

Ethical Decision-Making in Disability Management

Shelley D. Jodoin

B.A. General, University of Alberta (1980)

L.L.B., University of Alberta (1983)

Thesis Submitted in Partial Fulfillment of

The Requirements for the Degree of

Master of Arts

in

Disability Management

University of Northern British Columbia

December 2008

© Shelley D. Jodoin, 2008



Library and
Archives Canada

Bibliothèque et
Archives Canada

Published Heritage
Branch

Direction du
Patrimoine de l'édition

395 Wellington Street
Ottawa ON K1A 0N4
Canada

395, rue Wellington
Ottawa ON K1A 0N4
Canada

Your file Votre référence

ISBN: 978-0-494-48722-8

Our file Notre référence

ISBN: 978-0-494-48722-8

NOTICE:

The author has granted a non-exclusive license allowing Library and Archives Canada to reproduce, publish, archive, preserve, conserve, communicate to the public by telecommunication or on the Internet, loan, distribute and sell theses worldwide, for commercial or non-commercial purposes, in microform, paper, electronic and/or any other formats.

The author retains copyright ownership and moral rights in this thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without the author's permission.

AVIS:

L'auteur a accordé une licence non exclusive permettant à la Bibliothèque et Archives Canada de reproduire, publier, archiver, sauvegarder, conserver, transmettre au public par télécommunication ou par l'Internet, prêter, distribuer et vendre des thèses partout dans le monde, à des fins commerciales ou autres, sur support microforme, papier, électronique et/ou autres formats.

L'auteur conserve la propriété du droit d'auteur et des droits moraux qui protègent cette thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

In compliance with the Canadian Privacy Act some supporting forms may have been removed from this thesis.

Conformément à la loi canadienne sur la protection de la vie privée, quelques formulaires secondaires ont été enlevés de cette thèse.

While these forms may be included in the document page count, their removal does not represent any loss of content from the thesis.

Bien que ces formulaires aient inclus dans la pagination, il n'y aura aucun contenu manquant.

ABSTRACT

A qualitative, phenomenological, exploratory study of a small purposive sample of disability management coordinators, including union representatives, explored how ethical dilemmas are identified and resolved, revealing that dilemmas arise out of interaction by the parties within the disability management environment in conjunction with professional imperatives.

Key findings include the identification of preconditions, factors that facilitate ethical decisions (e.g. competency, training, balancing the parties' interests, and best practices) or predispose the accommodation process to dilemmas (e.g. dual clients and access to sensitive information), and the use of features of the Ethics of Care, Kantian Ethics, and Beauchamp and Childress' ethical principles in ethical decision-making.

Based on the findings a visual model of dilemma formation and resolution, a theoretical approach to ethical decision-making combining the Ethics of Care and Kantian Ethics and a decision-making framework were developed, incorporating participants' experiences, best practices literature, ethical theories and principles and facilitating evidence based practice.

ACKNOWLEDGEMENTS

I would like to express my sincere appreciation to:

The disability management coordinators who participated in my research for their
time and candour,

The members of my Supervisory Committee, Dr. Shannon Wagner, Arlene Ward,
and Dr. Eleanor Wint, and the External Examiner, Dr. Boris DeWiel,

My academic supervisor Dr. Henry Harder for taking a chance on me,

Douglas R. Mah, WCB-AB Secretary and General Counsel, for his long-standing
support of my professional development,

My friends in the Masters in Disability Management Program, Marg Creen and
Linda van Cleave, for their assistance,

My friend Leah Milton from whom I have learned so much about disability
management,

My daughter Marissa Gilmar for her support and understanding beyond her youth,
and not least,

My parents, Bob and Julia Jodoin, for their unfailing encouragement of my
education over the years.

Thank you.

TABLE OF CONTENTS

ABSTRACT.....	i
ACKNOWLEDGEMENTS.....	ii
List of Tables	v
List of Figures	vi
Chapter I.....	1
The Problem	1
The Research Gap Identified.....	2
The Research Question.....	3
Objectives	4
Chapter II	5
Literature Review	5
Disability Management	5
Ethical Theories.....	6
Beauchamp and Childress' Ethical Principles	20
Ethics Literature in Disability Management	26
Ethical Decision-Making Processes and Organizational Factors Influencing Decision-Making	27
Ethical Issues.....	29
Strategies and Practical Approaches for Ethical Decision-Making	30
Chapter III.....	32
Method.....	32
Key Terms	33
Participants	36
Method of Inquiry	37
Chapter IV.....	39
Results	39
Introduction	39
Sample.....	39
How do Disability Management Coordinators Identify Ethical Situations and Dilemmas?	42
What Ethical Situations and Dilemmas do Disability Management Coordinators Experience?	44
What Challenges and Barriers Obstruct and What Factors Facilitate Ethical Decision-Making in Disability Management?.....	51
How do Disability Management Coordinators Resolve Ethical Dilemmas and What Ethical Decision-Making Tools and Strategies do they Use?.....	58

Common Themes	66
Chapter V	76
Key Findings	76
Ethical Decision-Making is a Complex Process	76
Without Ethics Training Disability Management Coordinators Develop Their Own Ethical Decision-Making Strategies	81
Ethics Training by Itself is not Sufficient to Ensure Disability Management Coordinators Use Structured Ethical Decision-Making Strategies; a Supportive Professional or Organizational Culture is Also Needed	82
Disability Management Coordinators Use Elements of Beauchamp and Childress' Ethical Principles and Concepts to Guide Ethical Decision-Making	83
Disability Management Coordinators Use Elements of the Kantian Ethics and Ethics of Justice, and the Ethics of Care and Feminist Ethics Theories to Guide Ethical Decision-Making	85
Most Disability Management Coordinators Do Not Use Other Ethical Theories to Guide Ethical Decision-Making	91
Theoretical Constructs	92
A Model of the Formation and Resolution of Ethical Dilemmas in Disability Management	92
A Combined Theoretical Approach for Ethical Decision-Making in Disability Management	108
A Framework for Ethical Decision-Making in Disability Management	116
Limitations of the Study and Recommendations for Future Research	122
Summary and Conclusions	124
References	130
Appendix A	135
A Framework for Ethical Decision Making in Disability Management	135
Appendix B	146
Research Ethics Board Approval	146
Appendix C	147
Information Sheet	147
Appendix D	150
Research Study Informed Consent Form	150
Appendix E	152
Interview Topic Guide	152
Appendix F	154
Workers Compensation Board-Alberta Ethics Program	154

Appendix G	156
Appendix H	158
Burkhardt and Nathaniel's A Guide for Decision Making	158
Appendix I	160
Hill, Glaser, and Harden's Feminist Ethical Decision-Making Model	160

List of Tables

Table 1: Identification of Ethical Situations and Dilemmas

Table 2: Examples of Ethical Situations and Dilemmas

Table 3: Challenges and Barriers to Ethical Decision-Making

Table 4: Facilitators of Ethical Decision-Making

Table 5: Formal Tools and Strategies for the Resolution of Ethical Situations and
Dilemmas

Table 6: Informal Tools and Strategies for the Resolution of Ethical Situations and
Dilemmas

Table 7: Common Themes

Table 8: Evidence of Beauchamp and Childress' Ethical Principles

Table 9: Evidence of the Ethics of Care and Feminist Ethics

Table 10: Evidence of Kantian Ethics and the Ethics of Justice

List of Figures

Figure 1: Evidence of Rules

Figure 2: Evidence of Relationships

Figure 3: Evidence of Beauchamp and Childress' Ethical Principles

Figure 4: Evidence of the Ethics of Care and Feminist Ethics

Figure 5: Evidence of Kantian Ethics and the Ethics of Justice

Figure 6: A Model of the Formation and Resolution of Ethical Dilemmas in Disability
Management, the Core Elements

Figure 7: Professional Imperatives

Figure 8: The Disability Management Environment

Figure 9: The Parties to the Return to Work Process

Figure 10: The Consequences of an Ethical or an Unethical Decision

ETHICAL DECISION-MAKING IN DISABILITY MANAGEMENT

Chapter

The Problem

Disability management coordinators (hereinafter referred to as DMCs) have considerable influence over whether injured or ill workers return to work that accommodates their functional abilities and is sustainable. Planning the return to work of workers requires decisions of resource allocation, prioritization of worker needs, and the management of worker and employer expectations (Keatings and Smith, 2000). These decisions are not only decisions of day to day practice, they are also ethical decisions.

Ethics is a branch of moral philosophy that attempts to translate values and morals into daily living. Ethics must be distinguished from values, which are our beliefs about what is right, wrong, fair, just, good or bad. Ethics move beyond values. They “are behaviours and tell people how to act in ways that meet the standard our values set for us” (Salopek, 2001). Put another way, “ethics are values in action” (Workers' Compensation Board-Alberta, 2008, p. 6).

“A limited understanding of ethical theory, lack of awareness that we are facing ethical issues, lack of knowledge and skill required to address them, and lack of appropriate system supports often lead to avoidance of the issues” (Keatings and Smith, 2000, p. 13). Understanding ethical concepts therefore alerts DMCs to potential ethical issues, provides resolution strategies, and aids the assessment of moral choices. Since disability management is done collaboratively, clear communication is essential. The study of ethical theories and perspectives provides a common language for the discussion of ethical situations with colleagues. It helps a DMC understand the values, interests,

beliefs and perspectives of colleagues and the parties to the return to work process. Moreover, consensus around the resolution of ethical issues is not possible without a shared ethical language (Botes, 2000b; and Keatings, and Smith, 2000). For these reasons, the study of ethical concepts is important to disability management praxis.

My interest in ethics began when I wrote an ethics course for a post-secondary certificate program in disability management (Jodoin, 2004). At the time I found only a few pages about disability management ethics in a text (Dyck, 2002). Accordingly I was faced with the challenge of relating traditional ethical theories, and the ethics literature in other disciplines, to disability management practice. As a discrete profession and discipline, disability management should develop its own ethical theoretical approach and decision-making tools.

The Research Gap Identified

The academic literature on disability management ethics subject is sparse compared to other disciplines. Besides the Dyck text (2002) just one other published work exists (Harder and Scott, 2005). Both works consist of disability management texts that contain a general chapter on ethics.

Disability management is distinct and separate from other health care disciplines with a unique set of professional values. Although studies have been conducted on how other health care professionals make ethical decisions, no research has been done on the ethical decision-making of DMCs. Furthermore, there is significant overlap between the concepts of ethics, morality, values, codes of ethics, ethical principles, standards of practice in the ethics literature, but little discussion as to how they apply in a disability

management context. For these reasons, the ethical decision-making of DMCs is worthy of study.

The Research Question

This study consists of qualitative interviews with DMCs. The research question has two parts: How do Alberta DMCs know when they are facing an ethical situation, and how do they make ethical decisions in their day to day practice? In other words how do DMCs determine the right course of action, or the right thing to do, when presented with an ethical situation? Secondary to the main research question, this thesis explores the organizational, environmental, cultural, or personal factors that facilitate or obstruct ethical decision-making.

This research investigates ethical theories and principles, and suggests a theoretical ethical foundation for disability management informed by the findings. It also generates recommendations for ethics training.

The research question is interdisciplinary because the study's participants come from different disciplines. In the last twenty years, disability management carved a niche apart from rehabilitation, occupational health nursing, physiotherapy, occupational therapy, human resources, and occupational health and safety, yet it is from these backgrounds that DMCs came into the profession. Standards of practice, codes of ethics and professional values have only been formulated for the profession in the last ten to 15 years (Canadian Association of Disability Management Coordinators, 2003; Canadian Association of Rehabilitation Professionals, 2003; Certification of Disability Management Specialists' Commission, 2005; National Institute of Disability

Management and Research, 1999; and National Institute of Disability Management and Research, 2000). The codes of ethics are aspirational only. While some work has been done in these areas, no consensus exists among Canadian DMCs and employers on the profession's key values, codes of ethics, education requirements and occupational competencies.

Objectives

The research undertakes a qualitative study of Alberta DMCs through personal interviews. It explores new ground and:

1. Gives a voice to the experiences of DMCs,
2. Uncovers themes in the manner in which DMCs identify and resolve ethical situations, and in their ethical decision-making processes,
3. Identifies organizational, environmental, cultural, and personal factors that facilitate or obstruct ethical decision-making,
4. Generates possible theoretical constructs that explain DMCs' ethical decision-making processes,
5. Explores how traditional ethical theories and principles relate to disability management,
6. Advances disability management praxis by:
 - Linking the study's findings and theoretical constructs to day to day practice, and
 - Identifying practical decision-making strategies and tools.

Chapter II

Literature Review

To interpret the data collected from the DMCs' qualitative interviews a knowledge of several areas is necessary:

- Disability management concepts,
- Ethical theories and principles,
- Ethical issues in return to work facilitation that may be identified during the interviews, including organizational factors,
- Resources DMCs might use in ethical decision-making, including codes of ethics, standards of practice and ethical decision-making models.

The first two points provide a theoretical framework for the research and will inform my analysis of the findings.

