserted. It's very subjective but a point may come where you feel that they need support themselves in order to be able to help them to manage themselves and also for them to know how to manage with Jim and offer the best support possible to Jim (social worker 37).
>
> I'd be exploring options with them to see if there was some way I could offer them support (chaplain 62).

These responses bear considerable similarity to the reasons for disclosure

to family or friend discussed in Vignette One. However, Vignette Two differed from One by including a third party who was clearly not a fellow professional, nor closely related to the primary client - the neighbour whose relationship with Jim is said to be anything but close and friendly. Uniformly respondents were very wary about disclosing any information to this person. They tended to fulfil any duty they might acknowledge towards the neighbour in ways which avoided actually breaching Jim's confidentiality to this person (e.g. providing information to another professional instead), as the following illustrates:

> I would not even bother to tell the neighbour because I'd be pestering the doctors really. I think I'd be trying to make things move more quickly so that the neighbour wouldn't be involved. I think it might be time - Jim's assessment as regards going into hospital. So it's consulting with the doctor in terms of getting Jim hospital care (nurse 3).

In Vignette Two safety to third parties was the most important factor in respondents' decisions. The Vignette was designed to suggest a potential for some kind of risk of harm to both the neighbour and to family. The level of risk fluctuates in the different variations of the Vignette from the lower level (shown through Jim's general anxiety) to the intermediate level (Jim having a history of petty vandalism) through to the higher level (Jim possessing a criminal record for violence) and, finally, to the highest level (Jim living with his potential victim - a factor which elevates risk considerably). However, in all variations, the exact degree of risk is never very clearly defined; it remains vague and indeterminate, open to the respondents' interpretation. Quite deliberately, an extreme and immediate risk of serious harm or danger (e.g. Jim saying he intended to kill someone) was <u>not</u> included in the vignette.

As expected, where respondents recognised a danger or risk to a third party they became more likely to disclose information, although not necessarily to the person who was at risk. This is particularly interesting when considered in relation to the American Tarasoff case, where the professionals were criticised for not warning the potential victim (a member of the public, rather than a fellow professional).

This vignette provided the most uniformity between respondents' decisions. More clearly than any other, it demonstrated a kind of 'sliding scale' of professional judgement about management of risk and maintenance of confidentiality. Even in the initial version of this Vignette confidentiality was limited. Moreover as risk increased in the later variations, respondents fairly quickly became willing to disclose information to someone, deciding this was justified on the basis of risk to and concern for third parties. This could be equated to some kind of 'duty of care' to people being put at risk by the actions and emotions of their primary client. Such reasoning may be seen in the sample quotations:

> So you're in a sense implying that he might be a danger to his family? I think that if I thought he was a danger to his family I would actually confront him with this and say your family need to know (nurse 21);
>
> It would depend on how urgent or serious the situation is at the moment, whether I'd talk with his family. There clearly would be a point where I would be foolish and negligent not to alert people. If people were in danger I would be inclined to speak to the family about it (nurse 19);
>
> Well I think they have a right to know if they are in danger because he's living with them (nurse 13).

However, the duty to third parties could be variously motivated. It could also spring from recognition of a public duty as much as from concern for an individual. The public duty was derived from the respondent's supervisory or monitoring role under the Mental Health Act, 1983. This is seen from the following excerpts from transcripts:

> I think if we thought there was serious risk to someone else the question would be 'Do we take him to hospital?' I think if he was at the point where we felt we had to inform the neighbour then really we'd reached the point where he had to go to hospital (nurse 5);
>
> I would feel that if there is a risk of Jim assaulting his neighbour I would want to set up a full assessment under the Mental Health Act (social worker 33);
>
> If there was real risk to someone they might be looking at sectioning (non-qualified social worker 53);
>
> So if he deteriorates then he can be hospitalised to stop either him harming himself or others. It might mean being sectioned but I'd hope it didn't come to that (chaplain 61).

VIGNETTE THREE:

Twenty-nine percent of the reasons given for disclosure in Vignette Three involved loyalty to third parties. It was the second most common type of justification for this case, but the 12 occasions when it occurred represent only 10 percent of the total incidence of phrases indicating this reason-category appearing in the interviews. Initially this seemed high, higher than expected. It was higher proportionately than the frequency of this reason cited for disclosure in Vignette One. However, this must be seen in the context of a relatively 'low' disclosure rate (56 percent) in Vignette Three in contrast to the relatively 'high' disclosure rate (91 percent) in Vignette One. Potential third party loyalties in this case included Mark's parents, other members of the social skills group, and the shopkeeper.

No respondent opted to disclose to the shopkeeper. However, although no one specifically discussed any sense of duty or responsibility toward this third party, some sense of concern about the shopkeeper was implicit in the decisions of two respondents (one of whom is quoted below). Although they show concern for the shopkeeper, the primary concern appears to be that the client Mark should learn to take responsibility for his actions:

> We would suggest to him perhaps 'is there any way he wanted to actually recompense the shopkeeper'. Even if it was, I mean I've done it with young people suggesting they've pinched that, saying, 'okay, let's put a postal order in and send it back to him and you don't have to go' and it's given them the consequences of their actions without someone as vulnerable as him coming down like a ton of bricks right at the start (nurse 4).

Concern or some form of 'duty of care' was also expressed toward the other members of the social skills group. It must be noted, however, that although this could provide a reason for disclosure against Mark's wishes, it did not necessarily mean the worker intended to discuss Mark with other members of the social skills group:

> Well, if he was bringing other youngsters, clients into this habit, then you just can't let things like that get out of hand, can you. I should be wanting to talk to workshop staff

(non-qualified social worker 55);

> It's the degree of what he's doing that's deciding whether I'll tell the person in charge - and the effect on him and the possible effect on others, I mean if everybody's going down with alcohol poisoning. That's the extreme but I'm looking at risk and trying to sus out the risk he's going to be under from police picking him up and what's going to happen to the other kids who are receiving because they are bound to know he's pinching it (social worker 36).

In fact, in only one case did a respondent decide to discuss the problems with other members of the social skills group (at the point at which Mark was providing stolen alcohol to the other workshop clients):

> I think if he were doing that then I would bring in the social skills group. But then again, you wouldn't do that before saying to Mark, look Mark this is obviously a problem. You're involving other people here. It's not just your problem then, it's a few people's problem and we need to look at this in a group and open this up to discussion. It's so that the group, not just Mark, share the responsibility and look at consequences and it's a social skills learning experience (nurse 24).

As expected, several respondents felt that Mark's parents had a 'right to know' which transcended Mark's desire for strict confidentiality:

> I feel actually that if there was a problem, they as the people who were looking after Mark, would have the right to know certain relevant points. I would professionally have to let them know certain things (nurse 5);
>
> His parents; he's sixteen years old so they need to be aware (social worker 31);

VIGNETTE FOUR:

In Vignette Four, 52 percent of the reasons given for disclosure involved loyalty to third parties, and the 31 such citations represent about a quarter of the total reason-category. In all cases the issue was safety of the client's (Mary's) children. The following examples were typical of the phrases used to explain the reasons for disclosure:

> I'd be wanting to ensure the children's safety (nurse 19);
>
> I would speak to someone about it more or less straight away. I'd tell my line manager and he would then make the decision but I would have to make somebody aware because I think that

> Mary herself as a child had a poor role model and doesn't know any better. She probably thinks well this is what you do and I would be really concerned for the children (non-qualified social worker 58);
>
> I would want to talk with the doctor and the child care social worker. I would have to because of the health of the child (social worker 37);
>
> Because if a child is being hurt then I have to consider his safety (chaplain 67);

Not surprisingly, given the pre-school ages of the children in the vignette concern for their safety and happiness did not equate with discussing Mary's situation with them. However, interestingly, no respondent chose to breach Mary's confidentiality by discussing the child care problems she was having with her estranged husband. Some respondents mentioned they would encourage her to improve communication with her husband, or offered to help her to discuss her problems with him (i.e. act as facilitators), since they saw him as a potential source of valuable practical support for Mary where the children were concerned. However, in all cases, when reminded that Mary would not agree to this, respondents were prepared to accept Mary's decision. Whenever their concerns became serious enough that they were prepared to contravene Mary's wishes about confidentiality, they chose to contact other professionals rather than the children's other parent, even though that person held legal parental responsibility for the children in question.

Loyalty to Other Professionals

As discussed earlier, nurses, social workers, and chaplains rarely work in isolation. Commonly they share clients with other professional and para-professional workers (i.e. one client may see a G.P., psychiatrist, C.P.N., social worker, pastor, hostel worker). Professionals frequently work within teams which share responsibilities and workloads to some degree. This situation generates recognition of a duty towards fellow professionals. Sometimes this is characterised as simple 'fellow feeling' toward another worker who is also trying to help solve difficult problems involving complex situations. It might represent just a sense of 'fair play', as examples show:

> It would be very unfair to leave them with somebody who could potentially kill themselves (vignette one - nurse 25).
>
> I don't think it is fair to the residential establishment that she is placed in it without them having certain knowledge of the history (vignette one - social worker 33).

In some circumstances the respondents argued the other professional needed all available information in order to provide an adequate service, and so, if the client was unwilling to provide it then the professional colleague must.

> ... but the staff should be given some help - they need to know (vignette one - nurse 10).
>
> The staff in the shelter would need to know that (vignette one - non-qualified social worker 55).
>
> I'd also be interested in educating so that they could actually support her effectively and so that she's actually getting what she needs (vignette one - nurse 24).
>
> They need to know (vignette three - non-qualified social worker 54).

At other times respondents mentioned that there might be formal procedures in place requiring them to share certain kinds of information with certain people. This situation was commonly described by nurses, and they took it for granted that their cooperation was not only expected but was professionally acceptable. This is not surprising. Nurses typically receive most of the practical part of their training within hospitals which require them, as a matter of routine, to record and report back to other professionals (either to fellow nurses or members of other professions). Thus, from the earliest stage in their careers, this training accustoms nurses to the concept of limited confidentiality. In particular, if they received referrals from G.P.s or psychiatrists, as the nurses in this sample regularly did, they explained they had an obligation to report back to the referring agent. The growth in fund-holding practices with nurses employed by multi-disciplinary teams which work on a contract basis may also be having an impact on their decisions.

> The decisions relate to the fact I'm discussing with someone who's already part of the clinical team. I'm making the

> assumption, probably because of my clinical experience, that I wouldn't be involved unless the doctor was already well aware of the situation and that's how I'd become involved (vignette four - nurse 20).
>
> Colleagues from the centre. It would be my overview of the situation of what was happening because we work in a similar way to a ward situation where we have twenty-four hours, seven days on call, consequently we need to have some sort of continuity and information on this client because we all could be on call for that (vignette four - nurse 6).
>
> So there are two clear areas of referral, one from a psychiatrist and one from a G.P., so as far as I'm concerned, there is always a medical influence. Therefore I wouldn't foresee a problem discussing the situation with the doctor because the doctor would actually have referred him to me. So the way it works is the referring agent, either the psychiatrist or the G.P. would write a letter of referral to me, asking me to see this person and assess them, see if there was anything I could offer, and then write back to the G.P. who referred him on trust, with the identified problems that had come up (vignette four - nurse 24).

A minority of respondents acknowledged that the professional rules which bind other workers might affect their own access to information about a given client. They recognised that, in fact, more information might flow out from themselves to other professionals, than be received by them.

> If you were really worried and there were lots of things you didn't know and to access more information, probably a visit to the G.P., if he was willing to tell you anything because of his code of confidentiality (vignette two - chaplain 66).
>
> A doctor might not want to talk to me because he's got his confidentiality rule which is virtually similar to mine (vignette four - social worker 33).

As was anticipated, nurses in the sample tended to be clearer about (and more comfortable with) their obligations to report information to other professionals, than were social workers or chaplains (see Table 16). Many of them discussed the need to set ground-rules with clients during the first few visits, so that long before the actual dilemma described in the vignette arose, they had already established a pattern of regularly consulting with or disclosing to other professionals. In some cases this effectively eliminated any dilemma for them, since from the beginning, both client and respondent were very clear where the professional's prime loyalty lay. The following are two of the many nurses' discussions which clarified nursing's general approach to the confidentiality issue:

> My first meeting with him, one of the things I would say is that I would like to keep things confidential but though most things can be kept between the two of us, I'd be clear about what couldn't be (vignette two - nurse 15).
>
> Right at the outset the first thing I would say when I met someone would be the fact that yes I work in a team.... Often people don't seem to realise that actually it is until it comes to a point where I am actually sharing something that they don't want me to. So then I talk about it again (vignette two - nurse 5).

Professional experience or training also imbues professionals with an awareness of the limits of their expertise, or roles. In other words, their professional conditioning imprints the knowledge of what they are qualified to do *versus* what other professionals are qualified to do. The interview discussions made this distinction especially evident with respect to medication. Only a medically qualified person (e.g. G.P. or psychiatrist) is allowed to prescribe, although a nurse may administer and monitor the use of medications. Professionals from all three groups demonstrated an awareness about limitations of expertise, although, not surprisingly this was discussed most explicitly by nurses:

> ... part of my involvement would be to monitor medication, monitor her response and that information would be hopeless unless I was feeding that back somewhere (vignette one - nurse 8).
>
> It's a situation that should be assessed by somebody else (vignette four - nurse 13).

Loyalty to some other professional(s) was the second most common reason given during the interviews for breaching client confidentiality. The incidence varied with the four vignettes, as was shown in the transcripts from which the following quotations are taken.

VIGNETTE ONE:

Overall, 36 percent of the reasons for decisions to disclose in Vignette One involved loyalties to other professionals, and the 36 citations related when considering this vignette represent almost 36 percent of this disclosure reason-category. Within these reasons, some of the discussions about whether to disclose illuminate the special roles certain workers

play in our health and welfare system. The distinction between respondents' own particular approach to professionals and non-professionals became evident when reviewing this scenario. Clearly some respondents were more likely to disclose to people they perceived as 'professionals' rather than to those who were 'non-professionals'. There was a frequently stated expectation that professionals could be trusted to deal with information in acceptable ways: (1) with discretion, having the clients' best interests at heart rather than being influenced by some self-seeking motive; and (2) by working within a set of professional procedures and guidelines about confidentiality comparable to their own, rather than randomly, without tact and possibly with dysfunctional publicity. This distinction between professionals and non-professionals was made clear when explaining the rationale for not disclosing to friend(s) or family:

> I don't think I would with a non-professional, which is essentially her mother, because I'd find it hard to justify that decision (nurse 14).
>
> I think that is the key difference. I think I would feel that rightly or wrongly to have some guarantees about how the person would use that information if they were professional staff, but if they were friends, family, I'd have no guarantees about how they would use that information (nurse 7).
>
> I would have some trust which may be misplaced in professions that they would use that information in Cathy's best interests (non-qualified social worker 55).
>
> You know you can speak to a doctor about anything, their ethical contract, whatever you want to call it, whatever is discussed, whatever comes from Cathy is just him and Cathy. But with her mum - her mum might just... I don't know what the relationship is with her mum and she might not have a gentle approach or anything with her daughter (chaplain 62).

In other cases the distinction arose when respondents were deciding whether or not to discuss Cathy's situation with para-professional residential staff. The extent to which respondents recognise these staff as fellow professionals affected their decisions to discuss Cathy's case with them and also influenced the extent of disclosure.

> I think I should actually discuss it with the doctor. Obviously because if she's needing medication then you've got

> to talk to the doctor.... I don't know about discussing things with residential staff because what possibly may be their knowledge of her mental health or their understanding of the thing and so I'd be very careful what sort of approach I took with them (non-qualified social worker 54).
>
> I'd probably discuss it with her doctor but not with residential staff.... Because I feel that somebody in that situation who's tried to rebuild their lives, it's the same as any other relationship - they need to have control over how much and what people know about them and *they aren't involved in her medical care* [emphasis added]. They are there as caring human beings and Cathy needs to have control over what she tells them (nurse 27).
>
> It's also to do with supporting the workers in the hostel because they're my colleagues as well (social worker 30).