Disability Management

While it is beyond the scope of this review to make an exhaustive examination of disability management principles and concepts, the essential elements of effective disability management programs are:

- 1) Early intervention and early return to work philosophy
- 2) Joint labour-management commitment and involvement
- 3) Multidisciplinary interventions (e.g. medical, vocational, psychological, ergonomics, engineering)
- 4) Case management/case coordination
- 5) Effective disability prevention strategies

- 6) Employee education and involvement
- 7) Utilization of employer-based and community resources
- 8) Supportive policies and procedures to facilitate accommodations and job-site modifications
- 9) System that ensures accountability of all parties
- 10) Management information system for programme evaluation. (Shrey, 1996, p. 409)

Another author, Dyck, makes some important additions to the list:

- 1) Stakeholder education and involvement
- 2) Supportive benefit plans
- 3) A communications strategy
- 4) A Graduated Return to work Program
- 5) Measurement of outcomes, and
- 6) Disability prevention, including workplace wellness, attendant support and occupational health and safety initiatives. (2002, p. 191)

The fundamentals of disability management and return to work coordination are reviewed in Shrey and Lacerte (1995), Dyck (2002), and Harder and Scott (2005).

Ethical Theories

This section undertakes an examination of major ethical theories and principles. Ethical theories consist of a systematic collection of related rules and principles for the guidance of moral behaviour (Keatings and Smith, 2000). A thorough review is warranted because it will demonstrate that no single ethical theory, or set of rules based

on a theory, is sufficient to guide ethical behaviour generally (LaFollette, 1991; and Rachels, 2003) or disability management practice in particular.

Cultural and Ethical Relativism.

Cultural Relativism shows how values and morals change over time and between cultures. Maintaining that our values have no moral superiority over those held by other societies, Cultural Relativism warns us of the dangers of cultural xenophobia and teaches us to keep an open mind (Rachels, 2003). We should not be quick to judge the moral standards and practices of other cultures simply because they are different from our own. Rachels (2003) points out that all societies have common values arising from communal living. Societies that appear to have different values may actually have similar values; it is only the expression of those values that is different. From Cultural Relativism, DMCs learn sensitivity to cultural diversity within the workplace.

“Ethical relativism is the thesis that ethical principles or judgments are relative to the individual or culture” (LaFollette, 1990, p. 146). The concept is similar to Cultural Relativism except that Ethical Relativism can exist within a particular society. Using the civil rights movement as an example, LaFollette demonstrates that diversity of ethical codes can lead to healthy social change (1990).

Cultural and Ethical Relativism are important in the workplace relationships that facilitate return to work. Values about communication, health, illness and treatment (e.g. folk and alternative medicine), and decision-making (e.g. person-centred or family-centred) may be different. These differences may affect how the disability management

program is communicated, how it is perceived by employees, supervisors and management, and whether the DMC gains the trust of all the parties.

According to Rachels (2003) Cultural Relativism is flawed. Most people acknowledge certain human rights as fundamental, yet Cultural Relativism prevents criticism of human rights violations in other countries. Rachels also argues that moral standards of behaviour may be judged by a single standard, and that the standard should be “whether the practice promotes or hinders the welfare of the people whose lives are affected by it” (2003, p.28), something Cultural Relativism cannot do. If what is ethical varies between cultures, and even within cultures, then the value of Cultural and Ethical Relativism as a guide for ethical behaviour is severely limited in disability management, beyond recognizing that other people in the workplace may hold values not shared by the DMC.

Kantian Ethics and the Ethics of Justice.

Kantian Ethics is a form of deontology, a broad category of ethical theories in which right and wrong is determined by rules and principles which are in turn deduced from moral duties and obligations (Keatings and Smith, 2000). Writing in the 18th century, Immanuel Kant developed a categorical imperative requiring that systems of morality be universal. Rules or principles guiding behaviour apply to all persons, places and times. Ethical judgments made in similar circumstances but at different times should therefore be the same (Burkhardt and Nathaniel, 2002; Davis, Aroskar, Liaschenko, and Drought, 1997; and Keatings and Smith, 2000). A second practical imperative requires that persons be treated as ends, and not the means to another individual’s purpose (Davis,

Aroskar, Liaschenko, and Drought, 1997). The second imperative has been interpreted to mean respect for the person and his or her autonomy, and equal treatment of individuals.

Equality, justice, and fairness figure prominently in Kantian Ethics, as does reason. Universal rules and principles for ethical behaviour and judgments are derived through reason from the imperatives (Davis, Aroskar, Liaschenko, and Drought, 1997).

Kantian Ethics, then, has several salient features:

- Moral obligation or duty arises from universal rules,
- A set of universal rules or moral laws may be discovered through reason,
- Rules guide the identification and resolution of ethical situations,
- Respect for persons; they must be treated as an end and not a means to another's purpose,
- Consequences are not considered in determining the right or wrong of a moral action (Keatings and Smith, 2000) because the action is more important than the outcome (Rogers, 2002), and
- An emphasis upon justice, fairness and equality.

The Ethics of Justice represents a refinement of Kantian Ethics by Kohlberg and has been referred to as the Ethics of Rights. It is exemplified by:

- Decision-making that is reliable and verifiable, and
- Fairness, impartiality, objectivity, equality, and autonomy (Botes, 2000a).

Kantian Ethics and the Ethics of Justice have heavily influenced the development of modern societal institutions. As a theoretical approach its advantages include treating all persons equally, treating individuals as an end, the establishment of clear rules for determining right and wrong, and the use of reason in ethical decision-making.

Although Kantian Ethics and the Ethics of Justice offer guidelines for ethical decision-making, significant disadvantages prevent it from use in disability management alone. First, it deals with inflexible universal guidelines that cannot take into account individual needs, relationships, and cultural values. Second, it does not consider the consequences of moral acts. Third, it cannot guide ethical decision-making when two or more moral duties conflict. Fourth, universal rules do not always result in clear answers to ethical dilemmas since rules are open to different interpretations by different moral actors, resulting in different outcomes (Botes, 2000b).

Ethics of Care and Feminist Ethics.

Traditional ethical theories such as Kantian Ethics have been criticized for failing to reflect the life experiences of women. A colleague of Kohlberg, Carol Gilligan studied differences in the moral development and moral perspectives of women and men (Gilligan, 1982; Norman, Murphy, Gilligan, and Vasudev, 1982). She argues that men and women make ethical judgments differently. According to Gilligan men generally view moral issues as problems to be solved. They apply rules and logic to situations of competing rights. Instead of applying a defined set of principles or rules as in Utilitarianism and Kantian Ethics, women tend to view moral issues in terms of the relationships between the affected parties (Burkhardt and Nathaniel, 2002; Davis, Aroskar, Liaschenko, and Drought, 1997; and Keatings and Smith, 2000). Moreover, women are more likely to seek conflict resolution through communication. Woods (1996) reviews studies done on the moral development of men and women and concludes that, while on the whole men and women are more similar than different in how they

resolve ethical dilemmas, there is some empirical support for Gilligan's assertion that men and women view moral issues and resolve dilemmas differently.

Gilligan's work became the foundation for the development of the Ethics of Care and Feminist Ethics:

In the justice perspective, an autonomous moral agent discovers and applies a set of fundamental rules through the use of universal and abstract reason. In the care perspective, the central preoccupation is a responsiveness to others that dictates providing care, preventing harm, and maintaining relationships. (Davis, Aroskar, Liaschenko, and Drought, 1997, p. 39)

In the care perspective, moral duty therefore arises from the relationships between the individuals involved, especially between the care giver and the person who is cared for. That which promotes or sustains the relationship constitutes morally righteous behaviour. Additional salient elements of the care perspective include:

- Empathy and support for the individual,
- A holistic approach to care giving, and
- Consideration for individuals' needs.

Feminist Ethics amounts to an extension of the Ethics of Care. Feminists agree with the basic premises of the Ethics of Care and add that:

- Caring is a task valued in society,
- The values and experiences of minorities and women must be respected,
- The inherent power imbalance in the relationship between the care giver and the cared for person must be acknowledged, and that

- Intuition and emotion have a legitimate place in ethical decision-making (McAuley, Teaster, and Safewright, 1999).

The Ethics of Care and Feminist Ethics is particularly suited to the nursing profession. Considerable literature has been produced on the topic. As a guide for ethical behaviour the care perspective has several advantages. It accounts for decisions made within relationships, particularly between the care giver and the cared for person. It recognizes power imbalances. Lastly, emotion and intuition are incorporated into ethical decision-making.

Like nursing, disability management takes place around a central caring relationship. In disability management the DMC is the care giver, while the injured or ill worker is the cared for person. Due to this similarity, the Ethics of Care and Feminist Ethics is worth considering as a scheme of moral guidance in disability management.

While the care perspective of the Ethics of Care and Feminist Ethics may guide ethical decision-making, it too has significant weaknesses:

- “Merely caring for someone does not provide the [care giver] with many guidelines for ethical decision-making.” (Botes, 2000a, p. 1073)
- It is labour and resource intensive, with the result that a smaller number of individuals are cared for (McAuley, Teaster, and Safewright, 1999),
- It cannot assist program managers in the fair distribution of resources, and
- Making ethical decisions solely based on emotion produces decisions that are potentially uncertain, arbitrary and inconsistent.

Ethics of Virtue.

The Ethics of Virtue is the oldest theory of moral philosophy. Its origins lie in the writings of ancient Greek philosophers such as Aristotle, Socrates and Plato. According to the Ethics of Virtue a moral person is a virtuous person, someone who possesses certain virtues or qualities (Rachels, 2003). Philosophers subscribing to the Ethics of Virtue devote their attention to the question of what virtues comprise a virtuous person. Their discussion evolves into an enumeration of virtues, including benevolence, compassion, courage, dependability, generosity, honesty, and tolerance to name a few. A comprehensive list is likely impossible, as well as impractical.

The Ethics of Virtue is an incomplete theory (Harder and Scott, 2005; and Rachels, 2003). It is of little practical use to guide behaviour because being a certain type of person does not tell a moral actor how to resolve a dilemma. For that reason, its application to disability management is extremely limited.

Ethical Subjectivism and Emotivism.

As a system of ethics, Ethical Subjectivism consists of "the idea that our moral opinions are based on our feelings and nothing more" (Rachels, 2003, p. 33). Simple Ethical Subjectivism has been criticized because it entails a circuitous argument (Rachels, 2003). When a person states that something is morally bad or wrong, he or she is not doing anything more than expressing his or her feelings about it or expressing approval or disapproval. Since another person's personal preference cannot be challenged or disputed, disagreements about moral or ethical truths are not possible (Botes, 2000b; Harder and Scott, 2005; and Rachels, 2003).

Emotivism represents the second stage of Ethical Subjectivism as a theory. Moral statements or judgments are the means by which people try to influence the attitudes and conduct of other people (Harder and Scott, 2005; and Rachels, 2003). Any factual declaration that an individual believes will influence behaviour or change attitudes constitutes a reason that supports or challenges a moral judgment. According to Rachels (2003), though, not all facts constitute legitimate reasons for or against a moral judgment; the fact must be relevant. Emotivism therefore cannot accommodate reason in ethics and cannot provide guidance for ethical behaviour, nor can Ethical Subjectivism.

Psychological Egoism and Ethical Egoism.

In Psychological Egoism all behaviour is motivated or prompted by personal interest. According to Rachels (2003), Psychological Egoism uses a strategy of reinterpreting motives. As soon as the premise that all behaviour is motivated by self interest is accepted then even altruistic behaviours can be reinterpreted and a selfish motive substituted. The flaw with this argument is that people are motivated to act from other motives, and sometimes from plural motives at the same time. Rachels discusses the example of Raoul Wallenberg, a Swedish diplomat. Wallenberg disappeared after giving passes to thousands of German Jews in World War II, permitting them to enter Sweden and escape the Nazis. His behaviour may be interpreted as self-interested (i.e. seeking a sense of purpose) under Psychological Egoism, but few people would consider him selfish (Rachels, 2003).

While morality requires people to balance their personal interests with the interests of others, no one can be faulted for attending to their needs (Rachels, 2003).

Ethical Egoism, however, states that everyone should pursue his or her own interests exclusively, without regard to others and distinct from pleasure or desire. In other words, people only have a duty to do what is best for them.

Rachels (2003) presents three arguments supporting Ethical Egoism: a) altruism is self-defeating; b) Ayn Rand's argument that providing assistance, or altruism, to an individual leads to a denial of his or her value; and c) Ethical Egoism may be interpreted in a way that is compatible with common sense morality (e.g. the Golden Rule, the duty to not harm others or lie, and the duty to keep promises).

Ethical Egoism cannot realistically guide behaviour, though, because it cannot handle conflicts of interest. It does not support helping others, a value inconsistent with disability management. It is logically inconsistent and unacceptably arbitrary (Rachels, 2003). For example the theory divides people into two groups, our selves and the rest of the world. It permits the interests of one group (our selves) to be favoured over another, which Rachels objects to in a system of morality. Moreover, the concept that people are always degraded when they are made the objects of assistance ignores our societal obligation to help certain people, especially children and oppressed minorities who have neither the opportunity nor the means to help themselves.