VIGNETTE TWO:

This was another scenario in which the justification for disclosure commonly involved loyalty to another professional person or group, or to one's own colleagues. Overall 28 percent of the reasons to disclose in this vignette involved loyalties to working relationships with other professionals, and the 36 reasons in this disclosure-category, represent almost 39 percent of the category total. This case had been written to provide clear distinction between professionals (e.g. G.P., psychiatrist) and non-professionals (parents, neighbour). No para-professional workers were introduced. Examples of reasons given for disclosure, therefore, tended to rest on the particular expertise or professional role which the information recipient (individual or agency) possessed, and existing inter-professional arrangements for information sharing.

> I feel actually that I would want him admitted, preferably on some medication. It would want to be a referral through a G.P. and the fact that I would be involved would mean that it would probably come through a psychiatrist anyway because I work closely with psychiatry (nurse 16);
>
> I would envisage that it would be an ongoing process with the doctor. I would be communicating with the doctor regularly, and I'd explain that to Jim right from the start. I would be seeing him as part of a team (nurse 10);
>
> We need to talk to the C.P.N., and off the record I would tell her. The C.P.N. could be more available than us to discuss the situation with Jim. He's not wanting his medication; he's refusing; we are struggling to have him still accept his injection. You need to talk to everybody involved with that person, you need to have them on tap, to work together (social worker 32);
>
> If he has schizophrenia I think it is likely that C.M.H.

> would [already] have some contact with him and I work within the system, so I'd go through C.M.H. first.... So almost certainly he'd have a C.P.N. somewhere so I'd go to the C.P.N. and let the C.P.N. deal with the doctor. I want there to be clear professional oversight to his illness and monitoring (chaplain 61).

VIGNETTE THREE:

Loyalty to other professionals was particularly evident as a reason for disclosure in this type of case. 38 percent of the reasons given for disclosure in this case belonged in this reason-category. Vignette Three also specifically asked respondents to consider discussing Mark's illegal behaviour with the police. Although police may be considered fellow professionals, they clearly have a very different role from that of a fellow *treatment* professional (such as a doctor, nurse, social worker, counsellor or chaplain). Police and health and social care professionals all acknowledge that they have a duty to be concerned about the best interests of individuals as well as duties to the 'public interest', but, the relative weights they attach to these sometimes conflicting duties can differ. Police do not commonly have a 'duty of care' to an individual who is suspected of committing a crime in the same sense that a nurse, chaplain, social worker or some other 'caring' professional might have.

Police have discretionary powers about arrest and cautioning, particularly where young people or people with language or learning difficulties are concerned (Bottomley, 1973; Werthman and Piliavin, 1978; Metropolitan Police, 1985). In addition, their interpretation and report of events, especially in situations where it might not be deemed in the best interests of the public to prosecute, might well involve dilemmas of conflicting loyalty. However, their role in relation to shoplifters and or underage youths consuming alcohol is not generally viewed as a 'caring' role. This police image was made manifest during the interviews with this sample of members of the traditional 'caring professions'. The distinction became clear when respondents were asked to consider informing the police about Mark's shoplifting alcohol. Issues underlying the different approaches to what is regarded as confidential information also surfaced.

> I'd definitely tell his parents because he has a good relationship with them and they have his best interests at heart... I wouldn't tell the police (nurse 22).
>
> The workshop staff have a duty of care toward Mark so they have to know, but I wouldn't tell the police because they don't have that (nurse 14).
>
> I wouldn't discuss it with the police. It's hard to explain why. It's about identifying people who would see full confidentiality as being important if I was to share something with them (social worker 35).
>
> There again the people in a residential home have a duty of care to Mark because he is under their charge and they would have some bearing and confidentiality in regard to who they were looking after. I would professionally have to let them know certain things. I couldn't put myself in a police role (nurse 5).

This type of comment certainly represents the majority opinion of all the respondents, regardless of professional group. However, there was a minority prepared to consider discussing the situation with the police in specific circumstances, as the following quotations reveal:

> Sometimes there's an arrangement with the local policeman just to come and talk to him and talk about the seriousness of shoplifting. So you can ring him up and arrange without it being all official (nurse 26).
>
> Well if it keeps up you might get the police coming round because of a complaint (social worker 31).

VIGNETTE FOUR:

This was not the type of case where respondents seemed to feel that disclosure was desirable because of their loyalty to the needs of other professionals who should know certain confidential information. Only eight percent of the reasons given for disclosure in this vignette involved loyalties to other professionals, and the citations represent only 15 percent of this disclosure-reason category. It seems that, at least as far as this case was concerned, for the sample interviewed, other reasons for disclosure were more compelling. When they decided that disclosure, even in the face of the client's expressed wishes, was needed for reasons related to co-working practices, this took place in the beginning stages of Vignette Four, before issues of risk of harm to the children had been introduced. Once the complications were heard, then the compelling reasons

for disclosure surfaced: loyalty to third parties and clients' best interests. So in this vignette, the five disclosure decisions which involved informing other professionals as standard working procedure were voiced early in the case discussion, responding from the beginning to their common practice.

> I think [I would disclose to] the doctor. I'm assuming he's referred to us, but I wouldn't go into detail. There's nothing there that makes me feel alarm bells ringing at this point. So basically I would just feed back to him as I do every so often when I'm seeing this lady for stress management counselling (nurse 6);
>
> I'm sort of the eyes and ears of the G.P.; that's part of why I'm there (non-qualified social worker 58);
>
> Probably the social worker. Looking at the job I do; she'd probably have a qualified social worker and I'd have to feed back information to her (non-qualified social worker 57).

Loyalty to Self

It is reassuring to note that, regardless of which vignette was being discussed, workers' self-interest was voiced only as a minority reason for disclosure. This totalled only 11 percent of the reasons given for all vignettes combined. There were, however, occasions when respondents acknowledged they felt compelled to disclose information about a client in response to self-interest as professionals. These discussions reveal an awareness of the risks they take, either in terms of choices to share information without a client's consent, or other kinds of decisions about case management. Such 'self-interest', as was described in these interviews, could be judged to have positive implications for overall good, responsible and effective casework. For example, the disclosure might reflect a simple desire to seek supervision in order to help with decision-making.

> That's not something I would share without seeking some supervision about it because I think it's a very difficult area (vignette one - nurse 18).
>
> I'd discuss it first in supervision which would give me a clearer picture and I would probably take longer to think about it than I am here in the interview (vignette four - nurse 12).
>
> ... to safeguard her because being a fallible human being, I

> might make an error of judgement and so I check out my judgement. I might decide on the same course but I've heard other objective experienced views about the situation, so its not relying just on me (vignette one - chaplain 61).
>
> We have supervision with our team manager and obviously we've got to discuss our cases that we're working with. So you can't go every time and say I've nothing to report. You know, sometimes you haven't because everything's running smoothly. But to me in situations like that you've got to say, Oh she's started to cut herself again (vignette one - non-qualified social worker 56).

Alternatively, disclosure in supervision could be used as a form of self-protection which helps maintain a healthy working environment.

> I cannot keep things to myself that are going to be a worry and a stress to myself (vignette two - social worker 34).
>
> ... because you've got to think of your own, you've got to think of yourself as well. Some of it's taking the burden of responsibility away or perhaps easing my conscience. We have supervision for this purpose (vignette two - non-qualified social worker 55).

Respondents also acknowledged that they disclosed information to other professionals because they had reached the limits of their own professional expertise. This is similar to the nurses' acknowledgement about working within a network of professionals each of whom has different responsibilities (e.g. monitoring medication *versus* prescribing medication). However, in these instances the respondents were seeking guidance from another professional who knew more about the specific specialist area than themselves:

> Well yes, because I'm not very skilled in terms of child care and I would probably need to be having discussions with the child care team manager for the area (vignette four - social worker 39);
>
> I really don't know enough to deal with it so I'd have to ask for advice (vignette three - nurse 3);
>
> I would need to discuss it in supervision because I don't really know enough about the law in this area (vignette three - nurse 1).

On a less positive note, respondents sometimes openly indicated that 'messy' situations, like the ones portrayed in the vignettes, made them

feel personally at risk, and this had the potential to lead them to disclose information to other professionals in order to minimize their own risk by sharing uncertainties. This kind of defensive thinking because a worker may be held responsible on an individual basis is recognised in the professional literature (Kerrigan, 1997). There were differences between the vignettes in how this was expressed.

VIGNETTE ONE:

In this scenario, respondents' self-interested concern took the form of fearing they would be blamed for poor decision-making, particularly if there were a 'bad result' in a case like this one. Responses typical of this kind of disquiet were few but notable.

> I would certainly discuss it with my line manager in my workplace. ... not only to help arrive at a decision but I think I need to be seen to be acting correctly, that is to seek advice, and thrash the whole thing out. So there is an element of selfishness in there if you like, or self-protection (nurse 16).
>
> You'd say 'all right, fair enough if that's what you want me to do but I can't go away knowing you're doing that because it's not my job to do that. Because if you carry on and I've been to see you and I leave you like that, and you die it's me that's going to lose my job because I'm not doing my job correctly (social worker 36).

VIGNETTE TWO:

Worry that the circumstances described in this vignette hold high potential for the worker to be blamed if anything goes wrong was particularly evident in case discussions about Vignette Two, which described the case of Jim, a paranoid schizophrenic. This elevated level of concern was expected. The vignette had been deliberately designed to present a relatively higher risk situation of potential harm to third parties (although not an obvious 'open and shut' case of overwhelmingly immediate danger of violence or serious injury). In the past ten years in Britain there have been some violent incidents involving former hospital patients suffering from schizophrenia which have generated high media attention (e.g. Christopher Clunis). Mental health services have ben heavily criticised. Given this background it was expected that this vignette would stimulate much discussion amongst respondents about the

risks they run in their work in the mental health field. The expectation was fully realised. There were many personal experiences reported, although the end decision was not always to disclose. The excerpts below are from the disclosure group.

> You've got to report it because if he is going to hurt someone that is something you've got to monitor because social workers soon get in the papers for neglect (social worker 37).
>
> Because if you don't and something happens you'd end up in a mess (social worker 33).
>
> I'm afraid it is because I can get myself in hot water very easily if you don't do things right. I think the further you get away from the doctor the more dangerous you become (nurse 19).

That there was an element of personal risk, as well as professional risk, which workers were also aware of, was revealed by a small number of respondents.

> Again, it's the medication issue. I'd have to discuss since that would have an effect on his behaviour. I wouldn't tell Jim because if he is paranoid that's likely to make him worse. You've got to reassure him that you won't look into the matter. So it's to pacify him and then later to go off and try to find out, because there might be a danger (non-qualified social worker 57);
>
> It's my experience; I was attacked in a similar situation and I didn't have any powers to admit somebody. I can take people to hospital if they'll go but I haven't got any power under the Mental Health Act and this case was assessed by a psychiatrist who considered it suitable for hospital but the social worker and the G.P. didn't think that was suitable, so consequently I didn't go back. So I think in this situation I'd need a bit more knowledge about Jim really (nurse 11).

VIGNETTE THREE:

This was the vignette least fraught with risky complications, so it is the on for which few difficult disclosure reasons were 'mulled over' by the respondents. All of the seven reasons for disclosure in Vignette Three that could be termed 'self-interest' were examples of the 'positive' self-interest which involved seeking help in decision-making or recognising limits of professional knowledge. This scenario was designed to present the least risk to individual client, third parties, or the worker and this

seems to have been recognized by respondents. Their reasons for 'self-interested' disclosure were positive, rather than selfish (i.e. disclosure through fear they might be censured for a decision). The example given was typical:

> I'm not sure how to deal with this, so I suppose I'd need to talk it over in supervision... (nurse 21)

VIGNETTE FOUR:

In this case, 'loyalty to oneself' reasons for disclosing confidential information were seldom voiced. Some of these disclosures involved the 'positive' types already reviewed, but a few respondents raised the need for self-protection when reviewing the case involving child welfare concerns. The following is an example of such defensive reactions:

> There's a thing about social work now where social workers tend to cover their backs and maybe call in Child Protection earlier than they would have done in the past (social worker 30).

CONCLUSION

The interview discussions about the best way of handling cases like those in the vignettes and respondents' reasons for their decisions to disclose amply revealed a picture of the complex web of (sometimes) conflicting loyalties, which affect professionals' decisions. As Kohner (1996) notes the issue of conflicting loyalties is recognised in professional literature:

> Ideally, nurse, family, friends,and client all work together in these circumstances. But it is not unusual for the needs and wishes of relatives, and the needs or wishes of a client, to be in conflict. It may then become very difficult to reach ethical decisions about a client's care, and for the professionals concerned there are likely to be questions of - or feelings about - loyalty (p. 40).

In keeping with the issue as presented in the professional literature, my analysis of the interview transcripts also revealed how constant was the recurrence of such themes in the interviews, attesting to the conflicting

loyalties which drove respondents to consider whether it would be best to breach, rather than maintain, strict client confidentiality. They were acutely aware that there are others who 'need to know', that there are others for whom some 'duty of care' is required, that there are others who might be 'put at risk' by the actions of their client, and that they themselves run personal and professional risks. Review of the interview transcripts revealed that expressions of these loyalties could be classified into four categories without distorting the integrity of the comments: loyalty to the individual client, loyalty to other possible 'clients' and involved third parties, loyalty to other professionals (particularly workers in the caring professions), and loyalty to oneself. Within these broad groups there were many ways in which these different loyalties might manifest themselves in the cases described in the vignettes. Recognition of these were expressed in the interviews and led to discussions of how conflicting loyalties might be resolved in professionally acceptable ways.

Respondents' consideration of the vignettes demonstrated that professionals working in the mental health area operate in a web of complicated, sometimes conflicting loyalties - this is the essence of professional practice. Situations are seldom clear cut. Information is seldom complete. Perfect knowledge is seldom present and the full picture of a case is derived piecemeal.

It was apparent, particularly in the reasoning of the nurses, that professional networks and routine reference within work groups mean de facto that even at the early stage of case development there is very limited confidentiality of what is deemed to be relevant client information. Part of the difficulty arises from the circumstance that often there is not merely one client. There is a plethora of clients to be considered who have different needs for care and protection. Who is the primary client is not always obvious.

There is also the complication, in this day of strident demand for

'rights' and 'empowerment', arising from the question, whose is the primacy of judgement when the client judgement about his 'needs' conflicts with the worker's professional judgement about what is needed to solve or mitigate the client's problems? This is complicated by the fact that workers in the three professions chosen for this research are not self-employed; they work as salaried staff within other organisations which also have an interest in the case decisions being made. As Tindall (1997) notes:

> This can create difficulties for agencies which are funded by public money but have a firm commitment to empowering people they support. They may not only wish to act in accordance with the wishes of the people they support - and to assist them in taking risks in ways which will maximise the possibility of a positive outcome - but will be required to demonstrate that they have paid due regard to public concerns about the possibility of harm occurring to people who may not necessarily appreciate the possible outcomes of the actions they wish to take (p. 103).

Professionals (and the agencies which employ them) must be accountable for their choices. However, as the interview transcripts amply demonstrate, lines of accountability are not simple, and at times, a professional may choose to disregard his accountability to the named client because of responsibilities and accountability to other people.

Finally, questions must be raised about the nature and extent of such a general principle as 'confidentiality' and the commitment to this principle which is included in almost all codes of ethics, not just those of the three professions represented in this research. Is this merely a hollow principle representing rhetoric rather than reality, particularly when workers facing common practice decisions come up with more reasons to breach it than to maintain it?

CHAPTER NINE

RATIONALIZATION

This chapter discusses the extent to which respondents 'faced up' to the ethical dilemmas inherent in the vignette's case situations or, alternatively, either failed to recognise the ethical decision-making required or rationalized away their decisions. This is analyzed in three ways. First, the frequency and level of rationalizing statements *versus* statements acknowledging ethical conflict are discussed. Each vignette is reviewed separately and examples are given of two types of rationalizing statements, as well as examples of statements which clearly acknowledged the ethical dilemma respondents were facing. Second, differences between the three professional groups are mentioned and a possible explanation for them considered. Third, disclosure decisions and the incidence of rationalizing statements are compared to determine if a relationship exists between them. Three hypotheses were used to examine the possible nature of this linkage.

This research was designed to investigate the reasons behind professionals' breaching of confidentiality even when the client has refused to permit it. In addition, it was proposed to gather the kind of data which would reveal the extent to which a group of professional respondents rationalized disclosures to themselves. Such justification could well be separate and distinct from the actual purpose or reason for disclosing information. For example the *reason* advanced for the disclosure decision might be 'to protect the public', but the *rationalization* also offered during the interview might be that "confidentiality was not really breached because I only spoke with someone else in the department".

The conversations during the interviews revealed the presence of subtle pressures on the professional as he makes choices about disclosure. Some interviewees openly acknowledged the conflict which exists between maintaining very strict confidentiality, according to the wishes of clients in the vignettes, and various professional pressures to disclose at least some information at some point in a case. In short, they all

acknowledged freely that they recognize they are often making choices which (potentially) involve sacrificing one person's wishes or interests because they have to consider and protect those of someone (or something) else. None of the respondents was really comfortable with this and, it was evident in the discussions that, at various times stratagems are adopted, in a sense, to blur the decisions being made. These emerged vis a vis the vignette cases and can be seen in the transcripts.

Although one can qualitatively recognize such stratagems, it is extremely difficult to quantify how respondents acknowledge conflicts between confidentiality and disclosure, and the strategies they use to manage their dilemmas. Some participants made statements openly showing that they recognised the ethical dilemma present in the case, but this did not always happen. Some interviewees did not clearly state 'these two issues are in conflict' (or use comparable words) each time they made a decision for a vignette. Nor should that be expected in the kind of structured, but discursive, interviews which took place. But in discussing a vignette, respondents would make statements which seemed to acknowledge the conflict, only shortly thereafter (when considering another vignette) to make a comment which seemed to rationalize the conflict away. In theory, if at least once per vignette, each respondent had openly acknowledged the dilemma he was facing, there should have been recorded two hundred and twenty statements of this nature. However, to expect this to occur would be unrealistic.

It is more realistic to assume that, regardless of the respondent's actual decision and whether specific recognition of the dilemma was openly voiced, each participant implicitly accepted that a conflict did exist, unless during the interview he specifically said something which rationalized (or was intended to rationalize) this acceptance away. This assumption underpins the analysis in this chapter. It is important to remember that the general statements of ethical principles to which these workers adhere presume that confidentiality will be maintained as a general rule and only breached for a specific and compelling reason. These

professional workers do not, in fact, need to have a 'reason to maintain confidentiality'. On the contrary, they need a 'reason to disclose'. As a result, probably, in an interview where they are asked whether, in the circumstances, they would choose to disclose and had to make an immediate choice, there would be a greater personal or professional discomfort when deciding to disclose - particularly in the full knowledge that it was stated that the client would not be happy with disclosure and could question it since this ran against his expressed wishes. Therefore, decisions to maintain the confidentiality, which the vignette clearly indicated the client wanted, should not provoke in the participant any need for rationalizing statements of the kind that decisions to disclose might provoke as necessary justification.

The following four tables show how many respondents made statements which appear to rationalize away their decision to breach confidentiality arranged so that the totals can be compared with the number who made specific statements which show an active acknowledgement of the dilemma, as well as the number whose recognition of the dilemma they were facing in making their decision choice had been inferred from the case discussion, for lack of a specific statement. Some interviewees made multiple rationalizing statements (i.e. more than once during the same vignette) and some made multiple statements acknowledging ethical conflicts they were facing, but the multiple (duplicative) statements were not counted. It should be noted, therefore, that the tables record the number of people, not the number of statements, which was much higher than these numbers indicate. The 'Total' column refers to the total number of respondents who decided to disclose for that particular vignette, not the total number of professionals interviewed. The percentages were calculated using this base figure. In other words these tables show the percentage of respondents who disclosed and made rationalizing statements to support their decisions in comparison with the percentage of respondents who disclosed and accepted (explicitly or implicitly), without any rationalizing comment, that an ethical conflict existed but they had to take the responsibility for action.

VIGNETTE ONE

TABLE 18

Distribution of Rationalizing Statements, Statements Acknowledging Conflict and Inferred Acceptance of Conflict in Vignette One by Professional Group

	Rationalizing Statements		Acknowledged Conflict		No Statement (acceptance inferred)		Total	
N	6	22%	10	37%	11	41%	27	100%
SW	7	35%	6	30%	7	35%	20	100%
C			1	33%	2	67%	3	100%
T	13	26%	17	34%	20	40%	50	100%

N = Nurse SW = Social Worker
C = Chaplain T = Total

Levels of Rationalization and Acknowledgement: The rationalising statements generally fell into one of two types - avoiding the issue or redefining the decision. Those who avoided the issue indicated in the discussion that they would convince the client to agree to a breach of strict confidentiality. Even when they were immediately reminded that the scenario had a client adamantly opposed to any disclosure of information to a third party, nonetheless, these interviewees insisted that they could alter this viewpoint and get the client to agree to disclosure after all. In other words, they were only comfortable with their decision if they could change the terms of the case. For example:

> I definitely think her mother should know about that but I think what should happen is Cathy and I should work at it, sort it out and decide what to say. I'd actually say because her mum was frail, I had to tell and I couldn't not say something, and I'd use this as a motive really to make her agree what (nurse 23);
>
> I'd be very surprised if you couldn't get her to agree in the end (social worker 30).

In the second type of rationalization, respondents would justify discussing client information with another party on the grounds that they were not really breaching confidentiality because they were not disclosing new (or pertinent, or detailed) information; the third party must know it already. For example:

> The fact that if she has been actually diagnosed clinically depressed I'm assuming the doctor already knows about it... I wouldn't be involved unless the doctor was already well aware of the situation (nurse 4);
>
> The thing is her mother knows Cathy and, if she's living with her she probably knows more than me, so I'm not telling her anything new. But she needs me to prepare her so she knows numbers and places to go (social worker 36).

However, there were more respondents who specifically and fully acknowledged the professional dilemma and in the discussion were clearly agonizing over their disclosure decisions. For example:

> I've got a responsibility towards Cathy as mentioned before; I've also got a responsibility towards the staff, but also in telling the staff it's a responsibility - to me it's displaying my responsibility towards Cathy as well... I feel uncomfortable saying that because it's like you making decisions about what's best for somebody else and I'm not saying that easily. It's a very real dilemma (social worker 38).

VIGNETTE TWO

TABLE 19

Distribution of Rationalizing Statements, Statements Acknowledging Conflict, and Inferred Acceptance of Conflict in Vignette Two by Professional Group

	Rationalizing Statements		Acknowledged Conflict		No Statement (acceptance inferred)		Total	
N	4	15%	10	37%	13	48%	27	100%
SW	6	29%	7	33%	8	38%	21	100%
C			3	60%	2	40%	5	100%
T	10	19%	20	38%	23	43%	53	100%

N = Nurse SW = Social Worker
C = Chaplain T = Total

Levels of Rationalization and Acknowledgement: For this vignette respondents also made statements blurring and rationalizing the decisions they were making, statements which fall into the same two general categories as those which arose in the discussions on Vignette One. Several respondents outlined the stratagems they would adopt to get the client's agreement to disclose. This might be something as simple as setting ground rules from the point of first meeting the client (which is considered a normal part of good practice). Given the higher level of risk

involved in Vignette Two (the type of diagnosis and case history), it is questionable how much this practice represents rationalization and how much it simply reflects the fact that few professionals would ever work with this type of client without regularly consulting with other professionals already involved with his care. For example:

> I'd be telling him from the start that I had to talk to people - like the G.P. who referred him, so he'd have to agree to or I wouldn't see him (nurse 9);
>
> The job I do I always report back so they know that and I don't see them if they don't go along with it (unqualified social worker 54)

Nonetheless, some workers still rationalized their choices by claiming that simply by talking with another person they were not really breaching confidentiality, provided they did not discuss specific details about the client. For example:

> I don't see that as breach of confidentiality. I would say it's my concern and it would be information gathering really, and then obviously the intervention we use after that would be dependent on how serious we thought it was or the family thought it was (nurse 4);
>
> I can't go into the home without them knowing who I am but that's not the same as discussing everything (social worker 32).

The statements made by the respondents who openly acknowledged they were making an ethical choice were generally quite frank. There were twice as many respondents who openly acknowledged the dilemma than there were respondents who made rationalizing statements (20 acknowledgements *versus* 10 rationalizations). For example:

> It's a difficult choice because you want to respect his wishes but it's not always possible (chaplain 62).

VIGNETTE THREE

Levels of Rationalization and Acknowledgement: Similarly, when discussing Vignette Three some respondents would rationalize the disclosure decision by avoiding the issue of client disagreement altogether. 'By hook or by crook' they would get that client to agree to disclosure. For example:

> I've never had a situation where you couldn't persuade them to agree to you telling someone (social worker 40)
>
> Look, [I would say] I have to discuss this with them and it's best if it comes from you, not me. And we'd negotiate how much to say and how to do it.... I'd go with him and help. So in the end it would come from him not me (nurse 27)

TABLE 20

Distribution of Rationalizing Statements, Statements Acknowledging Conflict, and Inferred Acceptance of Conflict in Vignette Three by Professional Group

	Rationalizing Statements		Acknowledged Conflict		No Statement (acceptance inferred)		Total	
N	7	41%	4	24%	6	35%	17	100%
SW	4	33%	3	25%	5	42%	12	100%
C			1	50%	1	50%	2	100%
T	11	35%	8	26%	12	39%	31	100%

N = Nurse SW = Social Worker
C = Chaplain T = Total

And again, some respondents would make the distinction between breaching confidentiality by disclosing information, and merely 'talking to' a third party about the client - not disclosing specific details (which does not, apparently, constitute a breach of confidentiality in their minds). For example:

> I wouldn't be telling them anything - I'd just want to get a feel for what they know is happening (nurse 12)

For this vignette fewer respondents clearly acknowledged that they faced an ethical dilemma which had implications for them as practitioners since they were making disclosure decisions contrary to the expressed wishes of the named client. However, there were eight such acknowledgements. For example:

> We have a specific Code of Conduct which covers an issue [which can be] put against him, but [it] also says we should try to help client confidentiality at all times, so personally, I find this one quite difficult... The Code of Conduct is in conflict with me... Yes. I mean my personal feelings about the confidentiality issue as regards people

> not hurting themselves or in a general sort of risk, rather than contacting the police. I don't feel comfortable with that. I think it will primarily concern the welfare of our client and sometimes it's necessary to talk with someone and it's not immediately in step with the welfare or the upkeep of the laws of society. It's sort of a big decision really and I know I feel, Who am I to make it? But...[pause] so probably not the police... [pause] maybe his parents (Nurse 7).

VIGNETTE FOUR

TABLE 21

Distribution of Rationalizing Statements, Statements Acknowledging Conflict, and Inferred Acceptance of Conflict in Vignette Four by Professional Group

	Rationalizing Statements		Acknowledged Conflict		No Statement (acceptance inferred)		Total	
N	7	33%	5	24%	9	43%	21	100%
SW	7	37%	6	32%	6	32%	19	100%
C	1	17%	3	50%	2	33%	6	100%
T	15	33%	14	30%	17	37%	46	100%

N = Nurse SW = Social Worker
C = Chaplain T = Total

Levels of Rationalization and Acknowledgement: The type of rationalizations provided by respondents when discussing this vignette were very similar to those already referred to. Some respondents explained, when they made their disclosure decisions, that they were doing so on the basis that they would refer Mary to a number of agencies and/or various people who could provide help. However, they avoided acknowledging the fact that such referrals normally involve disclosing personal information about the family circumstances. For example:

> I want her to get extra support rather than tell on her, that wouldn't help. So maybe help with explaining to the day care about the stress and how busy so they could give her extra time (nurse 11);

> I would look to see what ways we could release the pressure Mary feels she's under and that doesn't necessarily mean informing other people, Child Protection Services or anybody else. ...services I may be thinking of introducing for relieving stress and the pressure on Mary... possibly some care, somebody who could go in and spend some time with the children mainly on an evening, or spend some time with Mary on an evening, or befriend Mary or befriend the children (social worker 38).

Once again, there were some respondents who found it a convenient help to solve this dilemma by redefining the boundaries of confidentiality in such a way as to allow them to discuss the case within their network of professionals without, thereby, feeling they had breached client confidentiality. For example:

> He already knows Mary and the children, so I'm not telling anybody new who doesn't already know what is going on (nurse 11);
>
> I got my referral from him so he already knows this (social worker 34).

And there were participants who acknowledged frankly that in making their disclosure decision they were placing one duty above another. For example:

> I am not helping Mary by ignoring the children; I'm not helping the children by ignoring Mary. So obviously you've got to deal with them all...[pause] It's just ridiculous; I can't tolerate that. They would have to be separated from Mary and I would deal with Mary separately... In terms of confidentiality, if a child was involved, or any other person a victim of an aggressive act that is continuous, then confidentiality is nothing to do with it. My professionalism would be entirely my duty of care towards the person who is being hurt (nurse 3).

DIFFERENCES BETWEEN THE THREE PROFESSIONS

Some interesting trends became apparent when number in the four tables above were compared. This was particularly the case when the 'Acknowledged Conflict' and 'No Statement' columns were combined. Firstly: in all vignettes the social workers were slightly less likely than the nurses to acknowledge, or even implicitly accept, that they were making ethical choices when breaching confidentiality. In Vignette One, only 65 percent of social workers accepted that an ethical conflict existed as compared to 78 percent of the nurses. In Vignette Two, the comparable proportions were 71 percent and 85 percent. Vignettes Three and Four showed greater similarity between the participants from the two professions - 67 percent of social workers *versus* 69 percent of nurses, and 64 percent *versus* 67 percent respectively.

Secondly: the chaplains showed far less tendency than the members of the other two groups to rationalize away the disclosure decisions they had just made. Only one chaplain offered a rationalizing statement (in Vignette Four). However, this finding needs to be treated with caution because of the small number of chaplains participating in the research. A possible explanation is that chaplains are less likely to be fully incorporated into an inter-professional network of practitioners all working with the same clients and regularly liaising with one another as a day-to-day part of their jobs. The research findings reported in Chapter Seven ("Consistency") show that the chaplains were less likely to disclose (or to disclose at a later point) than the other respondents. Perhaps, when they actually do bring themselves to make a disclosure decision, because it is a less common occurrence, they are likely to have thought about it for some time and thoroughly considered the reasons for it. Therefore, they may feel less need to rationalize it away.

THE RELATIONSHIP BETWEEN DISCLOSURE DECISION AND RATIONALIZATION

My third analysis was to compare the frequency of disclosure for the different vignettes with the frequency of rationalization statements by the members of each professional group. This is presented below.

Social Workers:

	% disclosing	% rationalizing
Vignette 1	95	35
Vignette 2	100	29
Vignette 3	58	33
Vignette 4	90	37

Chaplains:

	% disclosing	% rationalizing
Vignette 1	43	0
Vignette 2	71	0
Vignette 3	29	50
Vignette 4	86	17

Nurses:

	% disclosing	% rationalizing
Vignette 1	100	22
Vignette 2	100	15
Vignette 3	63	41
Vignette 4	78	33

I was searching for some relationship as a possible explanation for the incidence of rationalization. Three hypotheses presented themselves and each was 'tested' with the available data.