Religion as a Theory of Moral Philosophy.

As a theory of moral philosophy, right or wrong is defined in religion by a supreme being. The divine command theory holds that a moral action “is right if God commands it, wrong if God forbids it” (Rachels, 2003, p. 50). Harder and Scott (2005) criticize this premise by arguing that such moral directives are subjective or random.

The theory of natural law is another ethical theory applicable to religion. Natural law describes both the purpose of things, and how they should or ought to be. Our world and all the natural phenomena within it are part of a rational system with inherent values and purposes. In other words, all things have a purpose in nature and a place within a hierarchy (Harder and Scott, 2005; and Rachels, 2003). When something does not serve its natural purpose then it is unnatural, even morally wrong. Harder and Scott (2005) suggest that natural law theory is too simplistic because many things exist in nature for more than one purpose. They disagree with the premise that if something exists in nature that is the way it should be. Natural phenomena are not always fair, ordered or right.

Although effective for many people, as a theory of moral philosophy religion has a couple of limitations. First, different religions have different moral codes or definitions of right and wrong. The moral codes of some religions are more proscriptive than others. This means that consistency in ethical decision-making within an organization or a discipline like disability management, for instance, is not possible if individuals use moral codes from different religions. Second, those moral codes may or may not be sufficiently explicit to provide ethical guidance. Third, not everyone uses religion as a moral compass.

Social Contract Theory.

Social Contract Theory was developed in the 16th and 17th centuries by Hobbes and others. For people to thrive they must live in a society with social order, but social order is impossible unless people agree to abide by a set of rules. To escape social chaos (called the state of nature) and gain the benefits of living in a stable society, in ancient

times people agreed to certain moral rules and to the enforcement of those rules by an institution (i.e. government) (Rachels, 2003). Called the social contract, it is not an actual contract but is implied. Present day citizens are considered to agree because they participate in society and partake in the benefits of social living. Accordingly “morality consists in the set of rules, governing how people are to treat one another, that rational people will agree to accept, for their mutual benefit, on the condition that others follow those rules as well” (Rachels, 2003, p. 145).

Social Contract Theory is useful for analyzing societies and their institutions, but is inadequate when applied to disability management. As persons with severely impaired intellect and animals are not capable of rational thought they cannot participate in the social contract and are not held to it. We in turn have no responsibility to them, something with which most people would disagree (Rachels, 2003). Were Social Contract Theory widely accepted among employers, disability management programs would be limited to people able to participate in the social contract. Persons with severe mental illnesses or impairments would not be eligible for disability management services.

Although it is unclear if Hobbes and other social contract theorists would agree, to stay relevant the social contract must evolve. Social Contract Theory was developed at a time when Western society did not have complex employment relationships, nor an infrastructure to care for people with profound disabilities. If the social contract is capable of evolving, it could be adapted to the microcosm of the modern workplace where it would have relevance to disability management. The new social contract would be: Workers agree to provide labour to employers who in return agree to provide wages,

benefits, a safe place to work, as well as disability management and other services should employees become injured or ill. Sounds remarkably like labour relations.

Utilitarianism.

Utilitarianism was developed by Jeremy Bentham and John Stuart Mills in the 18th and 19th centuries. Like Kantian Ethics and the Ethics of Justice, Utilitarianism is a rule based theory based not on a set of rules but on a single rule, utility. The standard by which actions are assessed is the happiness, or utility, of all. According to Bentham's Principle of Utility, whenever a choice is to be made between more than one social policy or action, that which maximizes the greatest utility for the greatest number of people must be chosen (Rachels, 2003). Unlike Kantian Ethics and the Ethics of Justice, in classic Utilitarianism actions are judged solely by their consequences hence its classification as a teleological moral theory. Simply stated, the end justifies the means.

Utilitarianism is commonly found in the public policy realm where cost-benefit analyses are used to assess social and other programs. In disability management programs, budget is always a consideration. Utilitarianism helps employers choose those cost-effective services shown to have the greatest benefit for the largest number of employees. In addition, Utilitarianism directs disability management program managers to consider outcomes in program evaluation.

Utilitarianism has several significant flaws. Foremost is its incompatibility with the concept of justice. Utilitarianism permits interference with basic human rights in pursuit of the common good. In a return to work context, it may conflict with an employee's rights under the duty to accommodate. For example, if an accommodation

requires co-workers to take on physically strenuous duties normally performed by the injured worker, Utilitarianism would disallow the accommodation if it resulted in less utility for the co-workers.

Second, Utilitarianism cannot consider past behaviour or facts, but can only consider the future consequences of an action. Third, Utilitarianism maintains that common sense cannot be trusted because it incorporates prejudices and irrational elements absorbed from the moral actor's family, society, and religion. Stein (2002) inadvertently demonstrates a fourth flaw; utility is a subjective concept. He assumes that persons with disabilities have less utility or happiness than persons with few or no impairments. He would therefore prevent them from accessing scarce resources within a program because he assumes they will receive less welfare, utility, or benefit from the resource than an employee with fewer or no impairments. Stein's assumption is erroneous because many persons with disabilities lead productive and enriched lives. Policies in disability management and other programs should not be based on such subjective definitions and assumptions.

Finally, Utilitarianism is inflexible. It can only consider the utility of the organization, community, or society at large, and not the utility of minorities or individuals. If a particular scarce resource will provide a significant benefit to a small number of individuals within a disability management program, Utilitarianism will not permit those individuals to access the resource if it would benefit a different but larger group of people, albeit to a lesser degree. Utilitarianism also cannot countenance programs adapted to workers' individual needs. It is consequently an impractical

theoretical foundation for disability management programs because such programs must tailor return to work plans to each employee's circumstances.

In summary, all the major traditional ethical theories have been reviewed and found wanting. Each has considerable weaknesses that prevent it from being a complete theory of ethical behaviour (Harder and Scott, 2005; and Rachels, 2003). Of these only Kantian Ethics and the Ethics of Justice, the Ethics of Care and Feminist Ethics, Religion, and Utilitarianism provide guidance for ethical behaviour. The other theories are unsuited to disability management or, due to the manner in which they are constructed, cannot guide behaviour.

Beauchamp and Childress' Ethical Principles

Kantian Ethics and Utilitarianism predominated ethics in the health care professions until bioethicists Beauchamp and Childress proposed an approach that applies a set of principles to ethical situations (Pinch, 1996). Since 1979 their principles have had considerable influence in health care. The authors deliberately eschew traditional ethical theories because most use a top-down approach in which rules derived from theories are applied to ethical situations (Beauchamp and Childress, 2001). They criticize this approach by disputing the precedence major ethical theories exercise over "traditional practices, institutional rules, and case judgments." (2001, p. 386). They also argue that real life ethical situations do not always neatly correspond to a linear top-down approach.

Beauchamp and Childress developed their ethical principles from cultural morality, norms and medical practices in Western society. Four major principles,

autonomy, beneficence, nonmaleficence, and justice were developed as guidelines for decision-making and ethical behaviour (2001). Additionally they discuss the ethical concepts of veracity, fidelity, trust, conflicts of interest and privacy.

Autonomy, the first principle, “refers to respect for individuals and their right to make decisions about matters that directly affect them” (Jodoin, 2004). It encompasses the "right of self determination, independence, and freedom" (Bailey, 2002, p. 28).

Autonomy is composed of two essential components: a) liberty, the ability to make decisions free from undue outside influences; and b) agency, the capacity to make decisions and carry them out (Beauchamp and Childress, 2001). As may be inferred from agency, autonomy is not absolute. Individuals have decision-making capacity if they:

- Understand all relevant information to their care,
- Formulate values and goals to guide decision-making,
- Use reason in decision-making, and
- Communicate their understanding of the information and their decision

(Burkhardt and Nathaniel, 2002).

In the nursing and bioethical literature, informed consent is derived from autonomy. It is defined as the:

Process by which patients are informed of the possible outcomes, alternatives, and risks of treatments, and are required to give their consent freely. It assures the legal protection of a patient's right to personal autonomy in regard to specific treatments and procedures (Burkhardt and Nathaniel, p. 45, 2002).

Informed consent requires two components, information and consent (Beauchamp and Childress, 2001; and Burkhardt and Nathaniel, 2002). First, sufficient information must

be disclosed and the individual must comprehend the information, implying decision-making capacity or competence in the individual. Second, consent must be voluntary and requires that the individual be free to choose or reject alternatives. In other words the individual must voluntarily give consent free of undue influence from family or care givers. While the care giver may make suggestions, these must not cross into coercion. Consent also requires the individual to authorize implementation of the chosen alternative.

The second principle, beneficence, “refers to a moral obligation to act for the benefit of others” (Beauchamp and Childress, 2001, p. 166). It is comprised of a positive duty to assist other individuals in the determination of their rightful and justifiable interests, including the protection of their rights. According to Bailey, “beneficence requires that the patient be approached in a holistic manner, respecting his beliefs, feelings, and wishes (Aitken & Catalano, 1994)” (2002, p. 28). Mercy, humanitarianism, charity, altruism, kindness, and love are considered expressions of beneficence (Bailey, 2002). Beneficence is not to be confused with paternalism, in which health care professionals make decisions on behalf of an individual. Even if accompanied by good intentions, paternalism interferes with autonomy.

Originating from physicians’ Hippocratic Oath, nonmalfeasance entails the obligation to do no harm to other persons, whether intentional or not (Bailey, 2002). Unlike beneficence it is a negative duty, or a prohibition from action. The following statements illustrate the distinction between nonmalfeasance and beneficence:

Nonmalfeasance

1. One ought not to inflict evil or harm.

Beneficence

2. One ought to prevent evil or harm.
3. One ought to remove evil or harm.
4. One ought to do or promote good. (Beauchamp and Childress, 2001, p. 115).

Conflicts between nonmaleficence, and beneficence or autonomy are common in disability management. For example a worker choosing an inferior treatment alternative may present a conflict of ethical principles for a DMC (Bailey, 2002).

The fourth principle, justice, encompasses the twin duties of equality and fairness (Jodoin, 2004). Justice is both a right and an obligation. It is the obligation to treat others fairly and equitably. It is also the right of all persons to equal treatment without regard to marital status, gender, diagnosis, socioeconomic status, religion, and race (Bailey, 2002). I suggest equal treatment encompasses the grounds of sexual orientation, ethnicity, age, family status, and disability as well. Naturally, justice has its origins in Kantian Ethics. Distributive justice refers to the fair and equitable distribution of services, goods, and resources within the context of a society, organization, or program (Burkhardt and Nathaniel, 2002). "Its scope includes policies that allot diverse benefits and burdens, such as property, resources, taxation, privileges, and opportunities" (Beauchamp and Childress, 2001, p. 226). In the distribution of resources it takes into account such factors as equal shares, need, individual efforts, contributions, and merit (Beauchamp and Childress, 2001).

Fidelity is an amalgam of the principles of justice, autonomy, and the concept of utility. It is defined as "the obligation to act in good faith to keep vows and promises, fulfill agreements, maintain relationships, and discharge fiduciary responsibilities."

(Beauchamp and Childress, 2001, p. 312). In other words, fidelity is the obligation to be faithful and loyal. Fidelity requires loyalty to the moral actor's colleagues and profession, meaning the professional must uphold the standards of practice and codes of ethics and maintain the occupational competency requirements of the profession. Fidelity also requires loyalty to the cared for person. Although conflicts of interest are discouraged by the concept of fidelity, professionals may find themselves in a conflict of interest, or divided loyalties, in situations where they owe fidelity to more than one party (i.e. third parties, institutions, and the cared for person). In acute situations divided loyalties produce contradictory moral duties, the reconciliation of which can only be achieved by altering one loyalty or giving it up entirely (Beauchamp and Childress, 2001).

I suggest disability management requires loyalty foremost to the worker due his or her vulnerability. Injured and ill workers are vulnerable because they:

- Face a power imbalance in the employment relationship and have access to fewer resources than the employer with which to equalize the imbalance,
- Risk re-injury and prolonged recovery if the accommodation is not tailored to his or her functional abilities and limitations, and
- Risk impecuniosity if the return to work fails and they lose their job.

Applying Beauchamp and Childress's reasoning (2001) to disability management, the duty of fidelity requires a DMC to give precedence to a worker's interests in two ways: a) the DMC must divest her or himself of any personal interests that clash with those of the worker; and b) the DMC must prefer the worker's interests over others (e.g. the employer, insurer and coworkers).

Veracity arises out respect for the person. It consists of a positive obligation to tell the truth, and a negative obligation not to deceive or mislead (Bailey, 2002). Veracity is compromised when false information is disclosed, but may also be compromised by omitting critical information that creates an erroneous impression of the facts. Although not counted among their formal ethical principles, Beauchamp and Childress link veracity to fidelity and autonomy (2001).