Hypothesis One:

The vignettes can be rank ordered consistently and rationally as to disclosure and rationalizing, therefore the higher the level (proportion) of disclosure the higher would be the volume (percentage) of rationalizing. This proved not to be the case for any of the professional groups as the following rank orderings show (the highest is mentioned first; they are in descending order):

1. Social workers' rank ordering of disclosure:
   Vignettes 2-1-4-3
   Social workers' rank ordering of rationalizing:
   Vignettes 4-1-3-2

2. Chaplains' rank ordering of disclosure:
   Vignettes 4-2-1-3
   Chaplains' rank ordering of rationalizing:
   Vignettes 3-4-0-0

3. Nurses' rank ordering of disclosure:
   Vignettes 1&2-4-3
   Nurses' rank ordering of rationalizing:
   Vignettes 3-4-1-2

Only in the case of social workers' consideration of Vignette One were the rankings congruent. For Vignette One they gave the second highest percentage of disclosure decisions and the second highest number of rationalizations for those decisions. The hypothesis, therefore, was not proven.

Hypothesis Two:

The relationship is inverse. In other words, if a vignette had a very high level of disclosure decisions, that indicated that the respondents were confident in making these decisions and had no need to talk away their disclosure or ignore the issue (since manifestly the situation called for third party consultation). So the ranking of disclosures, by vignette, would be in descending order (highest percentage first) and the ranking of rationalizations would be in ascending order (lowest first). If the hypothesis were correct, they should match. They are as follows:

1. Social Workers' ranking of disclosure decisions:
   Vignettes 2-1-4-3
   Social Workers ranking of rationalizations:
   Vignettes 2-3-1-4

2. Chaplains' ranking of disclosure decisions:
   Vignettes 4-2-1-3
   Chaplains' ranking of rationalizations:
   Vignettes 4-2-0-0

3. Nurses ranking of disclosure decisions:
   Vignettes 1&2-4-3
   Nurses ranking of rationalizations:
   Vignettes 2-1-4-3

The hypothesis is not sustained, except in the case of the nurses where something of this pattern of relationships is apparent. Vignettes One and Two, which found all nurses making a decision to disclose also showed significantly fewer nurses rationalizing away these choices. Moreover, the bare figures shown in the table above suggest that there is no difference between the nurses' disclosure rates for the first two vignettes, but it must be borne in mind that the data reported earlier showed the nurses decided to disclose faster (i.e. at earlier stages of the vignette) for the second vignette than for the first, and fewer nurses rationalized away their decisions for Vignette Two than for Vignette One. Similarly, Vignette Three shows the lowest percentage of nurses' disclosure and the highest percentage of nurses' rationalization, while Vignette Four, which had a somewhat higher percentage disclosure than Vignette Three, had a correspondingly lower percentage of nurses rationalizing their choices.

Hypothesis Three:

The higher the level of risk in the case, the higher the incidence of disclosure decisions and the lower the incidence of rationalizing statements (because there would be little felt need to discount the decision). Therefore, if the vignettes were rank ordered in descending order by level of risk, there should be an evident match to that of the rationalizing statements ranked by ascending order of percentage use. Thus, the four vignettes, ranked by descending order of risk were: 2-1-4-3. The social workers' rationalizations (in ascending order) were 2-3-1-4; the chaplains' were 1&2-4-3 (virtually a complete match); and the nurses' were 2-1-4-3 (also a match). In other words the levels of rationalization reflect perceptions of the different levels of risk inherent in the circumstances of the cases: the higher the risk, the less the need to justify the decision to breach client confidentiality; the lower the risk, the less frequent the disclosure decisions, but the greater the need to argue away (i.e. make some sort of rationalizing statement of justification) the disclosure which had been decided upon.

CONCLUSION

Even when they had decided to disclose, respondents sometimes rationalized their choice to share confidential client information. They clearly understood the reasons behind their decisions, but occasionally, some avoided facing up to the exact nature of what they were doing - generally by using a rationalization. This happened in a substantial minority of cases. Two main stratagems were adopted for this.

1. Some respondents would not fully accept that, by their decision they were disclosing information against the clients' wishes. They felt strongly (indeed insisted) that they could convince the client, in the end, to agree to disclosure. Alternatively, they could present the matter to the client in such a way that suggested the client would control what would be disclosed and how, while de facto the very agreement to the decision would have removed control from the client.

2. Some respondents argued that, by their disclosure they would not really be breaching client confidentiality. This revealed itself in a number of ways. Interviewees might define the boundaries of confidentiality in such a way that disclosure to certain other professionals (even when the client was reluctant to agree with this) fell within the definition of accepted bounds of maintaining confidentiality. This stratagem, in effect, allowed the professional to ignore the fact that the decision which he had just made was directly contrary to the clients' expressed wishes as set out in the vignette. Alternatively, some respondents argued that they were gathering information when consulting a third party, not disclosing information. Therefore such action was not a breach of confidentiality. However, this sophistry ignores the fact that when a professional gathers information from a colleague (or some other knowledgeable source), the simple act of asking questions may, of itself, alert the third party to the possible presence of detail and issues he previously had not considered. It also ignores the fact that the client who refused any permission for the professional to speak with anyone about the circumstances of his problems might still consider their action to be a breach of confidentiality in its strictest sense.

At some point, in some vignettes, members from all three professional groups resorted to rationalizations. However, some differences were noted among the groups. Firstly, the chaplains rationalized their decisions and actions less than the social workers or nurses, and the nurses slightly less than the social workers. Secondly, the nurses rationalized their decisions to disclose rather more in the lower risk situations (Vignettes Three and Four) than the higher risk ones (Vignettes One and Two), and the rank ordering of the total disclosures also suggests that risk was an important intervening variable which affects the level of personal confidence which nurses have with the decisions they make to share information, which in turn affected the respondents' sense of the need (and hence the incidence) to rationalize this breach of their ethical

norm. The rule seems to have become: when risk is high, consultation and the sharing of confidential information is necessary and justified. But for some, even this had to be argued away. This was demonstrated more by the nurses than for the other two professional groups.

As discussed in Chapters Two, Three and Four, professional ethics and ethical decision-making are linked with issues of professional accountability, both at the level of the occupational organisation and at the level of the individual practitioner. Part of individual professional accountability comes from accepting responsibility for making difficult choices and acknowledging when they are being made, something which these data indicate is difficult in actual practice and often does not happen in a clear and unmistakeable form.

CHAPTER TEN

FRAMEWORK FOR DECISION-MAKING

This chapter examines the extent to which respondents were both aware of the laws, professional guidance and employer policy relating to confidentiality, and/or referred to them when making their decisions about disclosure. The first three sub-sections of the chapter report on the awareness respondents displayed about these three different frameworks within which their decisions about boundaries of confidentiality were being made. The extent to which respondents openly referred to 'the law', policy or professional practice standards is then discussed with examples of references drawn from the interview transcripts.

Respondents' discussion about the vignettes and their decisions revealed the exact points of disclosure and their reasons for these choices. However, professionals do not make these choices in isolation. They must abide by various laws of the land which govern the use of information - for example, the Data Protection Act, 1984. In addition, they work for organisations which generally have policies and procedures intended to provide guidance to the worker. The professional bodies also expect a certain standard of behaviour with regard to the use, recording and disclosure of information, usually specified briefly in their Code of Ethics (Code of Conduct) and expanded upon in various policy documents, guidelines for best practice and discussion papers. Agencies and professional organisations expect that, when a decision has been made or an action taken, the worker (member) will be able to demonstrate that he has applied the practice guidance, policy and the principle embodied in the professional code to the specific set of circumstances with due professional judgement, when making a decision which involves an ethical dilemma - about confidentiality or some other matter[55]. Thus, for this

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[55] Nowhere is this more evident than in Edwards' professional text for nurses which exhorts and teaches what he terms a "principle based approach":

> *... in the framework, each level provides justification for the level below it. Hence, judgements are justified by rules, rules are justified by principles, and principles by level-four theories (Edwards, 1996, p. 39).*

thesis, using the evidence gathered from a sample of respondents who are members of three of the 'caring' professions, it was important to try to determine two matters:

1. to what degree were the respondents aware of the laws, codes of ethics and/or policies which provide a general framework for the choices they made about the conduct of the cases in the vignettes; and

2. did respondents demonstrate awareness of this legal framework, codes of ethics (codes of conduct), and professional and employer policies when making their decisions?

These were assessed in two ways. Firstly, towards the end of each interview, after each respondent had finished discussing the four vignettes and making decisions about disclosure/ non disclosure of confidential client information, some general questions were asked about whether the respondent's awareness of, and knowledge of, the legal framework, policies, and professional and institutional/agency guidance about confidentiality. He was also asked how he felt these affected the decisions he had made during the interview.

Secondly, when transcribing the interview tapes and studying the transcripts, it was specially noted whenever a respondent cited 'the law', some policy, or their professional code when making a decision for a vignette case, or during the discussion about consultation,

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However, Edwards, who discusses various ethical problems from a theoretical level does not give any specific guidance about exactly what is the correct way to arrive at a decision, how much weight to place on employer policies and how much on the guidance of the professional association, nor which philosophical framework assists the practitioner more. He merely points out that:

> *we should not retain an exclusive commitment either to Utilitarianism or to a Kantian duty-based morality, but rather adopt the general stance in our moral decision-making that it is necessary to consider both consequences and duties (Edwards, 1996, p. 48).*

confidentiality and disclosure which ensued.

GENERAL AWARENESS OF THE LAW

'Confidentiality' is not a legal concept; it is a professional one. There is no 'law of confidentiality'. However, there are laws which apply to information use, which affect how agencies and professionals define what information is confidential, how information is recorded and how it is used. Since this is not a legal dissertation and neither I nor any of the respondents are legal professionals I did not expect them to be able to quote in detail which laws applied (statutory or common-law) and exactly why or how they affected confidentiality. However, it was important to determine whether these professionals had some general understanding of the areas of law which apply, and of their complexity. So each interviewee was specifically asked:

> *Are there laws (legal duties) which affect your decisions in situations involving dilemmas about limits of confidentiality? How do they affect your decision?*

The table below shows how many of the respondents were able to identify some of the laws which might affect their decisions about confidentiality. Column One simply indicates how many from each profession indicated that law(s) existed which affected confidentiality. Column Two shows the number of respondents who either said they did not know of any law affecting this area (or who answered that they were sure there was but they had no idea what it was). For this analysis, social workers have been divided into two groups: those without the professional social worker qualification (U. S.W.) and those with (Q. S.W.), and the percentages have been calculated based on the total number of each type of social worker (i.e. 10 unqualified, and 11 professionally qualified), rather than on the full sample of both types of social worker combined. Twenty-six members of the sample of 55 were aware of laws which would affect considerations of confidentiality of information.

It was expected that, as members of the most highly professionalised and

regulated group, the only registered profession represented among the participants in this research, the nurses would be the most aware of the legal framework for their decision-making, that the social workers would have a lesser awareness, and the chaplains have the least awareness. Within the social work group, it was expected that those who were professionally qualified and (generally) had had the benefit of a longer education and training (often taken within a university setting) would show higher awareness than their unqualified counterparts.

TABLE 22

Awareness of Legal Framework by Profession

	Aware of Law		Not Aware		Total	
Nurses	10	37%	17	63%	27	100%
U. S.W.	4	40%	6	60%	10	100%
Q. S.W.	11	100%			11	100%
Chaplain	1	14%	6	86%	7	100%
Total	26	47%	29	53%	55	100%

The finding that the qualified social workers displayed the greatest awareness of the legal framework for practice of all the professionals who participated in this research was something of a surprise. All of them demonstrated that they were aware of laws affecting their professional judgement about the boundaries of confidentiality. A smaller percentage, but substantial minority, of the unqualified social workers also demonstrated awareness of the law - in fact a marginally higher percentage than that of the fully professionally qualified nurses (forty percent *v* thirty-seven) and much above the chaplains.

Oddly enough, the higher degree of 'professionalization' of the nurses (in the sense of having been thoroughly socialized into the 'professional mind-set' and inter-professional cooperative network) may actually explain this unexpected finding. When answering this question, fourteen (fifty-two percent) of the nurses, cited the United Kingdom Central Council of

Nurses, Midwives and Health Visitors as the 'law' which governs their practice, showing no knowledge of any actual area of law which governs their actions. However, one might argue that in citing their governing council, in effect they were invoking an agency that was a proxy for 'the law' in some generalized sense. If that argument is accepted, and the nurses who demonstrated an awareness of the legal framework are combined with those who cited the U.K.C.C. then the total amounts to eighty-nine percent, greater than the percentage of the qualified and unqualified social workers (combined), seventy-one percent of whom demonstrated awareness of the law. This accords with the expected progression: nurses most aware, social workers somewhat less, and chaplains decidedly least, and the hypothesis of this thesis about the continuum of the three occupations' relative development and integration into a professional network with acknowledged public responsibilities beyond the narrow 'best interests' of an individual named client.

The next table indicates how many areas of law were identified by those respondents who acknowledged that laws did exist which affect their practice decisions about the boundaries of confidentiality, and would have an effect upon the disclosure decisions they were making in the interviews. Twelve of these interviewees proved to be surprisingly knowledgeable about different areas of law which might have an impact on disclosure decisions, citing three or more examples. Once again the social workers were split into two groups for the analysis.

TABLE 23

Numbers of Areas of Law Identified By Each Profession

	1	2	3 or More	Total
Nurses	2 20%	3 30%	5 50%	10 100%
U. S.W.	4 100%			4 100%
Q. S.W.		4 36%	7 64%	11 100%
Chaplain	1 100%			1 100%
Total	7 27%	7 27%	12 46%	26 100%

The areas of law identified by the respondents include patient records (right of access), negligence and liability and the 'duty of care', the Mental Health Act 1983, supervision orders, the Official Secrets Act, the legal requirement to report if a child is at risk of abuse, common law about preventing harm, the legal requirement to report illicit drugs use (controlled substances), the legal requirement to report life threatening situations, contract law about employment, the law on privacy and the Data Protection Act, the law about access to public information, case law about informed consent, and statute law about criminal records. Of course, many of these items were identified only by one person - for example, only one nurse referred to the Official Secrets Act - while other items were mentioned several times - for example. nine nurses, three unqualified and six qualified social workers, and one chaplain all mentioned that they were required by law to report any child at risk of abuse.

GENERAL AWARENESS OF PROFESSIONAL GUIDANCE

The professional associations for nurses, social workers, and chaplains all have certain expectations about boundaries of confidentiality. These expectations are codified in Codes of Ethics (Codes of Conduct). The nursing and social work associations also have issued other documents giving guidance on confidentiality. Therefore, it was important for this thesis to try to determine the level of awareness of such professional guidance among the three groups of respondents. Participants were asked:

> *Do you belong to a professional association (which)? Does your professional association offer any guidance about how to deal with dilemmas involving confidentiality (e.g. policies, training, consultation)?*

Not all respondents were members of a professional association; Table 24 shows the thirty-six who were, divided as to professional group. Once again, the social workers were divided into two groups for the analysis.

Nurses held the highest membership, but since this is a registered profession which requires all practising nurses to be registered and members of the U.K.C.C. this was expected. Social workers and chaplains

are not registered professions.[56] There is no legal or professional requirement that they join a professional association. But, as expected, more than half the professionally qualified social workers had joined a professional association, substantially different from the case of the unqualified social workers (despite the fact that one of the main social work associations, The Social Care Association, does not bar membership to non-qualified people). Also, a smaller proportion of chaplains were members of a professional association than were qualified social workers. This was expected because the occupation has only recently formed a professional association and is only now becoming 'professionalised' in this way.