Trust is another ethical concept enunciated by Beauchamp and Childress. Annette Baier characterizes trust as a “reliance on others' competence and willingness to look after, rather than harm, things one cares about which are entrusted to their care” (Peter and Morgan, p. 5, 2001). Trust is closely related to veracity because it utterly depends upon veracity (2001). Trust must be earned (Jodoin, 2004) and veracity is one of the means by which it is earned. In disability management, as in the health care sector, relationships between the care giver (i.e. the DMC) and the cared for person (i.e. the worker) are fostered and maintained through trust. Trust is also critical in the DMC's relationship with employer and union representatives, and with colleagues.

Although not an ethical principle, Beauchamp and Childress argue that the protection of confidentiality and privacy of individuals is justified by the principle of autonomy and associated concepts of trust and fidelity (2001).

Beauchamp and Childress' ethical principles and related concepts assist health care professionals in the assessment of ethical situations and the selection of an appropriate course of action. In any ethical situation, however, more than one ethical principle or concept may be breached. For example the behaviour of a DMC who chooses not to advise a worker of relevant information or to involve him or her in return

to work decisions is more than paternalistic. In spite of worthy motives, the behaviour may contravene:

- The worker's autonomy if his or her decision-making authority has been denied,
- Veracity if the professional has misrepresented the truth through acts or statements of omission or commission, and
- Nonmaleficence if harm comes to the worker as a consequence of the decision or withheld information (Jodoin, 2004).

Where several ethical principles or concepts are invoked, they must be balanced against each other to reach a decision (Beauchamp and Childress, 2001). This balancing act is made more difficult because the authors insist that no single principle has precedence over another. The main weakness of Beauchamp and Childress' ethical principles and concepts, therefore, is an inability to guide moral actors in a conflict between two or more ethical principles or concepts.

Ethics Literature in Disability Management

Only two works have been published in the academic literature on ethics in disability management. Rogers (2002) briefly discusses ethics and ethical decision-making models in Dyck's text (2002). Harder and Scott's (2005) work contains a chapter discussing different ethical theories and an ethical decision-making model. In addition an ethics course developed by the author is offered by Grant MacEwan College (Jodoin, 2004), but is only available to students of the Disability Management in the Workplace Certificate Program.

Ethical Decision-Making Processes and Organizational Factors Influencing Decision-Making

Ethical decision-making involves a “complex interaction between the individual, organization and the issue” (Beu, Buckley, and Harvey, 2003, p. 90). According to Beu, Buckley, and Harvey, “ethical dilemmas are difficult to solve because they are not black-and-white issues - ethicality is not a categorical variable” (2003), p. 103). Their research, which tested an ethical decision-making model based on accountability, showed that ethical decision-making is a function of "individuals' thought processes (cognitive moral development), personalities (locus of control, hostility and aggression, Machiavellianism), and gender" (Beu, Buckley, and Harvey, 2003, p. 102). They conclude that employees can be trained to make better ethical decisions.

People bring their personal and professional values, education and training, life experiences, emotions, religious, cultural and societal influences, and the facts of the situation to bear when faced with an ethical issue. Accordingly judgment, organizational factors, and emotion are important in decision-making.

Luntley (2003) confirms that judgment is critical in ethical decision-making. Ethical decision-making takes place in a multifaceted business environment in which the consequences of decisions are frequently uncertain. In an objectivist orientation to moral uncertainty, uncertainty is removed through discovering, learning and then applying a set of rules to ethical situations. Unlike an objectivist orientation, a realist orientation recognizes ethical uncertainty as a property of the business environment that is eliminated only through the application of judgment. Luntley discusses the role of judgment versus reliance upon rules in ethical decision-making, and concludes that reliance on rules alone

is insufficient to eliminate ethical uncertainty. Competent ethical decision-making does not require the application of rules to a particular situation; a general set of rules are valuable, but once developed are not of much assistance in individual situations. Instead, ethical decision-making requires judgment. He defines judgment as a cognitive skill set perceptual in nature and through which the individual focuses on details and monitors the business environment. The individual must have the “capacity to attend to the particulars and make judgments of similarity and dissimilarity from which a patterned behavior will emerge” (Luntley, 2003, p. 331). Luntley therefore advocates a realist orientation to ethical uncertainty and the use of judgment.

Like nurses (Keatings and Smith, 2000), DMCs are influenced by many conditions in their ethical decision-making: past experience; perceived possible consequences; societal beliefs and values; personal and professional values and beliefs; relationships with the people affected; and the situation (Keatings and Smith, 2000). As employees, DMCs will be influenced by the organizational context within which they work.

Vitell and Paolillo’s research offers insights into the role of organizations in ethical decision-making (2004). They compare the relationship of corporate culture on ethical decision-making to the larger culture in which an individual finds him or herself, and conclude:

Personal and organizational factors have such an impact on perceptions regarding importance and social responsibility. These results tend to highlight the important role that the organizational (micro-culture) culture plays in ethical decision-

making regardless of the more macro-culture (i.e. country) that one is operating within. (Vitell and Paolillo, 2004, pp. 194-195)

An organization's commitment, perceived strong values, ethical climate, and enforcement of a formal code of ethics were also found to be significant in daily ethical decision-making by employees (Vitell and Paolillo, 2004). This is consistent with findings reported by Patterson that "organizational factors, such as philosophy, expectations, policies, and supervision, often exert greater influence over ethical/unethical decisions than individual factors, values, past experiences, knowledge, and attitudes" (1989, p. 44). Crowley (2002) would agree.

The role of emotion and intuition is acknowledged as having a place in ethical decision-making by Feminist Ethics and the Ethics of Care. Emotion functions to alert the moral actor to the presence of dilemmas and assists in the assessment of solutions. Hill, Glaser, and Harden's ethical decision making model (1995), developed for feminist therapy, incorporates emotion into ethical decision making. Burkhardt and Nathaniel's ethical decision making model also considers the emotions of moral actors and how the decision affects them (2002).

Ethical Issues

In order to identify potential ethical issues raised during the interviews, I reviewed the academic literature of professions in which the roles of the professional and client are similar to the roles of DMC and employee. In their discussion of ethical issues in feminist therapy, Rave and Larsen (1995) identify issues of power imbalances, dual roles, emotion and intuition, and cultural diversity. Foye, Kirschner, Wagner, Stocking

and Siegler (2002) discuss the most frequent ethical issues experienced by occupational therapists, including patient refusal of treatment recommendations, terminating or withholding treatment, the patient's role in decision-making, goal setting conflicts, patient rights, and veracity. In Vogel Smith's study of ethical decision-making in nursing, a perceived lack of power to make decisions, or decision-making autonomy, was commonly identified as a barrier to ethical decisions (1996).

Strategies and Practical Approaches for Ethical Decision-Making

I reviewed several codes of ethics and standards of practice in disability management because they represent formal tools for decision-making available to DMCs (Canadian Association of Disability Management Coordinators, 2003; Canadian Association of Rehabilitation Professionals, 2003; Certification of Disability Management Specialists' Commission, 2005; National Institute of Disability Management and Research, 1999; National Institute of Disability Management and Research, 2000).

The academic literature in disability management and other professions was reviewed for practical strategies that might be used by DMCs to identify and resolve ethical dilemmas. Several ethical decision-making models in disability management and other disciplines were critically reviewed.

In disability management the Canadian Association of Rehabilitation Professionals' model, see Appendix F, recognizes that rehabilitation professionals such as DMCs make ethical decisions within the context of an organization, requiring the professional to evaluate the organizational processes that gave rise to the dilemma and

how they might be changed (2003). It does not, however, consider the loyalties, values, rights, and obligations of the parties. Nor does it incorporate emotion, ethical theories or principles.

In nursing Burkhardt, and Nathaniel's model (2002), set out in Appendix G, considers the emotions of the parties and asks the professional to assess the values, responsibilities, rights and perspectives of the key participants.

In workers' compensation, the reasonable person, credit and values tests of the Workers' Compensation Board-Alberta (2008) form part of a formal ethics program described in Appendix E, and may readily be applied in most situations.¹ On the other hand their value may be limited in complex situations.

Finally Hill, Glaser, and Harden (1995) advocate a decision-making model for feminist therapy, set out in Appendix H, that takes into account power imbalances, dual roles, emotion and cultural diversity. In my opinion, however, the decision-making model places too much emphasis on emotion and intuition.

¹ The Ethics Program at the Workers Compensation Board-Alberta (hereinafter referred to as "WCB-AB") was developed in 2000. The program consists of five components described in Appendix E. The author is a WCB-AB employee and was an Ethics Committee member from 2005 – 2008.

Chapter III

Method

The absence of prior research on ethical decision-making in disability management means no theoretical models are available to explain DMC's decision-making behaviour, or to generate a hypothesis using a deductive approach. This research is therefore exploratory. A qualitative study using an inductive approach was chosen. In addition, the study is phenomenological in nature, as DMCs were asked during interviews to make sense of ethical situations they encountered.

The key assumption in the research is the acceptance of participants' testimony at face value. No questions or tests were devised to verify the congruity of participants' statements with their actual decision-making processes. If participants said they identified dilemmas, made decisions, resolved dilemmas in a certain way, or used certain decision-making strategies, they were taken at their word. The assumption is necessary because the research is trying to uncover participants' internal decision-making processes. It is also reasonable considering the research's exploratory nature.

The methodology of the study consists of:

1. Defining key terms,
2. Determining the study's participants,
3. Determining a method of inquiry to collect the data,
4. Collecting the data through participant interviews,
5. Topic coding the data,
6. Analysing the data, including axial or theoretical coding,
7. Determining key findings, and

8. Developing theoretical constructs.

Topic coding, axial coding, also known as theoretical coding, and data analysis will be informed by the ethical theories and principles reviewed in Chapter II.

Key Terms

The following terms are essential to the research question and to this thesis in general. They are defined as follows:

1. **Codes of Ethics:** Sometimes called codes of conduct, codes of ethics represent the written goals and values of a profession, and are aimed at guiding professional behaviour (Jodoin, 2004). In disability management codes of ethics are aspirational and not enforceable, as DMCs are not required to belong to a professional association or meet certain education or training requirements (Canadian Association of Disability Management Coordinators, 2003; and Canadian Association of Rehabilitation Professionals, 2003). Some DMCs belong to mandatory professional associations, however, such as chartered psychologists and occupational health nurses (hereinafter referred to as OHNs).
2. **Decision-Making Capacity:** The Burkhardt and Nathaniel (2002) definition referred to in Chapter II will be used.
3. **Disability Management:**

A proactive process that minimizes the impact of an impairment (resulting from injury, illness or disease) on the individual's capacity to participate competitively in the work environment. . . . Disability management

strategies and interventions are focused on three basic objectives: (1) reducing the number and magnitude of injuries and illnesses, (2) minimizing the impact of disability on work performance, and (3) decreasing lost time associated with injuries, illnesses, and resulting disabilities (Shrey, 1998, p. 390).

4. Disability Management Coordinator: An individual who works for an organization, union, or a private consulting firm, and who coordinates the return to work of employees absent due to injury or illness, whether work-related or nonoccupational. The DMC facilitates return to work in collaboration with the employee and other stakeholders (e.g. supervisor, union representative, health care provider). For the purpose of this study, the participants must perform return to work functions for a significant portion of their job.
5. Ethical Situations: Consist of four types (Alberta Association of Registered Nurses, 2003):
 - a. 'Ethical Violations' occur when an individual neglects professional obligations;
 - b. 'Ethical Distress' occurs when professionals do not or cannot practice ethically due to events beyond their control, or make errors in professional judgment;
 - c. 'Ethical Uncertainty' occurs when professionals fail to identify an ethical situation, or cannot tell which ethical values or principles to consult when making a decision; and

- d. Ethical Dilemmas, which will be defined shortly.
6. Values: “Values are ideals, beliefs, customs, modes of conduct, qualities, or goals that are highly prized or preferred by individuals, groups, or society” (Burkhardt and Nathaniel, 2002, p. 67). Furthermore “values are our fundamental beliefs and principles. They define what we think is right, good, fair, and just” (Salopek, 2001). Values are acquired through interaction with significant others (e.g. parents and other family members, friends), communities, (e.g. religious, school, ethnic, geographic location), through immersion within society, and may be affected by gender (Keatings and Smith, 2000).
7. Standards of Practice: Standards of practice exemplify the values contained in a profession’s codes of ethics. They set out expectations and stipulate the core skills, training and education, and occupational competencies required by the profession. Furthermore, they signify the criteria by which a professional is measured or judged (Alberta Association of Registered Nurses Code of Ethics, 2003; and Jodoin, 2004).

Ethical dilemmas have been defined as a conflict between ethical principles (Hill, Glaser and Harden, 1995), “conflicting moral claims” and “equally unsatisfactory alternatives” (Davis, Aroskar, Liaschenko, and Drought, 1997, p. 6), or between equally convincing rationales for or against a specific option (Alberta Association of Registered Nurses, 2003). In my opinion these definitions do not define an ethical dilemma per se, but more accurately describe the conditions in which a dilemma arises. I prefer a definition that describes a dilemma as a decision point. In other words an ethical

dilemma is a decision to do or not do a certain thing or take a certain course of action.