TABLE 24

Professional Association Membership by Occupation

	Member		Non-member		Total	
Nurses	27	100%			27	100%
U. S.W.			10	100%	10	100%
Q. S.W.	6	55%	5	45%	11	100%
Chaplains	3	43%	4	57%	7	100%
Total	36	65%	19	35%	55	100%

Table 25 shows how many times different types of professional guidance about confidentiality were cited. It is important to understand that not all respondents were able to identify professional guidance, but some respondents identified more than one type of professional guidance. Therefore the sum of all the different times types of guidance mentioned is greater than the number of respondents. For this reason, totals are not shown in the table. In addition, one need not be a member of a professional association to be aware of its guidance about

[56] For many years the question of whether social work should become a registered profession has been the subject of much debate. Currently there are plans to develop a General Social Services Council which will serve the function of professional registration and regulation for qualified social workers employed in certain areas (as well as unqualified workers). However, at this time, social work is not a registered profession.

confidentiality, just as membership in a professional association does not necessarily mean that a person knows much about the guidance which is available from that particular organisation. The percentages, therefore, were based on the number of respondents belonging to that occupation who participated in the interviews, rather than the number belonging to a professional association. For the analysis, again, the social workers were spilt into two groups.

TABLE 25

Awareness of Professional Guidance by Occupation

	Code	Disc	Pol	Pap	Adv	Trai	Awar	No
Nur	19 70%	6 22%	12 44%	14 52%	6 22%	3 11%	6 22%	
U SW								10 100
Q SW	2 18%		3 27%	3 27%		1 9%		7 64%
Chap	1 14%						1 14%	6 86%

Code = Code of ethics and/or code of conduct
Disc = Discipline if respondent breaches expected behaviour
Pol = Written policy or procedures or instructions
Pap = Discussion papers or written advice about good practice
Adv = Advice or help with specific problems
Trai = Training about confidentiality
Awar = Heightened awareness amongst professionals
No = No code of ethics/conduct nor any other form of guidance

The nurses demonstrated a much clearer awareness of the professional guidance available to them than the members of either of the other two groups. Nonetheless, it is interesting to note that, despite the fact all were registered by the U.K.C.C., only nineteen (seventy percent) were aware that principles guiding confidentiality are included in the nursing code of ethics.

The unqualified social workers (none of whom belonged to a professional association) were uniformly unaware of any code of ethics or other form of professional guidance about confidentiality. Of the seven qualified social workers who believed there was no guidance available from their professional associations, two are members of a professional association

(British Association of Social Workers) which does have a code of ethics, has produced written discussion papers about confidentiality, has sponsored training seminars for its members, and also offers an advice and representation service. The responses from the chaplains demonstrated a generally poor awareness of professional guidance available to them from their professional association, code of ethics and discussion papers.

GENERAL AWARENESS OF EMPLOYERS' POLICIES AND GUIDANCE

None of these respondents was self-employed. All worked for large organizations which would have certain expectations about how their employees should conduct themselves in the course of their work. It is normal for employers to have written policies and standard procedures or instructions about confidentiality. These guide record-keeping, access to information and professional disclosure. It was important to determine how professionals perceive such policies to affect their judgements about the boundaries to confidentiality. Respondents were asked:

> *Does your employer offer any guidance about how to deal with dilemmas and decisions about confidentiality (e.g. policies, procedures, training, consultation)?*

The following table shows how many respondents were able to identify policies or procedures, orientation, guidelines, training, etc. existing within their organisation which can have an influence upon their professional decision as to the boundary of client confidentiality. The percentages show the proportion of respondents within a given profession who were aware of a specific type of policy or guidance available through their employers. It is important to note, however, that some respondents identified more than one type of employer guidance. Thus the sum of all the different times all types of policy, guidance documents, and employer advice were discussed is greater than the number of respondents. For this reason totals are not shown in the table, and the percentages are based on the number of respondents referring to an item, not the number of times it was mentioned. Again, the social workers were divided into two groups for the analysis.

TABLE 26

Awareness of Employer's Guidance by Occupation

	Pol 1	Pol 2	Manag	Super	Legal	Train	No	None
Nur	8 30%	1 4%	6 22%	8 30%	3 11%	5 19%	7 26%	4 15%
U SW	3 30%	1 10%	3 30%	5 50%		4 40%		1 10%
Q SW	5 45%		3 27%			2 18%	2 18%	2 18%
Chap	1 14%			1 14%			3 43%	2 28%

Pol 1 = Written guidelines or procedures about confidentiality
Pol 2 = Written policy about record-keeping
Manag = Manager's advice about standards of confidentiality
Super = Supervision or guidance about individual cases
Legal = Legal advice about individual cases
Train = Staff training about confidentiality
No = Policies exist but no idea what they say
None = Employer has no policy/guidance about confidentiality

It is difficult to draw conclusions from these data, beyond noting that (1) no type of employer guidance about confidentiality seems to have had an overwhelming impact on the decision-making of the majority of the members of any of the three groups in the sample - at least in so far as respondents were aware of; (2) only half of the unqualified social workers indicated that employer supervision or guidance about individual cases was likely to affect their judgement about the boundaries of confidentiality; and (3) as a group, the nurses showed themselves to be highly aware of a plethora of types of guidance and support arising from their employers, but even so, four nurses could not recall any when interviewed.

USE OF LEGAL JUSTIFICATIONS, PROFESSIONAL AND EMPLOYER GUIDANCE IN DECISIONS ABOUT VIGNETTES

Quite simply, no respondent directly cited 'the law' when giving his rationale for making any decision about any vignette, even if knowledge of such a mandate might have helped him to decide the course of action. For example, as explained in Chapter Seven, there were respondents who chose to breach confidentiality in Vignette Four because of child protection concerns. Awareness of their statutory obligation to report possible child abuse may have played a part in their internal reasoning, but this was never explicitly stated when they discussed why they had made

the choice to disclose, nor could it be implied from their words. In general, instead, they talked about risk or about wanting to help, about doing what is best for the mother and the children. Not one respondent ever made such blunt statements as: 'I have to do this because the law instructs me to'.

Similarly, respondents did not usually cite an employer's policy as the reason either for breaching, or for maintaining, client confidentiality. Not one respondent ever made a blunt statement such as, 'This is the procedure my agency expects me to follow in a case like this'. Only two mentioned employer policies peripherally when discussing their decisions. Examples:

> I guess I'd be looking for guidance on this one. I don't really know enough about it. I don't know if the policy would help because sixteen's a difficult age (Vignette Three - unqualified social worker 53);
>
> I think it's a policy that only doctors can say the diagnosis (Vignette One - unqualified social worker 58).

Professional codes of ethics (or codes of conduct) were also rarely cited or given as one of the reasons for a decision. Only four participants mentioned them; all were nurses. For example:

> I suppose I have the professional code of practice and so I suppose... if I felt the depression was so severe that she might actually be in a situation where she might harm herself or other, I think I would be discussing it with them, but I would be explaining to her the reasons why (Vignette One - nurse 15);
>
> There is a general sense of maintaining confidentiality unless it's in the person's best interests, so I think its breaking the code if you say anything because it's not in his best interests (Vignette Two - nurse 12);
>
> It's where does the rule of confidentiality end and the rule to protect the public start. No code of conduct can tell you that, you learn it by experience, so you know when you have to inform the psychiatrist and get him into hospital (Vignette Two - nurse 18);
>
> We have a specific code of conduct which covers an issue put against him but also it says we should try to help client confidentiality at all times, so personally, I find this one quite difficult (Vignette Three - nurse 7).

CONCLUSION

Originally it was expected that, as the most highly professionalised group - in the sense of being the most formally organised, most regulated, and most closely integrated into a professional network (which carries with it expectations of co-working, interprofessional cooperation and public accountability to the general public or the 'system', rather than simply to an individual client) - all the nurses would show keen awareness of the legal, professional, and policy framework for their decisions and would frequently refer to 'the code'. This expectation was not confirmed. In fact, the social workers showed considerably greater legal awareness than did nurses. The latter, however, did show the highest level of awareness of professional restrictions (or guidance) about confidentiality. It may be that, for most nurses, the legal framework within which they operate is filtered through their professional association and registration body, so that they are conscious of this as 'professional' regulation, rather than 'the law'.

It was difficult to assess the impact that employers' policies, guidelines, orientation, training and procedures might have had on these respondents' professional decisions. Such guidance may be so all-pervasive that it is taken for granted. It can be exerted in a number of subtle ways, under a variety of guises. Examples were mentioned in discussions about such possible influences, but only by a few members of each group, and only in a hypothetical context. No experiences were described. It would seem that no one method of accessing and incorporating employer's policies and guidance is used much. None, certainly, was recognized by any sizeable number of the respondents as having a serious impact upon, or constraining, their decisions about maintaining or not maintaining client confidentiality.

All in all, when one considers - from the point of view of an independent researcher's objective appraisal - the respondents' decisions about disclosure/non-disclosure in the four vignettes, none of the expected restraining and constraining influences of law, professional association

or employer seem to have had much direct effect, judged by the evidence provided by the informants themselves. This was as true of the laws which affect the use of information, as of the professional codes of ethics or conduct (which set out to define and dictate correct behaviour in practice situations), and of employers' policies and practices (which define and mandate institutional requirements, preferences and procedures). All seem to have played a negligible part in the participants' disclosure/non disclosure choices. One is forced to conclude, therefore, that on the whole, this sample of respondents found all these 'authorities' singularly unhelpful in guiding their actions when faced with taking specific decisions about complicated cases in difficult circumstances. This has implications for those who would claim authority for occupational control and professional accountability.

CHAPTER ELEVEN

CONCLUSION

This final chapter of the thesis has three sections. The first is a summary; the second looks at the implications of my research findings and the third contains a brief statement of my conclusions and suggestions for further research.

SUMMARY BY CHAPTER OF THESIS AND MAIN RESEARCH FINDINGS

This thesis investigated the relationship between the nature of professionalization and the development of degrees of professionalism. It examined the role of a profession's formal code of ethics and the way these principles are applied in practice. At issue was the influence which a set of theoretical principles has on decisions taken in daily work, when professionals encounter ethical dilemmas involving boundaries of confidentiality. This was investigated by reference to common practice situations in three of the 'caring' professions: nursing, social work, and the chaplaincy. The research focused on five specific issues:

1. To what extent do professionals use their ethical code to assist them to make decisions which involve ethical dilemmas? What alternative ethical framework do they use?

2. How frequently do professionals disclose information against clients' expressed wishes and how do they justify these decisions?

3. Are professional judgements consistent to such a degree that a common accepted practice standard (to which practitioners should generally adhere) can be determined?

4. What differences in decision-making exist between the three professions, and is this related to the extent to which each profession is "professionalized" and integrated into a closely knit inter-professional network?

5. What implications do the research results hold for professional accountability, the development of each occupation and policy-makers?

Following the Introduction, Chapter Two began discussion of the sociology of the professions. This literature provides a general theoretical framework within which my research is located. The existence of both 'macro' and 'micro' analysis about professional development was identified. The former tends to discuss issues of professional power, the relationships professions have with other organisations (e.g. unions, employers, bureaucracies, etc.), and the extent to which professions are part of the social establishment and act as an extension of the state, or are controlled by it. This discussion is generally located within the mainstream sociology of the professions. This discussion led to the debate about professional accountability. Questions have been raised about how professions and professionals can be held responsible for their actions and to whom they are accountable, and some of the literature relating to this issue was discussed. 'Micro' analysis about professions has tended to concern itself with the process by which workers are 'professionalized' (through their training, work environment and professional bodies), the influence a professional 'culture' exerts on day-to-day practice, and difficulties with inter-professional relationships. In particular, one of these issues - that of inter-professional relationships - was discussed fairly fully.

The research for this thesis is located within the tradition of 'micro' analysis of professional development, and touches on various aspects of this. Firstly, it explores the influence which inter-professional relationships, and integration into a cooperating professional network, can have on professional decision-making in 'grey' areas of practice. Secondly, it explores the influence which a profession's code of ethics (which forms part of the professional 'culture') can have on decision-making. Thirdly, it examines the framework for decision-making, and the extent to which the law, employer policies, or professional ethics and

guidance influences individual practitioners in making difficult ethical choices. Fourthly, it discusses issues of accountability for decision-making, both through the extent to which practitioners openly acknowledge responsibility for their decisions, and by examining the level of consistency and unanimity in the boundaries of confidentiality shown by respondents' decisions.

Chapter Three continued the theoretical discussion about professional ethics and professional identity. It began with a general discussion about the difference between ethics as belief and ethics in practice, drawn from the related theories of moral philosophy and Christian theology. The existence of two main competing ethical philosophies, deontology and utilitarianism, and their different contributions to professional ethics, was discussed briefly. This led to discussion about the development of group norms and professional standards, and their relationship with codes of ethics. Some comparison between such codes was then made, showing that, regardless of the different fields of practice, professions generally hold many ethical principles in common.

Chapter Four began the more specific discussion of the three professional groups chosen for this research. First, some of the similarities and differences between the codes of ethics of nurses, social workers and chaplains were discussed. Then some of their ethical dilemmas, as described in the various professional literatures, were described and certain common themes were revealed between the three professions (particularly nursing and social work). Finally, the specific ethical dilemma which this research focuses on - that of the appropriate boundaries of confidentiality - was discussed. There was brief introduction of the complex legal framework within decisions are made about the use of personal information and the professional debate about boundaries of confidentiality in mental health situations.

Chapter Five described the assumptions underlying this research, the specific research questions, and the methodology adopted for field

research. The research involved the collection and analysis of rich qualitative data by means of long face to face, one to one interviews. Four vignettes were developed as the basis for interview discussions. Each describes a relatively low-risk community mental health situation which involved ethical dilemmas about the disclosure of confidential information. In-depth semi-structured interviews, focusing on the vignettes, were conducted with a group of 27 practising community psychiatric nurses, 21 social workers employed in the mental health field, and 7 hospital chaplains. The vignettes all posed the ethical dilemma of possibly breaching the strict boundaries of confidentiality that the named client had specifically requested be maintained. The participants were asked at various points, to make a professional judgement and decision to disclose or not to disclose. They were also asked questions about their professional backgrounds, professional membership and legal/professional/employer guidance about confidentiality. Their responses were analyzed and reported in Chapters Seven through Ten, in relation to various themes which emerged in the interview information.

Chapter Six reported the personal (e.g. age, sex) and professional (e.g. education, length of previous employment) background of the respondents. All were of White/British extraction. The sample interviewed might loosely be termed 'young middle-aged': the nurses slightly younger than the members of the other two professions, chaplains slightly older. Males were over-represented in the sample group. This was particularly evident in the sample of social workers. This suggests that, if there is a significant difference between men's and women's opinions and professional decision-making when faced with dilemmas about confidentiality (a question which this research was <u>not</u> designed to test), then the research results may place more importance on the male point of view than a more representative sample might have shown.

Data about the academic and professional qualifications of the respondents revealed that they were generally a fairly well-educated group, not a surprising finding for a sample of professional workers. 53 percent held

(or were just completing) academic undergraduate degrees; 9 percent held (or were just completing) Master's level degrees. 18 percent were not professionally qualified (but had a combination of in-service training or related vocational training for their work). 25 percent held only the basic entry-level professional qualifications for their occupational group, and 56 percent held additional 'advanced' professional qualifications. (Since some respondents held more than one type of qualification these proportions do not sum to 100 percent). For the most part, the respondents were at the 'mid-career' stage in terms of professional experience.

Chapter Seven reported the frequency of decisions to disclose information, for each vignette, by professional group. Decisions to breach confidentiality and disclose information were made in a clear majority of cases. The highest rate of disclosure was made in Vignette Two (96 percent), with the disclosure rate in Vignette One following closely behind (91 percent). The disclosure rate was lower for Vignette Four (84 percent) and dropped quite significantly for Vignette Three (to only 56 percent). This finding mirrored the results which had been expected. Disclosure was highest in the more risky situations, and lower in the less risky situations.

Differences in disclosure were found between the professional groups. In general, nurses tended to disclose more readily (sooner) and more frequently than did social workers, who in turn disclosed more readily and more often than did chaplains. This result was also expected and conformed to the research assumption that a continuum of professional development exists among these three professional groups which relates to, and is reflected in, their decisions in ambiguous and complicated professional practice situations. However, this pattern is not perfect or absolute; it did not hold true for Vignette Four, where chaplains disclosed more readily than did nurses. One suggested reason for this is the relative familiarity and wider experience in day-to-day pastoral work that chaplains have with the kind of situation depicted (the stressed mother

who is having trouble controlling her children).

The findings on the question of whom to tell were also reported in Chapter Seven. It had been hoped that a 'general rule' (or 'rules' - one for each professional group, or for each vignette) would be established about who was the appropriate recipient(s) of disclosure. However, this did not prove possible. One of the most striking characteristics of the respondents' decisions was their lack of consistency about acceptable recipients of confidential information. Overall, the client's G.P. was chosen more often than anyone else. However, the frequency of this choice this did not amount to any 'rule' about this professional being the 'correct' recipient in most cases, particularly since this varied depending on the vignette (e.g. in Vignette Three, the G.P. was not even suggested as a possible recipient for disclosure; instead, the parents were chosen for 31 percent of the disclosures). However, the expected pattern of preferred disclosure within a professional network was found. Disclosure was made more often to other professionals, than to para-professionals (e.g. residential workers, etc.), and more often to para-professionals than to non-professionals (e.g. friends). As expected, the findings generally indicate that disclosure was made more readily to people who shared a 'duty of care' to the named client than to people who had no such duty.

Chapter Seven also reported on the extent to which respondents' reversed their decisions. Five participants changed their minds about decisions as a vignette progressed, and, realising they had made assumptions at an earlier stage, which subsequent information suggested were incorrect, effectively 'went back' and changed their earlier disclosure decisions. Four respondents changed their minds about who was the appropriate recipient for confidential information. Generally, however, respondents displayed a reasonably good ability to predict decisions they might make at a later stage of a vignette: 24 'predictions' were made, 17 of which accurately forecast the eventual decisions (i.e. a 71 percent accuracy).

This chapter also considered about the consistency/inconsistency of vignette interpretation. No matter how detailed the 'stories', these vignettes could not contain as much information as a practitioner would normally know about a client after he had been seeing him for several months, a year, or even longer. Thus respondents were forced to interpret the limited information they were given. Not surprisingly, sometimes they did this in very different ways. What appeared to be a serious situation to one respondent was often judged to be far less serious by another and such variations in interpretation led in turn to differences in disclosure decisions.

Chapter Eight discussed the reasons respondents gave about why their decisions were made, reporting them in terms of conflicting loyalties: to clients, fellow professionals, other potential clients and third parties, and to oneself. There were differences among vignettes in the frequency of type of justifications being used, and, not surprisingly, this was related to the type of case being discussed. For example, the risk of harm to the named client was more evident in Vignette One than in Vignette Four, and so, this type of justification was used more often in discussion about the former than the latter. Alternatively, risk of harm to third parties was higher in Vignette Two than Vignette Three, and so this justification was cited more frequently in discussions about the former.

The data recording the participants reasoning reveal the complexity of decision-making which occurred as the vignette cases were discussed. The 'fact' which emerged unmistakably is that the issue of professional 'loyalty' is not a simple one. Sometimes confidentiality was maintained less out of loyalty to the client and respect for his right to make choices about his life, and more because the professional's own judgement concurred with the client's own choice, or because the professional could not foresee any benefit to breaching confidentiality. Sometimes loyalty to the named client's 'best interests' (as defined by the professional, rather than the client) demanded disclosure. Often conflicting loyalties to other people resulted in the decision to disclose. On many occasions

these conflicting loyalties involved professional co-working relationships clearly indicating the 'professionalization' of many respondents into the close-knit inter-professional network indicated in the research hypothesis. Overall, the data strongly suggest the primacy of professional judgement over client judgement, when difference or conflict arises between the two.

Chapter Nine explored the theme of 'rationalization', examining the extent to which respondents openly acknowledged the ethical dilemmas they were facing and the difficult choices they were making, or whether, instead, they 'blurred' their choices, rationalizing away their actions. In general, only about a third of the respondents who disclosed at any point made statements openly acknowledging the ethical dilemmas which they felt were present and the heavy responsibility for making a difficult decision (32 percent). Even rationalizing statements were made only by a minority of the respondents who disclosed (21 percent). Across all four vignettes, respondents disclosed making no statement of either type (47 percent). Two differences between the professions emerged. Firstly, chaplains showed far less tendency to rationalize away their decisions, than did their nursing or social work counterparts. Secondly, the level of rationalizing statement was found to have an inverse relationship to the level of risk of harm included in each vignette. In other words: the higher the level of risk of harm, the lower the incidence of rationalizing statements to justify the decision to disclose. This relationship was found for both chaplains and nurses, but not for social workers.

Two main ways of rationalizing disclosure choices were observed: 'redefining the decision' and 'avoiding the issue'. Redefinition could sometimes be expressed as a 'positive'. This involved respondents redefining the boundaries of confidentiality in ways which allowed them include the other people they had decided to talk to. This effectively eliminated part or all of the dilemma. Such responses reflect what is current accepted 'good practice' when working with clients who concurrently are seeing other professionals: explaining to clients at the

point of first meeting that confidentiality will be limited and that the practitioner has a responsibility to report certain kinds of information to other people either on a regular basis, or should the situation arise. However, some respondents also, in effect, 'redefined the decision' by maintaining that they were not really breaching confidentiality because they were not *disclosing*; instead they were *gathering* information or they were helping the other person to *better understand* information they already knew. While these respondents clearly felt their choices were justified in the circumstances, and also clearly believed they did not constitute a breach of confidentiality, in the strictest sense they were indeed deliberately contravening the wishes of the named client about consultation and information use. The second kind of rationalization, 'avoiding the issue', occurred when some respondents simply refused to accept that the client had refused permission to disclose information. They stated their belief, despite being told otherwise that ultimately they would somehow 'convince' the client to allow them to discuss their situation with someone else.

Chapter Ten examined the relevance which the framework of legal rights and responsibilities, employers' guidance and policy about confidentiality, and professional guidance (of which the code of ethics is one part) had for the disclosure decisions respondents were making. First participants were asked questions to determine the level of their awareness of this framework, since clearly it could have little effect on their choices if they did not even know of its existence. Then, the interview material was analyzed to isolate instances where respondents actually cited legal responsibilities, employer policy, or professional guidance as reasons which lay behind or were the basis for their decisions. It was expected that the more highly 'professionalized'[57] group of respondents would show greater awareness of the legal, professional and policy framework within

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[57] In this case 'professionalized' is being used in the sense of having been thoroughly socialized into the professional role bringing with it greater awareness of the public duties imposed on them by virtue of the responsibilities associated with that profession and greater integration into a network of cooperating professional also operating within that milieu.

which their decisions were being made.

It was expected that nurses (who belong to a registered profession, and whose professional education and practice experience in a multi-disciplinary hospital setting would engender greater awareness of the need to cooperate and communicate freely with other professionals, inducting them into a close knit professional network) would show such awareness to a greater extent than would social workers (who do not belong to a registered profession and whose professional education and practice experience does not always include as high a level of inter-professional communication and cooperation). But it was also expected that social workers would show such awareness more readily than chaplains (whose seminary education does not stress the need to cooperate with other professions, and does not deliberately set out to not imbue them with the sense of being part of a professional network of helping agencies). However, these expectations were not confirmed. The social workers showed greater awareness of the legal framework than did nurses, who were more keenly aware of professional guidance. No great awareness of employer guidance (e.g. policy, supervision, etc.) was evidenced by the majority of respondents when discussing their disclosure decisions.

As the discussion of each vignette was analyzed, it was noted that no respondent cited a legal responsibility as the rationale for making any decision. Knowledge of their legal duties may have played a part in their internal reasoning, but no-one explicitly stated this when explaining or justifying a decision. Overall, relatively few respondents cited an employer policy (2) or professional code of ethics (4) when making a decision. This suggests that such policies and codes in themselves are of limited practical use to the individual practitioners when faced with an ethical dilemma about boundaries of confidentiality and forced to make a decision.

IMPLICATIONS OF THE RESEARCH FINDINGS

These research findings (in particular those reported in Chapter Ten have

serious implications for the education and training of persons who wish to enter the three professions addressed in this research and for the professional organisations to which they will belong. Confidentiality is a concept which underlies most areas of professional work. It is not specific to mental health situations, although these were the ones under scrutiny. It applies to work with the elderly, to work with children, with the disabled, and with prisoners, to name but a few. These respondents were not very clear about their legal responsibilities relating to confidentiality. Nor were they necessarily aware of the various types of available professional guidance they might invoke in solving ethical dilemmas. This suggests there may be room for improvement in the dissemination of this kind of information to nurses, social workers and chaplains, both through professional education at the point of qualifying training courses, and, through post-qualifying education (e.g. professionally accredited workshops and training courses) or guidance (e.g. discussion papers, advisory groups, etc.) available through professional bodies.

In addition, the research findings suggest that there is room for improvement in disseminating information about employer policies and guidance on boundaries of confidentiality. Some respondents reported that there was no policy or employer guidance available on this subject; some admitted they had no idea what the policy said (40 percent of the nurses, 24 percent of the social workers - qualified and unqualified combined - and 71 percent of the chaplains - quite a substantial proportion of the research sample!). Yet all these participants worked for organisations which have explicit recorded policies relating to use of information and confidentiality. Either the policies are not seen as being helpful (i.e. respondents feel they are not directly relevant to ethical dilemmas about boundaries of confidentiality), or staff have not been informed about them (e.g. by having personal copies of policies, through training workshops for existing workers and an orientation or induction programme for newly appointed staff). There seems to be room for improvement on the employers' parts in formulating and disseminating policy about confidentiality to

their staff.

The research findings of this thesis also have implications in terms of accountability. This is a concept with a long history (Day and Klein, 1987), and more than one meaning. In one sense being 'accountable' can simply mean being 'responsible'. It can mean being required to explain one's actions or priorities, providing adequate reason and justification (which may or may not be agreed with by the party calling one to account). There can be legal requirements for accountability, in terms of fulfilment of contracts and other written agreements. Additionally, there are questions about to whom a person is accountable: the client, professional governing body, employer, general public, or the state as embodied in the legal system administered by the Courts (Stacey, 1995). In four ways, these research findings have potential implications for the 'accountability'[58] of individual professionals, professional associations, and the organisations which employ them:

1. First, is the question of who <u>should</u> set the appropriate practice standards about the boundaries of confidentiality and who should hold practitioners to account for their professional decisions. This relates to my discussion in Chapter Two about the development of occupational associations, their relationships with other organisations (in particular, employers and governments - local and central), and the issues of who exercises control and how this is accomplished (e.g. Boreham, 1983; Torstendahl and Burrage, 1990).

   Nurses have struggled to 'professionalize' their occupation from its origins in philanthropy, patronage and 'noblesse oblige' (Jolley, 1989). Nursing already has developed into a registered profession, with a legal monopoly over the field of work, control over professional training, self-governing status and a disciplinary framework which encompasses the profession as a whole (Abel-Smith,

[58] I am using this word in its broadest or general sense, rather than a narrow legal definition.

1960). It already holds that 'special relationship' with the state to which MacDonald (1995) refers. Professional workers have considerable power over their clients, power which is exercised through their decision-making. In this research, vignettes exemplified the decision-making about the boundaries of confidentiality. When exercising power, the professional nurse, in many ways, acts as an agent of the state (Davies, 1980; Dingwall et. al., 1988) which has delegated this right to them. The nurses who participated in my research were all more conscious of the professional framework for their decision-making, and more aware of the lines of accountability within their professional governing body, than they were of the state apparatus which could hold them to legal account. In other words, the 'control' of standards of confidentiality filtered through that profession by means of its professional body down to the practitioners.

However, the same cannot be said of either social workers or hospital chaplains, and there are also substantial differences between these two groups of workers. Social workers, as an occupational group, have also strived to 'professionalize'. Professional education programmes were established (Jones, 1979), professional associations have been formed and consolidated (e.g. B.A.S.W.). The specialist monopoly of particular areas of work is now claimed (Stevenson, 1981). Social work has been reorganised in different employment structures (Seebohm, 1968) and the focus of its work has been transformed (Griffiths, 1988[59]). Cockburn (1977) argues that contained within reorganization was a major shift in orientation about the main aim in local government services away from one of "adequate administration" to that of "effective management". If true, this has implications for the role of the professional, professional development and autonomy and for occupational control.

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[59] This report also has had a substantial effect on nursing practice.

Amidst all of this, despite some dissenting voices (e.g. Walker, 1996), the drive has gradually gathered strength for social work to become a registered profession, as one mechanism for safeguarding standards of practice (Barclay, 1982; Parker, 1990; National Institute for Social Work, 1995; B.A.S.W., 1996a and 1996b; Cervi, 1996). However, the 'special relationship' with the Conservative Government did not develop and proposals for a General Social Services Council received only a lukewarm response, although they were never entirely dismissed (General Social Services Council Action Group, 1993; Brand, 1996; Downey, 1996). With the change in Government has come a change in approach and the proposals for professional registration are now being revamped. With Labour committed to reorganising professional social work and social care training and discipline under a single professional council (which will encompass both the professionally qualified staff and those 'unqualified' workers whose responsibilities involve direct service delivery to clients), implementing an enforceable code of conduct which will bind all social care workers, and developing a 'register' of professionals will be a complex task (B.A.S.W., 1998). In other words, in the United Kingdom, Government and the social work professional establishment now appear to be taking that step which nursing took earlier in this century.

Chaplains are in a different situation entirely. Firstly, as discussed in Chapter Four, not all pastoral care workers feel that organisation as separate professional body is the correct route to take. Secondly, traditionally, chaplains have been viewed by other professionals who operate in the same field, and by the clientele, as holding a very separate spiritual role, one which is valued for its difference and because it is not fully integrated into the professional network. Thirdly, relatively few pastoral care workers are full-time hospital chaplains. A large Health Trust may well employ several chaplains, each from a different denomination (Catholic, Methodist, Jewish Rabbi, etc.) on a part-time basis, for

one or two days per week. The minister who has his own parish with one or more churches to run, a regular schedule of services to give, and a congregation to tend, with all the conflicts these myriad duties bring (Dempsey, 1969 and 1983; Conrad, 1988, Jeavons, 1994), probably views his work for the Health Trust as an extension of his pastoral role which flows from his religious vocation and sense of responsibility for pastoral care to his religious community, rather than as a separate 'professional role' (Wright, 1980; Hospital Chaplaincies Council, 1987).

Fourthly, the cleric sees his prime accountability as being to God (Davies, 1994) rather than some professional body. Theological differences between faiths[60] about the nature of God and his wishes override any 'professional accountability' which might be expected to apply to all employed by the Health Trust (or other agency). It would also override any expectation of accountability to professional colleagues, such as nurses, doctors and social workers. Moreover religious history is full of highly celebrated examples of individual dissent with authority on the grounds of faith[61], and there is every reason to believe that the discipline of a professional body would be similarly challenged[62]. Despite the fact that the ministry is traditionally considered one of the original "professions", it has been suggested that in reality its hierarchical organisational structure conforms more with "semi-professional" limited autonomy (Jarvis, 1975). Chaplaincy, as a sub-group of the ministry, appears even less 'professionalized' in its organisation than does the ministry as a whole. I would suggest

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[60] For example: the Catholic church frowns on birth control, abortion, and considers suicide a 'mortal sin', while Protestant faiths accept birth control, abortion (in certain circumstances), and, while generally disapproving of suicide, do not consider it a 'mortal sin'.