For the purpose of this dissertation, therefore, an ethical dilemma will be defined as: A decision point to take or not take a certain course of action which arises from conflicting moral claims or ethical principles, equally unsatisfactory moral alternatives, or equally convincing rationales for or against a moral alternative.

Participants

Purposive sampling of participants, a form of nonprobabilistic sampling (Palys, 2003; and Seale, 2004), was chosen for two reasons: a) the population of DMCs in Alberta is not known and it is therefore not possible to generate a random sample using a sampling frame; and b) purposive sampling is especially suited to qualitative inductive exploratory research. Due to the heterogeneity of the DMC population in their education and working environments the participants were chosen according to six criteria. They:

1. Meet the definition of a DMC,
2. Practice in one of the following types of organizations:
 - a. A private sector employer carrying on business in a commercial or industrial setting,
 - b. A public sector employer,
 - c. A labour organization, or
 - d. A private consulting firm that performs disability management services for individual employers on a fee for service basis,
3. Live and work within Alberta,
4. Are individuals with whom I have a prior professional relationship. The

number of DMCs in Alberta is small, making it difficult to find sufficient unknown participants. In addition, a prior relationship has two advantages.

First, participants readily agreed to participate in the interview. Second, participants' candour was enhanced due to a previously established rapport,

5. Have a minimum of two years experience in disability management. They would be an "old hand" (Palys, 2003, p. 143). Participants with less experience may not have been exposed to many ethical situations and thus have less thoughtful responses, and
6. Be selected from a variety of professional backgrounds, including occupational health nurses as many experienced DMCs in Alberta are also occupational health nurses.

Method of Inquiry

For this study field observation was not used because the nature of the phenomenon, ethical decision-making, is an internal process and cannot be observed. The method of inquiry consequently consisted of unstructured face to face interviews with nine DMCs. The emphasis was on data collection, as opposed to data generation. The interviews followed a topic guide, set out in Appendix D, that included closed questions to gather demographic data on several variables (e.g. type of organization employed in, education, years of work experience in disability management, and professional affiliations), and open ended questions. The majority of each interview was spent discussing the open-ended questions and allowed participants to explore the subject as they wished.

Analysis of the data was aided by the qualitative data analysis software, NVivo8. The software kept track of more than 200 different topics, or nodes, discussed by participants. As relationships began to appear between the nodes, particularly during the axial or theoretical coding stage, the software readily allowed manipulation of the data (e.g. assignment, sorting, and merging into tree nodes). It generated: a) reports showing everything participants said on a particular topic; and b) charts showing what percentage of an interview a participant devoted to discussion of a subject. It also provided a tool with which I was able to draw a visual model to explain the formation and resolution of ethical dilemmas, discussed in Chapter V. These features clearly facilitated my analysis of the data.

Chapter IV

Results

Introduction

In this chapter, I will describe the participants as a sample and discuss their responses to the following questions:

- How do disability management coordinators identify ethical situations and dilemmas?
- What ethical situations and dilemmas do disability management coordinators experience?
- What challenges and barriers obstruct, and what factors facilitate ethical decision-making in disability management?
- How do disability management coordinators resolve ethical dilemmas and what ethical decision-making tools and strategies do they use?

I will also identify common themes and a couple of issues not found in the data.

Sample

Nine participants were interviewed between February 7 and April 8, 2006.

Interviews took place in restaurants, offices, and my home. Individuals were pre-screened to select participants who, as part of their job, perform the functions of a DMC at least part of the time. One participant, however, disclosed at the start of the interview that he did not facilitate return to work. I nonetheless proceeded with the interview and transcribed it, but later excluded his data in my analysis as his disclosure meant he did not meet the definition of a DMC.

Of the remaining participants, seven are female and one is male. This is consistent with the DMC population, which is predominately female. To safeguard participants' anonymity, I assigned them pseudonyms: Jeanette, Karen, Leanne, Margaret, Monica, Paul, Roberta and Ruth. While I will be describing the occupations and industries of the participants shortly, I will not attach specific industries to individual participants. Attaching an occupation and industry to specific participants risks their anonymity; although the population of DMCs in Alberta is unknown it is small.

At the time of the interviews participants collectively had more than 118 years of experience facilitating return to work, ranging from five to 27 years. Participants had an average of 14.75 years of experience.

Participants included three current or former Workers' Compensation Board-Alberta (hereinafter referred to as WCB-AB) case managers, two OHNs, two union representatives, and a psychologist. Five participants currently have responsibility for the delivery of a disability management program and perform the functions of a disability management professional as defined by the National Institute of Disability Management and Research (2004), in addition to return to work facilitation. Including the union representatives, six participants had facilitated return to work in a unionized work environment at some point in their career.

The range of industries in which participants facilitated return to work was highly diverse. Participants currently work in, or had previously worked in, several private sector industries (i.e. disability insurance; industrial construction; manufacturing; meat-packing; mining; property management; oil and gas refining; steel manufacturing and recycling; and transportation) and several public sector industries (health care; municipal

government; secondary and post-secondary institutions; telecommunications; transportation; and workers' compensation). In addition two participants had prior experience as a private consultant.

The educational background of participants includes bachelor or masters degrees in nursing, arts, education, sociology, physiotherapy, rehabilitation, and psychology. One or more participants are certified in human resources, licensed practical nursing, registered nursing, occupational health nursing, occupational health and safety, or as a Canadian Certified Rehabilitation Counselor, or Certified Disability Management Professional. The professional affiliations of participants include the Alberta Occupational Health Nurses Association, Canadian Association of Rehabilitation Professionals, Canadian Nurses Association, Canadian Occupational Health Nurses Association, and the College and Association of Registered Nurses of Alberta.

Seven participants have prior training in ethical decision-making.

The participants' years of experience, diversity of industries, occupations, and educational backgrounds contribute to the validity and reliability of the study's results. Due to the small sample size it is difficult to make generalizations that have much reliability based on gender or on any subsets of participants. For example the OHN and the union representative subsets consist of only two individuals each, too small to draw any conclusions. For descriptive purposes, however, I assigned participants into one of two types, occupational DMCs and union DMCs. The types are distinguished by two factors, who they work for and whether they perform disability management functions exclusively. The occupational DMCs in this study work for, or if an independent consultant are contracted by, the same employer that employs the injured or ill worker at

the centre of the return to work process. They generally do not perform other duties.

Union DMCs, on the other hand, are employed by the union that represents the injured or ill worker. In context of their return to work responsibilities their focus is on the worker and collective agreement. While some union DMCs concentrate exclusively on disability management functions, in this study the union DMCs carry out functions besides return to work facilitation, such as collective agreement monitoring and enforcement.

How do Disability Management Coordinators Identify Ethical Situations and Dilemmas?

Participants' responses show they use multiple strategies, both informal and formal, to identify ethical situations. The use of one strategy does not preclude the use of others.

The overwhelming majority, seven out of eight participants as per Table 1, use intuition or emotion to identify ethical situations. For these participants recognition of an ethical situation is an internal event. One participant describes it as subconscious process, another as a gut feeling. Still others describe it as an uncomfortable feeling, "when something doesn't sit well with you" as Karen put it, or "it's not quite right" as Ruth explained. Another continuously asks herself why she does not feel comfortable.

One participant, however, did not use an internal process or emotion to identify ethical situations. For her recognition of dilemmas comes through the contravention of rules. She is not alone in the use of formal rules to identify ethical situations. Half of participants use the contravention of rules, most of whom also use intuition. They refer

to a broad range of rules such as collective agreements, legislation, law, policies, procedures, and the codes of ethics and standards of practice of professional associations.

Additional formal tools used by participants include the WCB-AB's ethics program, and professional education and training.

Three participants use informal identification methods such as judgment, logic, common sense, and two use past experience. Roberta described it as an evolutionary process, "it unfolds. It's never usually right in front of my face". Participants use other individuals to assist identification as well. Two participants consult with peers, mentors or role models. For one participant, direct reports come to her with ethical situations.

Table 1

Identification of Ethical Situations and Dilemmas

	Number of participants	Number of references
Informal tools and strategies		
Intuition, emotion	7	9
Common sense, judgment, logic	3	4
Mentors, role models, peers	2	3
Values	2	3
Past experience	2	2
Evolving nature of ethical dilemmas	1	1
Identified by direct reports	1	1
Subtotal	8	23

	Number of participants	Number of references
<hr/> Formal tools and strategies		
Rules	4	10
Professional education	2	2
Ethical decision-making models, guidelines	1	1
Stages and steps in decision-making	1	1
Subtotal	8	14
Total	8	37

To conclude, the most common strategy used by participants to identify ethical situations and dilemmas is emotion and intuition, followed by the contravention of rules. Participants apply multiple strategies to the same situation, but whether strategies are applied simultaneously or sequentially is unclear.

What Ethical Situations and Dilemmas do Disability Management Coordinators Experience?

Six out of eight participants identify access to sensitive information, privacy breaches, and conflicts of interest as the most common dilemmas faced.

By virtue of their position and function within an organization, DMCs have access to sensitive information about workers and employers. According to participants' examples of ethical situations, sensitive information consists of:

- The worker's personal health information,

- Knowledge not directly related to the illness or injury but which may affect the return to work process (e.g. knowledge a worker is working while collecting benefits related to the disability),
- Exclusive knowledge of medical information that may impact entitlements under benefit plans, and
- Knowledge the employer is planning to implement disciplinary action, possibly termination.

As professionals, DMCs have a responsibility to keep certain information private and confidential, particularly the personal health information of injured or ill workers. Confidentiality is an occupational competency of disability management professionals, return to work coordinators (National Institute of Disability Management and Research, 1999 and 2000), and occupational health nurses. Privacy of employees' personal health information is a legal responsibility of employers under federal and provincial privacy legislation.² Moreover, according to the case and arbitral law, employers are not generally entitled to more than fitness for work information and work restrictions when planning employees' return to work (Alberta Government Services, 2005a; Bailey and

² Canadian privacy legislation is based on the *Model Code for the Protection of Personal Information* (Canadian Standards Association, 2005). The applicable Canadian and Alberta privacy statutes are:

Health Information Act, R.S.A. 2000, c. H-5.

Freedom of Information and Protection of Privacy Act, R.S.A. 2000, c. F-25

Personal Information Protection Act, S.A. 2003, c. P-6.5.

Personal Information Protection and Electronic Documents Act, S.C. 2000, c. 5.

Privacy Act, R.S.C. 1985, c. P-21.

Johnson, 2004; and *Ottawa Citizen*, 1996). Although developed later Canadian and Alberta privacy legislation is generally consistent with the case law and arbitration law. In addition, the obligation to keep personal health information private is rooted in Beauchamp and Childress' principle of autonomy and related concepts of trust and fidelity (2001).

DMCs must therefore make decisions about what information may be appropriately disclosed, to who and when, if ever. Possessing confidential information means they are exposed to pressure from other parties to disclose it. Leanne described the ensuing ethical situation as "when you're put in a position where somebody feels they need to or want to know more than the information than I'm prepared to disclose to them". Six participants cite inappropriate disclosure of confidential information, or the struggle to keep information confidential, as examples of ethical dilemmas. Three participants report incidents where the employer asked for the worker's diagnosis and treatment information. Another participant, Roberta, reports a situation in which the disability management program routinely procured psychological assessments of injured or ill workers from the employee and family assistance program, setting it up for potential privacy breaches.

Conflict of interest is another dilemma cited by six participants. These participants experience the divided fidelities or loyalties referred to by Beauchamp and Childress (2001) arising from the principle of fidelity. Examples of conflicts of interest brought up by participants include:

- Having dual clients, (e.g. the worker and employer),

- Combining the disability management program and the employee and family assistance program,
- Inappropriate disclosure of confidential information to a supervisor,
- Supervisors inappropriately intervening in the return to work process,
- A close personal relationship with someone in the workplace, and
- Receiving a gift from a worker.

These situations are thought to create, or have the potential of creating, a conflict of interest or the perception thereof. Furthermore they may result in damage to the disability management program's credibility. As one participant explains, "and it's the optics to boot".

Also frequently mentioned, by five participants, are dual clients. The DMC is in the curious position of having simultaneous responsibilities to the worker and employer. While unusual, a similar dilemma is shared by human resource professionals. DMCs are required to assist the worker's safe return to work while juggling the employer's workplace continuity, productivity, and safety concerns. They must, according to Leanne, balance the employer's need for a quick return to work with the employee's need for a safe and successful return to work. As Jeanette stated, DMCs are "stuck in the middle of making business decisions versus the disability management decisions". These participants experience the divided fidelities or loyalties described by Beauchamp and Childress (2001).