[61] Christian martyrs and saints. For example: St Catherine, St Joan, St Francis of Assisi, etc.

[62] In my own research, one chaplain described a situation when, in an act of individual conscience, he knowingly contravened the tenets of his profession.

therefore that the conditions which might potentially fuel a drive for increased occupational organisation of hospital chaplains along that path of developing into separate 'profession' (registered and self-governing, similar to nurses and social workers), do not currently exist. It therefore appears unlikely that at this time, chaplains will present a unified 'professional voice' with an established power-base recognised and accepted by other 'caring' occupations and state governing structures.

However they are organised and controlled - whether as individual nurses and social workers within self-regulating autonomous registered professional structures with special legal privileges accorded to them by the state, or as individual chaplains remaining within their different church structures but employed part-time by large health bureaucracies - the issue of these workers' accountability remains. For one occupational group the issue of whether the practitioner acted correctly and responsibly, may be determined by his professional governing body (or its disciplinary committee), for another it could be his employer who makes this decision (through the management and disciplinary structures of the job), or alternatively, if the matter results in legal action, a court of law could make this determination. What is an inescapable conclusion from the evidence of this research is that respondents in all these professions displayed relatively little awareness of the framework for accountability when discussing factors which might influence their decisions about confidentiality.

Whoever rules on accountability, professional decisions about the boundaries of confidentiality will need to be tested against some kind of standard of acceptable practice. This research has demonstrated that, at least for the sample of practitioners interviewed, the concept of a 'standard of practice' was blurred, the lines of accountability were diffuse, and the decisions about whose interests must take priority were complex, chaotic and

unpredictable. These issues are discussed further under points two and three.

2. The second set of implications from this research relate to what professionals can be held accountable for. In order to ensure good standards of practice and professional judgement, it is necessary to establish what the standards are and how they can be recognised. At least in theory, they ought to be consistent and predictable within the norms of their profession's common daily practice. However, the research findings reported in Chapter Seven suggest this kind of uniform professional standard of judgement and consistency of decision-making, which would make a professional's choices about boundaries of confidentiality in community mental health dilemmas predictable and reliable is not quite so simple as it would first appear.

Although the majority of respondents made the decision to breach strict confidentiality in all vignettes, there were considerable differences about what stage it was correct to do this. There was no clear cut 'standard' norm about when it was permissable (even desirable) to disclose information against the client's wishes, and when it was not. There was no clear agreement about who generally was the appropriate recipient of the disclosure and whether this changed according to the stage of the case at which point disclosure occurred.

If professionals' judgements can be relied upon to be consistent and uniform, then they ought also to be predictable - if not by the lay public, then at least among themselves. However, this proved not to be the case; 29 percent of the respondents' predictions about their later choices whether or not to disclose were *inaccurate*. Moreover, the differences in interpretation of the vignettes suggest another potential problem about professional standards. In theory, every member of a particular profession, should be able to demonstrate his

'competence' by 'correctly' interpreting the significance of certain case information in a similar way. However, as these research data demonstrate, this is not as simple as it first appears. The same case data can have more than one interpretation and lead to very different professional decisions.

These findings have implications for professional accountability if it is calibrated and monitored on an individual basis. If, for example, a professional's decision to disclose information without the client's consent were questioned after the fact, these findings suggest that a reviewing group of professionals might well not agree with the person being assessed, and would likely disagree with each other. Each member of the review panel might interpret the case information differently. Implications of such differences in interpretation are so serious that they bring into question the very concept of uniformly applicable standards of competence and ethical behaviour. Disclosure might be 'standard' at earlier or later points in a case; disclosure might be 'standard' but only to certain people, not to a wide variety of different people. How could the 'rectitude' of the individual practitioner's decision be determined when there is no clear consensus about the standard of good practice which ought to be upheld? That being said, however, these findings also suggested that the professional who finds his judgement 'under the microscope', will be more likely to find it in keeping with some general 'norm', if he (a) disclosed (rather than maintained confidentiality), and (b) disclosed to another professional who shared a 'duty of care', or failing this, disclosed to a para-professional who also shared a 'duty of care'. He is unlikely to receive approbation for disclosure to a non-professional.

3. Third, the research findings (in particular those reported in Chapter Eight) have implications about to whom a professional is accountable. They show that it is not a simple matter to determine. A decision to maintain confidentiality might please the individual

named client, but cause concern to other professionals and/or third parties. Professionals working in community settings come into contact with a variety of other workers and volunteers, as well as the public. Some are professionals with a 'duty of care' to the client. Some are close family or friends. Some are neighbours. To what extent is the professional required to be accountable for his actions to these parties? Who is to determine the primacy of interest of any given party - the professional's own governing body, the organisation which may employ more than one of these professionals in different branches of the service? Whose judgement is paramount? My research findings suggest that it is the judgement of the individual practitioner which reigns and is accepted, not that of the named client[63].

The research also reveals levels of accountability the individual professional accepts towards other parties. Increasingly professionals working in the community mental health field are expected to cooperate with one another in the normal course of their work. This is being espoused as 'good practice' guidance (Department of Health, 1996). That practitioners can be accountable to more than one person or agency at the same time has been acknowledged in professional literature (Bamford, 1982; Shardlow, 1995). Clearly some of the justification language used by professionals and reported in Chapter Eight acknowledges their loyalty and accountability to other parties, fellow professionals, other potential clients, the general public, etc. Clearly such "conflicting loyalties" can be equated with the inherent contradictions of having multiple different lines of accountability. They affect professional judgement. Some of the comments cited in Chapter Eight, demonstrated a sense of accountability being insistently present towards other professionals and/or third

[63] In this, my research findings concur with the legal precedents set by W. *versus* Edgell and R. *versus* Crozier, which also upheld professional judgement over the wishes of the named clients.

parties, which can override the practitioner's sense of being accountable to the named client.

4. Finally, questions must be raised about the usefulness of theoretical ethical statements about confidentiality, such as those contained in professional codes. The current Labour Government has promised to ensure, through the establishment of social work as a registered profession, that codes of practice are "enforceable". However, do ethical codes <u>really</u> assist the profession to achieve a good standard of ethically correct practice? Conventional professional wisdom would have it that an ethical code which ensures confidentially is very important. However, my research suggests broad general value statements, by themselves, are neither helpful nor enforceable.

Hugman and Smith (1995) noted that:

> As statements of value, ethical principles provide an important yardstick by which particular actions can be evaluated (Hugman and Smith, 1995, p. 2).

My research suggests that the "ethical principle" of confidentiality which is expressed in the professional codes of the research respondents proved to be of little use as a "yardstick" to help them make disclosure decisions or to evaluate whether or not those decisions were wise and justified. Respondents' discussions of the reasons why they were making disclosures (reported in Chapter Eight), indicated the presence of a strong refrain of searching for the 'good result'. This fits within the utilitarian theoretical framework for ethics. In contrast, the analysis of discussion about the vignettes (reported in Chapter Ten) revealed how infrequently respondents referred to the code of ethics as a basis for any decision. This suggests that a code of ethics, which operates at a deontological level in ethical theory, has limited usefulness to practitioners faced with making difficult choices involving dilemmas

of confidentiality. One, therefore, has to question what is the utility of a code of ethics which operates at the abstract level of theory, but which has relatively little direct application to day-to-day practice?

Related to this is the issue of how codes of ethics are worded, particularly in the clauses relating to confidentiality. The codes of ethics for nursing, social work and pastoral care are written in ways which suggest that confidentiality is maintained more often than it is breached. This sets up an expectation in the minds of clients, as well as members of the general public, that confidentiality is quite strict, and that only in exceptional and very dangerous circumstances, is it flouted; the client's express consent is paramount. In short, lay people tend to believe that they 'control' information about themselves, their consent must be obtained for all routine discussion, and this standard of confidentiality is only very infrequently breached for truly exceptional reasons. My research suggests otherwise. The responses to the case vignettes revealed how much professional liaison and cooperative co-working is the norm. Moreover, even in the relatively low risk situations described in my vignettes, strict confidentiality was breached more often than not. Information was disclosed to a variety of people, most of whom were other professionals, but not all.

This has implications for professional accountability: an ethical norm is being espoused which is patently not being followed in ordinary practice. I am not suggesting that the practitioners who participated in my research were oblivious to the ethical choices they were making. I am not suggesting they simply ignored client's wishes or were unconcerned about the breaches of confidentiality that they decided they would have to make. I am not suggesting they considered this was an irrelevant issue. On the contrary, they clearly all espoused the ethic of 'confidentiality' and thought

carefully about the decisions they were making. However, the research findings reveal the glaringly obvious disparity between the grand theoretical statement which suggests confidentiality is rarely breached, and the common ethical practice norm in which confidentiality is held within a network, and 'strict rules' do not apply[64].

Surely it would be better for professions and employers alike to espouse an ethical standard which more closely reflects the day-to-day experience of workers and clients? The present situation allows disparity and dissonance to be built-in between professionals' expectations about everyday situations and the lay public's expectations of practice. Clients might well feel aggrieved that their confidentiality is not being maintained as they expected, when in fact, all that is happening is normal professional co-working. Moreover the professions leave themselves open to challenge about whether they really adhere to their own proclamations about ethics.

Increasingly, in a 'mixed economy' of care, with market forces determining provision (at least to some degree), services are provided under contractual arrangements (e.g. N.H.S. Trusts which contract with Health Authorities and G.P. fund-holding practices). Bureaucracies which employ the individual practitioners are obliged to provide certain types of service to a standard guaranteed by Government legislation and the organisations' own mission statements (e.g. Local Authority Social Services Departments). When developing and implementing these services, increasingly N.H.S. Trusts and Local Authority Departments of Social Services may consult with the public about what they are doing and how. "Every public agency wants

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[64] In many ways this distinction equates to Timms' (1983) distinction between 'strong' or 'weak' confidentiality. However, the difference is that the research participants were all told that the named clients in the vignettes were refusing permission for information to be shared with another person or agency. Even in agencies or professions which espouse the 'weak' level of confidentiality to which Timms refers, this standard would require the professional normally to maintain confidentiality when expressly requested to do so by the client.

to do this, or at least to be seen to be doing this: none more so than health and social services" (Fletcher, 1998, p. 47). To this I would also add: professional associations.

However, taking the public's wishes into consideration in determining standards for confidentiality (and enforcing them through employment contracts and disciplinary committees), is a thorny problem. Firstly, which members of the 'public' should have a say: the named clients, their families, other agencies with whom professionals must work cooperatively, or members of the public generally? How are their opinions to be heard?[65] Secondly, in an increasingly litigation-prone society, once the consultation exercise was completed, employers and, to a lesser extent, professional organisations might find themselves potentially left open to lawsuits from a dissatisfied public when they tolerate a wide a gap between the principled statement of a code, backed up by an employer's mission statement, and the everyday reality of information sharing.

RESEARCH CONCLUSIONS AND SUGGESTED FURTHER RESEARCH

This thesis explored themes of professionalism, codes of ethics, and ethical judgement. This was done through reference to three 'caring' professions, and their ethical decision-making about risk assessment and boundaries of confidentiality in the field of community mental health. The research focused on certain particular issues:

(1) What effect did the professional code of ethics have on professional judgement about boundaries of confidentiality, and was there an alternative ethical framework which was used?;

(2) How frequently was strict confidentiality breached without the

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[65] The inclusion of lay members onto disciplinary committees does not always guarantee much weight is given to the lay perspective (Robinson, 1988).

client's consent in relatively routine or low-risk situations?;

(3) Were the decisions consistent and predictable to such a degree that a 'standard' could be determined for when and why confidentiality was breached?;

(4) What were the differences in decision-making between the three professions and was this related to the degree to which they were 'professionalized' into an occupational culture and integrated network of cooperating professionals;

(5) What were the implications of the findings for occupational development and policy?

This research, of itself, did not definitively answer the questions, but the results suggest that ethical codes offered little help to the practitioner faced with a specific ethical dilemma such as that being presented in each vignette case. It was clear that practitioners commonly and frequently disclosed confidential client information. Even in such relatively low-risk situations this is far more routine than the code of ethics suggests is acceptable. The research data supported the hypothesis that professionals made their decisions, at least in part, based on their loyalties to (or accountability within) a close-knit multi-agency network. However, there were also many differences both between and within professional groups about when to disclose, to whom information should be imparted, and why. There was so much variation in decision-making that, in the end, no 'standard' could be determined about when and why it would be appropriate for a professional to breach strict confidentiality without the consent of the client. This is an important message for professional organisations, employers and policy makers in terms of accountability for the practice decisions of the individual nurse, social worker or chaplain and the agencies where they work. As is typical for a project of this kind, the research raised questions which it could not answer.

Although one must be circumspect in pronouncing conclusions from a single research project, nonetheless, tentative answers may be given to that set of questions asked earlier about what contribution this research has made to:

(a) the common knowledge of ethical conflicts which members of the caring professions encounter in their daily work;

(b) the adequacy of (or improvement needed in) work routines, common standards of confidentiality and information sharing, and reporting procedures used in agencies employed in the area of community mental health; and

(c) the debate on the locus of final authority and accountability in professional work and the hiatus between (and implicit professional risk involved in) ethics as belief and ethics as behaviour involving judgements, decisions, actions and attitudes.

I would assert that the research evidence demonstrates that the actual practice in situations involving what could be described as mild ethical dilemmas involving conflicting claims of "need to know" is usually to disclose confidential client information, to breach the code's seemingly absolute diktat in favour of confidentiality, and fail to honour the client's specific instruction. I would also assert that the oft-rhetorically-pronounced primacy of the client's needs and wishes (enshrined in sentiments such as 'respect for the individual', or 'self-determination'), does not hold if they are judged to be in conflict with the professional's judgement about the desirability of sharing information, sharing authority, getting a second opinion, and sharing risk.

I would further assert that there is no evidence of a consistent standard of professional judgement about the modest, moderate, and quite common, 'everyday' practice conditions which would warrant - or not warrant -

breaching the confidentiality the client expects which has either been explicitly requested or implied by client behaviour. Professional decisions to disclose, at least judged by those decisions made for the research project's vignette cases, are idiosyncratic, arbitrary and inconsistent. In other words: they are unpredictable. They represent a high degree of the worker's individual autonomy within a professional reference and support network. This may well be extremely desirable, if not thoroughly necessary, for a good, comprehensive, and seamless service which ultimately greatly benefits both the individual client and society as a whole through efficient and effective management of people's 'problems', but it cannot honestly be said to hold the maintenance of confidentiality as anything more than a frequently unattainable ideal to which only lip service is paid.

I would contend that the rich evidence provided by the frank and detailed discussions with my interview respondents has made a unique and useful contribution to the debate on this issue. It has demonstrated just how difficult it is to maintain confidentiality, how readily the ethical ideal is breached, and the very ordinary conditions which justify this. It has demonstrated the complexity of the professional network in current practice situations for members of the caring professions, and how wide and pervasive is the circle of persons who 'need to know'.

I would argue that, in greater detail than was previously the case, my research has provided the relevant professional literatures of nursing, social work, and the chaplaincy, with benchmark examples of the inadequacy of work routines to ensure that clients' expectations about confidentiality in the mental health area are breached only in predictable and accepted conditions.

I would conclude that my research has demonstrated unmistakeably that practitioners are uneasy in dealing with ethical conflicts arising from differing demands for the confidentiality of information and the sharing of information. They are aware of risk to their own careers and

reputations (and those of their colleagues in the profession), risk to getting a "good result", risk to their own safety, that of colleagues and other workers, to family, friends, and to the general public, and of risk to the client's health, well-being and progress toward solving his problems. Yet, balancing these risks, they must act. They must make decisions. And they are aware that their judgements can be called to account. My research has demonstrated, in detail, that the maxim seems to be "when in doubt, tell someone about it". Discuss the case situation, consult, pass the decision on to a higher authority, or share it with your team if that is possible, but remember there is no standard universally accepted line of referral!