Participants report how conflicts in responsibilities to the employer and the worker arise when the DMC:

- Is asked to share the worker's personal information with the employer or insurer,
- Becomes aware that the employer plans to initiate disciplinary proceedings upon the worker's return to work, or
- Becomes aware that the worker is working while receiving disability benefits.

Of note is that the examples all relate to the possession of sensitive information by the DMC.

In one example a union DMC spoke of how her employer did not support, for financial or political reasons, pursuing a grievance she felt was in the best interests of the worker. In that situation she also had two clients, the worker and the union (as her employer). Yet another DMC referred to the difficulty inexperienced DMCs have maintaining a balance and how they tend to waiver between the interests of the worker and employer.

Five participants received knowledge at some point in their careers of a worker working while collecting benefits related to the disability. Concurrent worker performance issues are cited by half of participants as another dilemma. For participants in these situations, the dilemma consists of the nature of their role in the management of the performance issues.

Table 2

Examples of Ethical Situations and Dilemmas

	Number of participants	Number of references
Access to sensitive information	6	16

	Number of participants	Number of references
Privacy breaches	6	12
Conflict of interest	6	11
Dual clients - employer and worker	5	13
Work performance issues	4	5
Working while receiving disability benefits	4	4
Personal bias against worker	2	3
Lack of knowledge of rules	1	2
Union as employer	1	2
Worker non-compliant with treatment	1	2
Benefit plan structure	1	1
Total	8	71

Table 2 displays the different dilemmas referenced by participants. Access to sensitive information, confidentiality and privacy, and conflict of interest are the most common dilemmas reported by participants, followed by dual clients, work performance issues, and working while receiving benefits.

The categories are interrelated. The relationships between them make discrete categorization difficult because a dilemma as described by a participant may fit more than one category. For example, Paul describes a dilemma in which the employer decided to terminate the worker upon her return to work due to work performance issues.

As the DMC, Paul has access to sensitive confidential information from the employer of the impending termination. Due to his responsibilities to the worker and employer he has dual clients, and the question of whether he should disclose the information to the worker places him in a conflict of interest. If he discloses a breach of confidentiality will result.

His example was therefore coded into several categories:

- Access to sensitive information,
- Confidentiality and privacy,
- Conflict of interest,
- Dual clients, and
- Work performance issues.

Paul's dilemma was not the only example in the data coded into several categories. I found his example to be the rule, not the exception.

Access to sensitive information, privacy responsibilities, and dual clients therefore set DMCs up for dilemmas that may result in a conflict of interest or a privacy breach. If we define a dilemma as a decision point, then access to sensitive information and dual clients are preconditions to dilemmas. Privacy is an obligation or responsibility of the DMC. Work performance issues and working while on benefits may also be defined as preconditions. Conflicts of interest, privacy breaches, and compromised credibility are not truly dilemmas but represent potential consequences of unethical decisions.

What Challenges and Barriers Obstruct and What Factors Facilitate Ethical Decision-Making in Disability Management?

Participants were asked to identify organizational, environmental, cultural, or personal factors that in their opinion obstruct or facilitate ethical decision-making.

The most frequent challenges or barriers to ethical decision-making are organizational, program or environmental factors, reported by 100% of participants. A wide range of organizational challenges or barriers are discussed in this category:

- Benefit plan structure – different plans for different classifications of employees, entitlement rules,
- Collective agreements – cross bargaining unit accommodations, archaic language,
- Information – privacy breaches through inappropriate disclosures to internal or external third parties, and issues of timeliness, quantity, quality that delay return to work,
- Budget - limited budget for return to work placements, mentioned by half of participants,
- Dual clients,
- Employer structure – organizational silos, a bureaucratic decision-making structure, reporting structure, dilution of responsibility and ambiguous lines of accountability,
- Policies – restrictive, black and white, or a lack of policies, and
- Unions – difficulty in securing cooperation for initiating a grievance, mentioned by a union DMC.

Participants also unanimously report personal factors as challenges or barriers to ethical decision-making. Half of participants identify personal DMC characteristics as possible barriers. Obstructive characteristics include a personal bias against the worker, unethical decisions by previous DMCs, a strong need for control, inexperience, inappropriate close personal relationships in the workplace, and a lack of education in privacy legislation, disability management and the duty to accommodate.

Six participants report worker characteristics as potential barriers. Roberta, a union DMC, describes how “some employees are chippy. They're angry. They're angry at their disease. They're angry that they've got restrictions and limitations for the rest of their life, and they're just pissed at the world. Those are hard people to deal with.” In addition to frustration with the illness or injury, participants refer to worker characteristics such as unsatisfactory work performance, conflicts with supervisors, coworkers or DMCs, not being liked in the workplace, inappropriate behaviour, job dissatisfaction and a reluctance to return to work, a lack of skills (particularly literacy and computer skills), and a feeling of entitlement to disability benefits as barriers to ethical decision-making.

One participant referred to an employer bias against the worker as a barrier.

In summary, personal characteristics affecting return to work may be found in the DMC, worker and employer.

Different ethnicities or cultural backgrounds of workers are reported by half of participants. Participants suggest that the behaviour of these workers may not be perceived as intended, that they may have language comprehension difficulties that contribute to

misunderstandings, or that they may have different beliefs (e.g. family dynamics and the treatment of women).

An organization's internal climate or culture is referenced by three participants as a potential barrier to ethical decision-making. These participants spoke of very political organizations, and a mismatch between the ethics of the organization and DMC.

Table 3

Challenges and Barriers to Ethical Decision-Making

	Number of participants	Number of references
Organizational, program, environmental	8	32
Personal	8	28
Ethnic and cultural	4	5
Corporate climate or culture	3	4
Poor past ethical decision-making precedents	2	3
Privacy breaches and inappropriate disclosure	2	2
Total	8	74

In addition to barriers, participants were asked to identify organizational, environmental, cultural, or personal factors that, in their opinion, facilitate ethical decision-making. Like barriers, organizational or program factors are identified by 100% of participants as the most frequent facilitators of ethical decision-making. Participants identify a diverse range of organizational or program facilitators:

- Access to external resources and other tools,

- Benefit program structure,
- Clear lines of accountability in the disability management program,
- Ethical decision-making autonomy,
- Clear written program expectations, outcomes, roles and responsibilities that are communicated to the parties. This factor not only facilitates ethical decision-making, it reduces the risk of unethical behaviour due to ignorance,
- Fair adjudication process,
- Good managers,
- Job banks,
- Legislation,
- Open communication with employer management,
- Organizational structure, including DMC access to other departments' expertise (e.g. human resources, labour relations, legal, wellness, occupational health and safety),
- Standards of practice,
- Supportive personnel or individual management strategies,
- Supportive policies and procedures, mentioned by half of participants, and
- A solid disability management program.

A solid disability management program is described by Ruth as: a) having a clear philosophical purpose aimed at reducing the human and financial costs of disability; b) incorporating ethics training; c) being built on sound disability management principles; d) managing both occupational and nonoccupational injuries; e) taking benefit plans into account; f) having fair adjudication; g) having records management systems; and h)

having policies protecting the privacy of workers' personal health information. For Ruth a solid program facilitates ethical decision-making, and reduces the risk of unethical behaviour.

Half of participants observe that organizational cultures which foster transparency, value employees, and encourage professional development and involvement with professional associations also support ethical decision-making. According to Leanne, "I think in this organization . . . it's the . . . overwhelming demonstration of how they value their employees". Here, participants reinforce Vitell and Paolillo's research (2004) on the importance of organizational culture.

Unionized environments also enhance ethical decision-making. Employer-union collaboration is referred to by three participants. Both union DMCs use collaboration with the employer to facilitate return to work. Additionally, an occupational DMC spoke of how ethical decision-making is facilitated in her organization by: a) her employer's emphasis on the duty to accommodate and its involvement of unions in the development of return to work protocols; and b) the unions' collective agreement monitoring function. Collective agreement language that supports modified work is also identified as a facilitator.

Ethics training is referred to by three participants as a factor that not only facilitates ethical decision-making, but also reduces the incidence of unethical decisions.

Three participants identify DMC qualities that facilitate ethical decision-making, particularly a focus on the interest of the worker and not letting personal biases against the worker interfere with return to work planning. Ironically, the balancing act that

DMCs must perform between the interests of the worker and employer was stated by an occupational DMC, Jeanette, as facilitating ethical decisions.

Objective information or findings is mentioned by two participants as a facilitator. Used as a return to work tool, objective information produces decisions with greater reliability. Karen observes that “objective findings . . . is what we base our decisions on. So . . . you're taking the subjectivity out of . . . the picture. And by doing that, you know, it's a much more solid decision.” Objective findings also help the DMC achieve a balance between the interests of the worker and employer. Any gaps in the facts means the DMC must seek more information, according to Leanne.

Supportive legislation, policies, procedures, and collective agreements are referred to by three participants.

For some participants, facilitators and barriers of ethical decision-making are two sides of the same coin. Two participants report that when certain challenges and barriers are removed (e.g. budget constraints, organizational silos and politics), ethical decision-making is enhanced.

Open communication is identified by two participants as a facilitator of ethical decision-making. One participant felt that clear communication is particularly important when working with workers for whom English is a second language. Another participant emphasizes communication of roles and responsibilities to the parties in the return to work process.

Table 4

Facilitators of Ethical Decision-Making

	Number of participants	Number of references
Organizational, program, environmental	8	37
Corporate climate or culture	4	6
Personal characteristics	4	4
Employer-union collaboration	3	4
Ethics training	3	4
Legislation, policies, procedures, collective agreement	3	4
Objective information	2	3
Communication	2	2
Lack of barriers	2	2
Fair adjudication process	1	1
No personal versus professional ethics distinction	1	1
Standards of practice	1	1
Total	8	69

Only one participant mentions a facilitating factor that may be categorized as environmental. Physically accessible workplaces that accommodate people with mobility restrictions or disabilities are mentioned by Monica.

Asking participants what organizational, environmental, cultural, or personal factors facilitate or obstruct ethical decision-making may have encouraged participants to

respond about cultural factors. During discussion of this question I described cultural factors for participants as those related to ethnicity or an organization's climate. Although half of participants identify ethnicity and cultural differences as potentially obstructing the decision-making, nowhere else during the interviews is ethnicity mentioned. Nor do participants go into much detail in their discussion of ethnicity. This finding raises the possibility that participants would not have mentioned it but for prompting by the question.

To conclude, obstacles to and facilitators of ethical decision-making can be assigned to categories generally within the control of the worker, DMC or employer.

How do Disability Management Coordinators Resolve Ethical Dilemmas and What Ethical Decision-Making Tools and Strategies do they Use?

In this part of the interview I asked respondents two questions: a) how they determine the right course of action, or the right thing to do, when presented with an ethical situation or dilemma; and b) what strategies or tools they use to make ethical decisions. Upon analysis of participant responses, I realized the DMCs responded to the questions in the same way. In other words, the two questions are really the same question. I therefore merged the nodes for the two questions.

Tools and strategies utilized by participants are divided into two categories, formal and informal. Tables 5 and 6 demonstrate how the nodes are categorized and subdivided, showing the breadth of strategies used by participants.

One hundred percent of participants use a process to resolve ethical situations and dilemmas that involves stages or steps. Paul articulated the need for an ethical decision-making process to resolve ethical dilemmas in this way:

No matter which action we take we do compromise one or more of the ethical principles or guidelines. But, but nevertheless, recognizing responsibility in the situation for either the, the individual outcome or the business outcome I still require a process of guiding me through the thinking.

Unlike other tables the total number of references under Stages and Steps in Decision-making Table 5 does not match the individual subcategories because, in several cases, references were coded into more than one category.

Some participants use stages learned through ethics training. For others the stages are adapted from ethics and professional training, or developed separately.

The use of rules as an ethical decision-making strategy dominates participants' discussion. Seven out of eight participants talked about the necessity of identifying relevant rules early in ethical decision-making. Rules are used to identify and resolve ethical situations. According to Karen, "we do have the policies and procedures which really help because it's very definitive of what . . . you need to consider in making a decision." A broad range of rules were cited by the DMCs:

- Codes of ethics of professional associations,
- Collective agreements,
- Policies (e.g. worker's compensation),
- Legislation, (e.g. human rights law and the duty to accommodate, privacy, workers compensation), and

- Standards of practice from professional associations.

Formal ethical decision-making models are used by six participants. They identify models developed by the Workers' Compensation Board – Alberta (2008), Canadian Association of Rehabilitation Professionals (2003), Canadian Nurses Association, the College and Association of Registered Nurses of Alberta, Storch, Rodney and Starzonski (2004), and Redman and Redman.

Half of participants spoke of disability management programs, making a link between solid programs and ethical decision-making. One participant described how a clear philosophical purpose (i.e. reduction of human and financial costs of disability) and solid structure in the disability management program reduces the risk of unethical decisions. Two participants, consisting of occupational DMCs, talk about a focus on the interests of workers and their return to work. Another participant spoke about how DMCs' ethical decision-making is enhanced when an organization values its employees.