Therefore I would suggest that further study is needed along those paths whose exploration this research began. Some additional investigation is needed on the question of whose judgement is actually given priority, so that more informed debate can proceed about whose judgement should be paramount in given sets of circumstances, and what mechanisms are actually used to solve disagreements between contending parties. This should be compared with data about the range of what might be *permissable* practice, as agreed by a variety of people with an interest in the outcome.

The findings reported in Chapter Seven ("Consistency") - specifically the frequency of decisions to disclose despite the lack of consent from the clients - suggest that the judgements of the professional presently and immediately dealing with some aspect of the case take priority over clients' judgements, and, possibly, over the judgements of other professionals also sharing the client. The discussion in Chapter Eight ("Conflicting Loyalties") also revealed that professionals sometimes make decisions which coincide with client choices, but this does not necessarily mean they have accepted the client's judgement. Often they have made an independent assessment of the situation which just happens to lead to the same choice. The data reported in Chapters Seven and Eight, support the contention that today's professionals do not work in isolation; they are part of a network sharing information, and presumably,

also sharing decision-making about that information.

Proceeding from this is the issue of the primacy of judgement among several different professionals, or between professional and non-professionals who have a clear interest (e.g. the client's family or non-related members of the public, such as a neighbour). If a nurse believes certain information ought to be shared but the G.P. does not, should the nurse's professional judgement carry more weight, or would the doctor's[66]? In situations where there is disagreement between the professional and the employer, whose decision should be followed? What implications do such questions have for the professional governing bodies which require registered practitioners to be responsible as individuals who may not use the defence they were 'only following orders'? If a family member objects to certain information being passed on, and complains, who decides whether his judgement about the level of information sharing should be accepted rather than the professional's? If a neighbour whose life was directly affected by the client complains, does the professional have to account for his decision not to disclose which put this person in jeopardy? Such questions were outside the scope of my research.

My research put a group of professionals in the position of having to say what choices they would make if faced with certain ethical dilemmas about boundaries of confidentiality. These were forced choices in specified case conditions. It revealed how many practitioners analyze situations and make ethical decisions by trying to achieve a 'good result', rather than by trying to fulfil some abstract principle or ethical 'rule'. It would be useful, therefore, to take this investigation a stage further and have a group of professionals review others' decisions after the fact, to see if they explicitly or implicitly agree on some 'correct' boundaries of confidentiality, and what factors determined their agreement.

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[66] Dingwall's report about multi-professional teams suggests the doctor's judgement would probably be given more weight than would the nurses (Dingwall, 1980).

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APPENDIX ONE

VIGNETTES AND INTERVIEW QUESTIONS

Introduction

As a general principle it is an expectation of the caring professions that they are discrete, sensitive to client's wishes and maintain confidentiality. I'm studying the relationship between this general ethic and individual judgement in practice - in other words how do you actually achieve this in practice and what are the limits of this principle. I am interested in how workers make decisions about practice situations involving decisions about limits of confidentiality, where circumstances may mean they are not able to keep absolute confidentiality.

I'm going to show you some descriptions of cases where the worker involved has to make a decision about revealing information about the client to other people. I'd like you to read through the description and then I'd like to discuss how you would act if you were working with this person.

These are not actual cases I am describing but I've tried as much as possible to make these as much like "real life" as possible. Please feel free to relate them to actual situations you have encountered if you feel they are relevant.

In all the situations I have described the client is not willing for you to discuss their case with anyone else. Either you have suggested this to them and they have said no, or you are aware from past discussions with this person that they would refuse if asked. So, in all cases, if you decide to discuss the situation with someone else you will be going against the client's wishes. There are no "right" or "wrong" answers. You may decide you will not discuss the client's situation in any of the circumstances or you may decide you will. What I am interested in is how you arrived at your decision.

* * * * * * *

Before we get started on the cases there are a few general questions I'd like to ask you about your background:

1. Age: 2. Sex: 3. Race/Ethnicity:

4. Qualifications (professional and academic):

5. Current Professional Work (e.g. job title or function, agency name, generic, specialist or managerial work):

6. Years of Professional Experience and Type of Setting (e.g. 2 years full-time general nursing, 1 year hospital psychiatric, 1 year community nursing, etc.):

Vignette One

Cathy is aged twenty. One year ago she suddenly lost her husband and 1 year old child in a car accident. Shortly after she began seeing you for grief counselling. Despite her young age, Cathy has experienced a number of problems in the past, and issues arising from these past problems have affected her current depression. When she was fourteen her father died from cancer. The family went on income support after his death and moved into a council house in another neighbourhood and so Cathy lost all her friends for a while and became quite lonely and introverted. It took her some time to make other friends. She met her husband at sixteen at the shop she was working at. They married a year later and the baby was born a year after that. They were very happy and planning to try to have another child when the accident happened.

Throughout this period she has been diagnosed as clinically depressed and has received medication for this. She quit her job as cashier because she felt she couldn't cope after the accident, has been too depressed to find work since and is receiving sick benefit. Generally, Cathy's been finding it difficult to cope with day to day living and you are increasingly worried about her deepening depression. She says she's always felt that no matter what she does "something's just waiting round the corner to knock you down" and she's been unable to see the point in fighting this feeling since her husband and baby died. Two months after the accident, Cathy had to leave her previous flat because she could no longer afford the rent. For the last ten months she rented a room in a shared house, but frequent arguments developed with another tenant and she became frightened to live there. She was behind on the rent and so when she left suddenly the landlord kept her deposit, so she had nothing with which to rent a new place. Cathy's mother was unable to offer any help and so last week she moved into a shelter for homeless women. The residential staff are asking you about her diagnosis, clinical history and therapy.

Would you discuss Cathy's situation with her doctor and/or residential staff?

Are there any others you would discuss her situation with?

How much (what) information would you reveal?

What information about her situation has led you to make your decision?

What purpose do you hope to achieve?

Would you tell Cathy if you were going to discuss her situation with someone else (and if so when)?

Vignette One Variations

Would your decision change in any way if Cathy had a history of self-mutilation by marking herself with knives (no suicide attempt)?

Would it change if Cathy had a history of attempting suicide? She first took a paracetamol overdose (20 tablets) one week after the accident but vomited them up. She took another overdose two months ago but rang the Samaritans for help and they convinced her to go to the hospital emergency. She remains very depressed and says suicide is something she is considering.

Would your decision change if Cathy were living with her mother and her mother was asking for information? Would it change if her mother's health was frail (e.g. recovering from a serious heart attack)?

What if Cathy moved in with a female friend (former neighbour) she had been very close to but had lost touch with in the last year, since she'd had to move? The friend is concerned about Cathy's listlessness and is asking you for information.

Would your decision be affected if you became aware her friend was also going through a traumatic situation, was very depressed, and was also receiving counselling? Would you contact the friend's counsellor to discuss the situation?

Vignette Two

At 18 Jim was diagnosed as a schizophrenic (mildly paranoid type); he is now 34. Over the years his condition has been managed with a variety of psychotropic medication, usually as an out-patient. In the past he's had three brief periods of hospitalisation of no more than two weeks on each occasion, when his situation deteriorated by not taking medication. Once his mental condition stabilised he was discharged again into the community; the most recent of these was two years ago. For the last five years Jim has rented a small council flat and been supported by disability allowance. He's always shown mildly paranoid symptoms such as being suspicious about what neighbours are saying, worrying about what is written about him in files, and concern about people watching him, but there is no history of violence. You see Jim every month. During the last three visits he's discussed increasing anxiety about one neighbour, who lives in the flat downstairs. He says he's never liked this man but now he thinks the neighbour is "out to get him" by interfering with his mail and making complaints about him to other neighbours and the local police; Jim appears quite agitated and upset as he discusses this with you. Jim is taking his medication correctly and so this change is not due to a failure to take treatment. You have discussed Jim's health with his doctor. He agrees that the increasing paranoia is a symptom of a general slow decline in mental status but this is a normal deterioration with the progression of his schizophrenia. You have consulted with the doctor who does not believe any change in medication will assist Jim.

Would you discuss Jim's situation with his neighbour, his doctor or another doctor?

Is there anyone else you would discuss the situation with?

How much (what) information would you reveal?

What information about his situation has led you to make this decision?

What purpose do you hope to achieve by this decision?

Would you tell Jim if you were going to discuss his situation with someone else (and if so when)?

Vignette Two Variations

What if Jim had a history of retaliatory non-violent "nuisance" behaviour such as writing graffiti on the neighbour's door or intercepting the neighbour's mail. Approximately two years ago Jim retaliated in this way against a former neighbour. At the time he was not consistently taking his medication. He was charged with criminal damage and the court ordered him to pay compensation to the neighbour, who subsequently moved. Would this change your decision?

What if Jim had two previous convictions for assault? The background to both assaults involved Jim becoming anxious, paranoid, and increasingly angry about a neighbour whom he felt was acting against him.

Would your decision change if he lived with family (e.g. shared a flat with his parents but is still anxious about his neighbour)? Would you discuss the situation with his family and/or the neighbour?

Would your decision change if he lived with family and his anxiety and paranoia was focusing on his family (e.g. he accused his father of tampering with his post)?

Vignette Three

Mark is sixteen years old and lives with his parents and two younger brothers, aged 13 and 11. From an early age he was identified as having a mild learning difficulty. It is believed this was due to minor brain damage caused by lack of oxygen during a difficult birth. Mark has a supportive and loving family and his parents have always been interested in getting the best help possible for him. He was statemented in school from age seven and received special education thereafter. He left school without any qualifications and is dependent on his family for a weekly allowance and bus fares. Before he left school he was referred to a sheltered workshop/day programme for the mentally ill and slow learners. Mark began this a month ago and he's seemed to adjust well to the workshop. He is generally well-liked by other clients and appears happy and cooperative with staff. Mark is a member of your social skills group where he often seems to shine as a 'leader'. One day you notice Mark drinking some lagers during lunch break. When you ask him about this he admits he shoplifted it from a local supermarket on his way to the workshop.

Would you discuss Mark's shoplifting and/or alcohol use with:

- his parents
- the shopkeeper he stole from
- the police
- workshop staff
- other members of the social skills group

How much (what) information would you reveal?

Is there anyone else you would discuss the situation with?

What information about his situation has led you to make this decision?

What purpose do you hope to achieve by this decision?

Would you tell Mark if you were going to discuss his situation with someone else (and if so when)?

Vignette Three Variations

If you were aware Mark had been providing other workshop clients with lager would this change your decision?

Would your decision change if he were living in a residential home for people with learning difficulties? Would you discuss his situation with staff there?

If Mark were older (e.g. 26) would this change your decision?

Vignette Four

Mary is a 26 year old single mother of two boys (aged 1 and 3 years). The boys are normal and healthy children. She moved to Leeds two years ago when her husband found work here. She has no family in the area. When she was 6 months pregnant with the younger child, Mary left her husband because of his excessive drinking. She is living in a high-rise flat and works full-time as an administrative assistant for the health trust. It is a good secure job which she's had since shortly after she moved to Leeds. She likes the work and her co-workers, and the job gives her a feeling of accomplishment that she hasn't fallen into the 'typical trap of living on benefits like most single mothers'. The children are in day care when she works and she often finds it a rush getting between work and day care in time. Mary's husband has now moved to Bradford for work. He does not support the children, and although he visits them once in a while 'he can't be relied on to turn up when he says he will'. Mary says she used to receive tranquilizers for 'anxiety' from her previous doctor. Without them she found she was having difficulty sleeping at night since it was increasingly difficult to unwind after her busy days, even though she was very tired. Her former doctor retired a few months ago, and Mary's new doctor suggested she try stress management counselling instead. She decided to try it because she thinks it's healthier to live without pills. Mary appears very cooperative and positively motivated, but is very concerned about confidentiality because of her job with the health trust. As she discusses her day-to-day life she tells you that her older child in particular is very demanding and sometimes has temper tantrums. Sometimes she feels just like screaming back at him. Occasionally she fears she cannot cope.

Would you discuss Mary's situation with Child Protection Services, her husband or her doctor?

How much (what) information would you reveal?

Is there anyone else you would discuss the situation with?

What information about her situation has led you to make your decision?

What do you hope to achieve by this decision?

Would you tell the Mary if you were going to discuss her situation with someone else (and if so when)?

Vignette Four Variations

Would your decision change if Mary's husband lived locally and she said he was a very reliable character who did not drink to excess, regularly paid maintenance, and visited the children twice a week?

What if Mary said that last week she spanked her older son very hard, leaving bruises? It is the first time this happened, and she was able to stop herself, but she's afraid she won't always be able to in future.

Would your decision change if the older child had chronic health problems?

Would your decision change if Mary said she'd been hit herself as a child?

Finally, there are just a few more general questions I'd like to ask:

1. Are there laws (legal duties) which affect your decisions in situations involving dilemmas about limits of confidentiality?

How do they affect your decision?

2. Do you belong to a professional association? Which?

3. Does your professional association offer any guidance about how to deal with dilemmas involving confidentiality (e.g. policies, procedures, training, consultation)?

How does this guidance affect your decision?

4. Does your employer offer any guidance about how to deal with dilemmas and decisions about confidentiality (e.g. policies, procedures, training, consultation)?

How does this guidance affect your decision?

Thank you very much for all your help.

APPENDIX TWO

EXAMPLE OF AN INTERVIEW TRANSCRIPT (EXCERPT)

The following is a verbatim extract from one of the interviews. This example illustrates the complexity of multiple reasoning behind the decisions made by many of the respondents about disclosure when considering the cases presented in the vignettes:

Q In the next version Mary said that last week she spanked her older son very hard and left bruises? It's the first time it's happened and she was able to stop herself but she's afraid she won't always be able to in future. Does this information affect your decision in any way?

A Not about talking to the husband but I think I would ask for advice from the local Social Services, speak to the Principal and discuss the whole thing for their advice. Not particularly expecting them to take action, but I just feel I needed to do that.

Q So you're not actually asking them to do anything? You're gathering information for yourself?

A I'd be wanting advice. They'd probably want the name and check it on the computer and everything. So I'd be wanting advice really, just to ensure what the right way to go forward was. But I don't think I'd discuss it with her husband. I wouldn't think that there were indications.

Q Okay. What about the doctor?

A The first thing would be to tell Social Services. Just imagine they said 'Oh no, there is no particular worry; this sounds like something that happens everyday'. Then the ball is back in my court to make a decision, and say, if I asked her consent to tell the G.P. and she said no... With the doctor I'm thinking that effectively the doctor is part of the clinical team whether I work in the same building as him or not. He is part of the clinical team. If she said no... Yes I think I would tell the doctor, but if she said no I would discuss that with Social Services first. I think I might specifically ask them for their guidance.

Q Whether you should mention it to her doctor?

A Whether I should mention it to her G.P.. I think I would bow again to their advice on that. I don't think there are enough indications for me to definitely do it. So I'd have to ask their advice.

Q Okay. And the purpose in both cases is really getting advice?

A Advice for myself on managing her for the child's benefit ultimately. So my ultimate concern would be the child's benefit. But I guess this kind of scenario is one where the fact that she's spoken with it to me is a good thing. This is probably something that's happening up and down the country, people just aren't telling someone. The fact that she's told me is in fact a good and a positive thing, so that, ultimately the child's protection is okay. But it's not just as simple as saying, here is a child at risk. Here's someone who's actually having help for a problem and is in a therapeutic relationship where she's disclosed something. So yes, it's to help her and focuses very much on her but I see her as doing something that's very healthy. At the back of my mind is the child's welfare.