In the context of discussing tools and strategies for resolving ethical dilemmas, half of participants highlight the necessity of clear roles and responsibilities in a disability management program, and educating the parties in those roles and responsibilities. Providing education about roles, responsibilities, and rules prior to the return to work process reduces the risk of ethical situations. According to Monica, it is important to be:

Up front with the [worker] at the very beginning of your contact with them in explaining to them what their actual responsibilities are and what could jeopardize their benefits etc. and their qualification for certain levels of care. So what we try and do is make sure that we, we don't run into those kinds of situations as much by doing some education up front.

Five participants assess the consequences of potential options. Participants look at the various options and determine the pros and cons. They look at the impact or outcomes of the options on the organization, themselves, and the worker. In addition, they assess whether the option represents a win-win situation for the parties involved in the return to work process.

In a related category, two participants specifically refer to the use of logic and judgment in decision-making.

Table 5

Formal Tools and Strategies for the Resolution of Ethical Situations and Dilemmas

	Number of participants	Number of references
Stages and steps in decision-making	8	60
Identify relevant rules	7	43
Ethical decision-making models	6	11
Assess consequences	5	6
Gather facts	3	4
Judging process	2	5
Begin with the end	2	3
Clear roles & responsibilities	2	2
Algorithm	1	2
Appeals, grievances	1	1
Breakdown into components	1	1
Collective bargaining	1	1

	Number of participants	Number of references
Identify issues	1	1
Needs assessment	1	1
Putting dilemma down on paper	1	2
Review informal work practices	1	1
Disability management program	4	9
Educate parties in roles, responsibilities		
Forms	1	1
Total	8	70

One of the most interesting informal tools or strategies, used by six out of eight participants, is the identification of a worker as an independent moral actor. Although the DMC identifies an ethical situation, she or he essentially sets clear boundaries around her or his personal ethical decision-making while at the same time assigning ethical responsibility for the situation to the worker. Identifying a worker as a separate moral actor amounts to an acknowledgement of the worker's autonomy in the return to work process. Leanne spoke of workers' ethical dilemmas as red herrings for a DMC: "As a disability manager your outcome is your return to work process. So there are things that go on outside of [the] realm of return to work that may be unethical but do not play in . . . your return to work focus." Participants spoke of workers as moral actors exclusively in the context of acquiring sensitive information that may affect benefits; in other words the DMC discovered the worker was working and receiving benefits at the same time, or had knowledge of medical information that would affect benefits and entitlements.

Six participants consult a variety of colleagues in their decision-making including mentors, role models, peers, ethics committee members, and experts in other departments (e.g. labour relations, legal, human resources, occupational health and safety, and wellness). In addition, six participants refer to training as a means to resolve and reduce ethical situations and unethical decisions. DMCs mention training in both ethical decision-making and occupational competencies (e.g. legislation, policies, and privacy). As Karen stated, “I think the training we go through help [sic] us to make the ethical decisions”.

A balancing process was categorized as an informal strategy. Three participants describe weighing potential resolutions and their consequences in ethical decision-making, or the need to balance a worker’s family dynamics and other potential return to work barriers. Interestingly balancing the interests of both parties, which can be viewed as a subset of the balancing process category, is how participants manage the competing demands of dual clients. Balancing worker and employer interests is used by five out of eight participants. DMCs are caught, as we have seen, between balancing the employer’s need for a swift return to work with the worker’s need for a sustainable return to work. According to participants balancing worker and employer interests facilitates customer satisfaction and ethical decision-making. It is best achieved by getting the facts; above all the DMC must not compromise the worker’s safe return to work.

Five participants utilize collaboration to resolve or prevent dilemmas. Collaboration is used in relationships with the other parties in return to work situations, and also within the disability management program. According to Jeanette, an occupational DMC, employer collaboration is encouraged by the duty to accommodate.

Collaboration may also occur within an organization by using a multidisciplinary team approach to planning individual return to work placements.

Relationships are the means by which collaboration is accomplished.

Establishing working relationships with the employer was described by the union DMCs as a method for resolving dilemmas. In both cases, the union DMCs advised how frankness with the employer about a particular return to work situation led not only to the resolution of the situation at hand, but also to the establishment of a long term professional relationship based on trust. In addition one union DMC questions the employer collaboratively, when alerted to a potential ethical situation, to ascertain details as the dilemma unfolds.

Half of participants report work performance issues as a dilemma. One participant, Monica, feels the matter is a human resources issue and that she should not manage it. Monica and another participant use medical information about the worker's fitness for work as the determining factor in letting the employer proceed with any disciplinary action, ensuring no action takes place prior to return to work: "We do not manage the performance issues . . . but we do give . . . HR, the manager, or supervisor direction as to whether it's medically appropriate to deal with those ongoing simultaneously with . . . the disability."

At least three participants advise the employer that the work performance issues may be caused by the disability. As Margaret observed:

They [i.e. the worker] had some performance issues before they went off sick.

They're not well. They're not doing the best job, and that's all the employer sees.

And yes, on one level we will recognize that the health situation is impacting the

work, but on the other level all they [i.e. the employer] see is the mistakes the person made and the mess they had to clean up.

Another participant, Paul, asks the employer to give the worker a second chance. At the same time he prepares the worker to deal with possible disciplinary action upon return to work.

Five participants report receiving knowledge at some point in their careers that a worker is working while collecting benefits related to the disability:

- Three participants do not report the information to the employer. One participant advises the worker to stop the behaviour but does not tell the employer because by this point the employer usually knows. Another participant defines the ethical decision as the worker's decision, and not her's, by characterizing the situation as a red herring.
- One participant advises the employer to manage the employment relationship better, and
- One participant advises the employer.

Interestingly, three participants are current or former WCB-AB employees. All of these individuals raised the WCB-AB's Ethics Program. When asked to identify ethical decision-making resolution tools and strategies they referred to at least one of the five resolution steps recommended by the program. More detail about the program is contained in Appendix E.

Table 6

Informal Tools and Strategies for the Resolution of Ethical Situations and Dilemmas

	Number of participants	Number of references
Worker as moral actor	6	7
Education and training	6	6
Mentors, role models, peers	6	14
Balance interests of worker and employer	5	8
Collaboration	5	8
Balancing process	3	5
Values	3	3
Intuition	2	2
Relationships	2	3
Golden rule	1	2
Past experience	1	1
Prayer	1	1
Total	8	61

Common Themes

Several themes emerged during analysis of the different types of ethical dilemmas, identification and resolution strategies, and challenges and facilitators of ethical decision-making.

Competent practice as ethical practice.

Half of participants make no distinction between ethical practice and competent practice. For participants competency in disability management is defined in an ethical context. Ethical practice involves:

- Providing knowledge based and ethical practice,
- Keeping abreast of changes in law, particularly the duty to accommodate,
- Knowledge of the parties' roles and responsibilities,
- Knowledge of privacy laws and safeguards, and
- Knowledge of disability management principles.

Whereas, participants report that a lack of competency or qualifications result in:

- Well intentioned mistakes made through lack of knowledge and based solely on a DMC's value system,
- A lack of understanding of roles and responsibilities in the return to work process,
- Inconsistent ethical decisions or unethical past precedents, and
- An increased incidence of unethical decisions.

For these participants, disability management competency is a facilitator of ethical decisions as well as an ethical decision-making strategy or tool. A lack of competency impedes ethical decision-making. Roberta made an interesting point about competency. For her values are not a substitute for knowledge, since ethics may be manipulated depending on the moral actor's value system and decisions may easily be rationalized if a laudable reason can be shown. Instead Roberta relies on rules to guide decisions and behaviour during the return to work process:

I've made decisions because my gut told me it was for the right reasons, and at the end I said "I'm sorry". . . I've made my fair share of mistakes . . . And I don't think I made them purposely, but shame on me for not knowing better. . . I don't think it matters what side of the table you're on. If you're going to do disability case management, you better know what the heck you're doing. Because we're talking about a person's life who is at the most vulnerable in their life. And if they've got restrictions and limitations . . . we've got an obligation to do the right thing by that person. So you better know what you're talking about.

Rules.

In the study rules appear at every stage of the decision-making process.

Participants use rules to identify, assess and resolve dilemmas, as well as to assess potential resolutions, and evaluate the consequences of decisions. Rules have the potential to obstruct or facilitate ethical decision-making. Knowledge of the rules and adherence to them may reduce the incidence of ethical dilemmas. As Roberta explained, “rules are rules, and I think because rules are there that's a perfect guide,” and “there aren't very many ethical dilemmas when everyone's operating from the same set of rules. So that's what I find is the biggest solver of the problem.”

This finding is not surprising when one considers the vast breadth of rules that DMCs manage as part of the return to work process. For DMCs, rules fall into five broad categories:

1. Professional associations
 - Codes of ethics,
 - Standards of practice or care,

2. Organizations

- Collective agreements,
- Mission statements,
- Policies and procedures in the disability management, occupational health and safety, and wellness programs, as well as personnel policies,

3. Federal and provincial legislation

- Freedom of information and privacy,
- Human rights,
- Occupational health and safety,
- Workers' compensation (legislation and policies),

4. Case law and arbitration law

- Access to employees' personal health information,
- Human rights and the duty to accommodate, and

5. Occupational competencies.

Figure 1 shows the percentage of the interview spent by each participant discussing relationships as a challenge or facilitator of ethical decision-making, or as a factor in the formation or resolution of an ethical dilemma. Participants' scores range from 29% to 3% coverage of the interview.

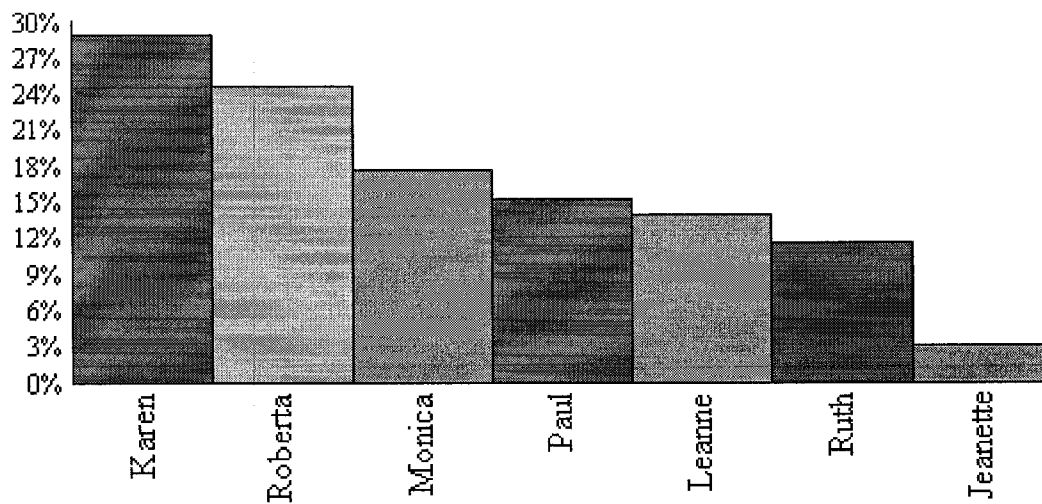


Figure 1: Evidence of Rules

Relationships.

Participants rely upon the development of relationships in the workplace with the worker, supervisor or other employer representative to facilitate return to work. Figure 2 shows the percentage of the interview spent by each participant discussing relationships as a challenge or facilitator of ethical decision-making, or as a factor in the formation or resolution of an ethical dilemma. Participants' scores ranged from a maximum of 48% to a minimum of 7% coverage of the interview. We cannot assume the percentage coverage of each participant is correlated with the value she or he place upon relationships in the return to work process because participants were not specifically asked this question. For instance we cannot assume that participants with a lower percentage place a lower value on relationships. A similar argument can be made about the relative importance of rules to participants. The comparative significance of factors impacting ethical decision-making to DMCs represents a future research opportunity.

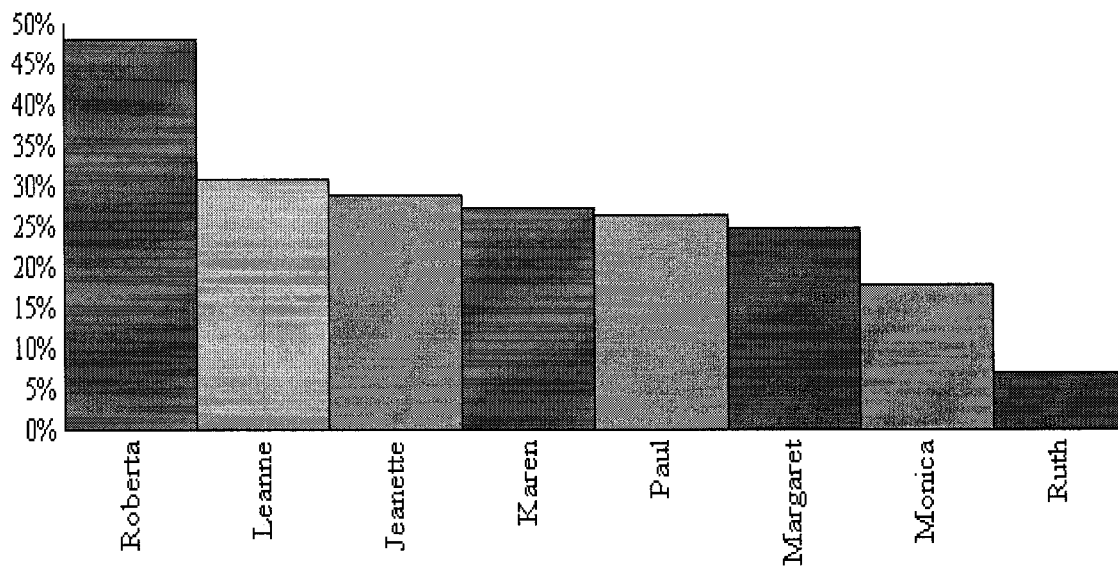


Figure 2: Evidence of Relationships

Closely related to relationships, collaboration and balancing the interests of the worker and employer are the primary strategies used by DMCs to manage potential ethical situations. Both collaboration and balancing interests take place against the backdrop of relationships. Through collaboration and balancing interests, DMCs are able to offset competing demands placed upon them by dual clients. Union DMCs, however, do not use balancing interests, likely because they do not regard the employer as their client.

Other themes.

Several themes appeared throughout the data. Earlier in this chapter the themes were explored thoroughly in the reporting of the results. Those discussions will not be repeated here. Table 7 illustrates the questions in which the most frequently mentioned themes or topics appear.

Table 7

Common Themes

	Identification	Dilemma	Challenges	Facilitators	Resolution
		examples			strategies
Access to		√	√		
sensitive					
information					
Balancing		√			√
worker and					
employer					
interests					
Collaboration		√		√	√
Competent	√	√	√	√	√
practice as					
ethical					
practice					
Confidentiality		√	√		
Conflicts of		√	√		
interest					
Corporate culture			√	√	
Dual clients		√	√		
Emotion	√				√

	Identification	Dilemma	Challenges	Facilitators	Resolution
		examples			strategies
Judging process	√			√	√
Organizational, program factors			√	√	
Personal characteris- tics		√	√	√	
Relationships	√	√	√	√	√
Rules	√	√	√	√	√
Stages in decision- making	√	√			√
Training			√	√	√
Worker as moral actor		√			√
Working on benefits		√	√		
Work performance		√	√		

Of interest is what was missing from the data. Six out of eight participants worked in a unionized environment at some point in their careers. The union DMCs

naturally bring a union perspective and trade union values to ethical decision-making. To address poor disability management practices in the workplace, one union DMC spoke of using collective bargaining and the grievance arbitration process to address ethical issues in individual return to work situations, options not normally available to occupational DMCs.

Apart from the union DMCs, however, ethical issues related to facilitating return to work in a unionized environment were brought up by just one occupational DMC. Jeanette describes how unions' collective agreement monitoring and enforcement functions facilitate ethical decisions during return to work. Moreover her employer initiated a collaborative process with its unions to develop return to work protocols.

As noted previously collective agreement language can be a facilitator of ethical decision-making if it supports accommodation, but it may also be a barrier.

What is also of interest is that, unlike in Vogel Smith's study of nurses (1996), participants do not demonstrate a perceived lack of personal decision-making autonomy in their descriptions of ethical dilemmas. Decision-making autonomy is not generally raised except as a potential barrier or facilitator of ethical decision-making. On the contrary one participant, Leanne, demonstrated a belief in her decision-making autonomy when she described her organization as supporting the ethical decisions of its employees.

In other examples, however, the data is not as clear. Five participants mention dual clients. Do these participants believe they have decision-making autonomy but are pulled in two different directions, or do they perceive a lack of autonomy due to dual clients? Karen talked about interference in decision-making by other supervisors or managers, but did not mention a lack of autonomy. Does she believe she has decision-

making autonomy but that it was interfered with, or does she perceive a lack of autonomy due to interference? The data is ambiguous.

Chapter V

Key Findings

Ethical Decision-Making is a Complex Process

Participants' ethical decision-making strategies and tools were described in Chapter IV, but their decision-making processes were not. A finding that 100% of participants developed ethical decision-processes is not unexpected. Reviewing their individual processes, though, is a worthwhile exercise. Participant's processes for resolving dilemmas are generally thoughtful, logical, mindful of relationships with the parties in the return to work process, and involve considerable reflection. Ethics is something they take seriously.

For most participants, ethical decision-making involves a series of stages or steps. Jeanette, an occupational DMC and current or former WCB-AB, employee uses the following steps. She:

1. Looks at the pros and cons,
2. Looks at how the consequences of the situation will affect others and the organization,
3. Looks at whether the resolution is a win-win situation,
4. May also apply WCB-AB's three tests, or the Canadian Association of Rehabilitation Professionals' ethical decision-making model (2003), and
5. Consults with peers and supervisors.

Monica, an OHN and occupational DMC:

1. Gathers data,
2. Accesses other resources, including peers,

3. Reviews options specific to the dilemma, and
4. Applies a scientific approach if possible.

A psychologist and occupational DMC, Paul describes his process as an algorithm. He:

1. Examines the dilemma,
2. Writes up the dilemma,
3. Lists potential outcomes and checks them against the Canadian Association of Rehabilitation Professionals' code of ethics,
4. Creates a course of action for each outcome, and
5. Shares the written document with a colleague if he is still unsure about a course of action.

Roberta, a union DMC:

1. Begins with the end, or the desired outcome, and determines the required steps by working her way back,
2. Is knowledgeable about rules, and
3. Ensures everyone involved in the return to work process understands the rules and their roles.

Ruth, an OHN and occupational DMC:

1. Does a needs assessment in which she:
 - i. Identifies the issues,
 - ii. Breaks down the issues into components,
 - iii. Gathers the facts,

2. Considers the legislation, professional standards, policies and procedures, and informal work practices or precedents that support a decision in one way or the other,
3. Sifts through what is right and wrong,
4. Weighs the pros and cons of potential options,
5. Looks at the consequences, impact, and outcomes of the options. She asks herself what is in the best interest of the parties, the organization and the worker, and
6. Makes a decision based on personal ethics and values. The chosen course of action may have several components.

Three participants apply steps but not necessarily in a formal sequence. Margaret, a union DMC, uses prayer and the Golden Rule (i.e. ‘Do unto others as you would have them do unto you’ from the New Testament) from a faith perspective and assesses the consequences. Empathy plays an important role in her decision-making process. She asks herself, “If I had that kind of disability or that kind problem, what would I want somebody to do for me? And then I tried to do that for that person”. Her question is similar to the question asked in Hill, Glaser and Harden’s ethical decision-making model, “Would I want to be treated this way?” (1995, p. 33).

Karen, an occupational DMC and current or former WCB-AB employee:

- Applies legislation and policies, and
- May apply the WCB-AB’s five step process for resolving ethical dilemmas, including the values, credit and reasonable person tests.

She notes that for WCB employees, “I think it's a lot easier in an environment where you do have the legislation, and you do have the policies in place. It makes it easier to make a decision, base your decision on that fact rather than on a judgment basis. Without that I think decisions aren't as solid.”

Leanne, an occupational DMC and current or former WCB-AB employee:

- Focuses on the outcome and the right or wrong of an ethical situation, and
- May apply the WCB-AB's three tests.

A review of participants' decision-making processes reveals several common stages:

- Identification of an ethical situation or dilemma,
- Application of ethical decision-making strategies and tools,
- Determination and implementation of the decision, and
- Evaluation of the decision's consequences.

Although not every participant mentioned the initial identification phase, it must be inferred because ethical decision-making strategies and tools cannot be triggered until identification of an ethical situation has been made. Evaluation of consequences, the last stage, appears to be optional among participants.

The use of decision-making processes, including stages, reflects the use of judgment in ethical decision-making and what Luntley refers to as a realistic orientation to ethical uncertainty (2003). Not surprisingly the steps are very much like those contained in the formal ethical decision-making models reviewed in Chapter II.

For the Disability Management Coordinators in this Study, Disability Management Best Practices are Synonymous with Ethical Decision-Making

Participants responded to questions about factors that obstruct or facilitate ethical decision-making and related tools and strategies, *as if they were asked simultaneously about factors facilitating or obstructing return to work*. For example Monica identified job banks as a facilitating factor. Job banks clearly facilitate return to work and are not at first glance associated with ethical decision-making. For participants, though, the two must be synonymous. In other words, factors that facilitate return to work also facilitate ethical decision-making.

Upon closer examination this association is not necessarily erroneous. If one of the desirable outcomes of sound ethical decision-making is sustainable return to work, then equating the two is reasonable. The corollary is also true for participants. Factors that obstruct ethical decision-making also obstruct return to work. A review of the factors listed in Chapter IV that facilitate or obstruct ethical decision-making shows that the majority of factors, if not all, may be interpreted as facilitators or barriers to return to work. The organizational, environmental and program factors, in particular, may be interpreted in this way.

The perception of disability management best practices as synonymous with ethical decision-making is consistent with the theme discussed in the previous chapter, competent practice as ethical practice.

Without Ethics Training Disability Management Coordinators Develop Their Own Ethical Decision-Making Strategies

The study reinforces the relationship between competency, ethical practice and ethics training. Most DMCs want to do the right thing. In particularly thorny ethical situations, however, the right course of action is often unclear. While training cannot teach immoral people to be moral, it provides guidance, decision-making tools, and can help them arrive at a decision.

As noted in Chapter IV, seven out of eight participants had prior ethics training. Having received professional ethics training does not guarantee a DMC will use the tools and strategies introduced in the training. It ensures awareness of ethical issues, however, and the need to use a formalized ethical decision-making process. The two OHNs and the psychologist, interestingly, appear to have adapted to their own needs ethical decision-making processes learned during their professional training.

One participant, Roberta, did not have any professional ethics training yet she developed her own thoughtful ethical decision-making process, ‘begin with the end’. Not all DMCs will be like Roberta. By not providing ethics training, organizations run the risk of DMCs using unstructured, or hap hazard means, to make decisions. Without ethics training:

- Issues and facts may be missed through lack of awareness,
- All the factors required to make a considered decision may not be taken into account – some may be left out, and
- The decision-making process may have gaps.

Ethics training not only assists with decision-making, but according to Ruth it teaches DMCs how to avoid ethical situations instead of stumbling into them through ignorance. Ethics training, therefore, provides a structured decision-making process that reduces the incidence of ethical situations through avoidance of such situations. It also helps to reduce unethical decisions and unethical behaviours.

Ethics Training by Itself is not Sufficient to Ensure Disability Management Coordinators Use Structured Ethical Decision-Making Strategies; a Supportive Professional or Organizational Culture is Also Needed

All participants who received formal ethics training through their profession or employer, except one, referred to ethical guidelines learned during training. Of note is that all current or former WCB-AB employees made reference to the WCB-AB's ethics program and the three tests in their decision-making.

The exception was Margaret, a union DM, who attended a workshop on ethics in disability management some years before her interview. She did not use a formal process for decision-making but instead used an informal process based on her faith, combining prayer and 'the Golden Rule', and which she found successful in resolving dilemmas. Margaret does not belong to a professional association, nor does she work for an organization that has a formal ethics program. Unlike the WCB-AB employees, the OHNs, and the psychologist, Margaret's awareness and use of formal ethical decision-making tools and strategies has not been reinforced by an employer or a professional association. This suggests that an organizational or professional culture of ethics is required to support the use of formal ethical decision-making tools and strategies. The

finding is consistent with Vitell and Paolillo's conclusions reviewed in Chapter II that organizations have a substantial impact on the ethical decision-making of its employees (2004).

Disability Management Coordinators Use Elements of Beauchamp and Childress' Ethical Principles and Concepts to Guide Ethical Decision-Making

Beneficence, veracity and trust are coded in separate nodes, but axial coding of all the other ethical principles or concepts involved reviewing topic nodes and assigning them to an axial node for each principle. Participants were coded positively for one of Beauchamp and Childress' ethical principles if their statements expressed the principle, or demonstrated it in an example of a dilemma and its resolution. The individual references by participants in each node were then checked for suitability to the principle.

Axial coding of Beauchamp and Childress' ethical principle of justice includes categories or nodes representing a balancing process, fairness and equality, objective information, and rules. Justice received unanimous support from participants.

Theoretical coding for fidelity incorporated budget, close personal relationships, conflict of interest, dual clients, focus on the needs and interests of the individual, needs assessment, perceptions, and supervisors nodes. Fidelity also received support from 100% of participants.

Non-maleficence axial coding included a subject node of its own, as well as competent practice as ethical practice, confidentiality and privacy. Autonomy includes its own subject node, as well as informed consent and the worker as moral actor. Six participants supported beneficence, autonomy, and nonmaleficence.

Table 8

Evidence of Beauchamp and Childress' Ethical Principles

	Number of participants	Number of references
Justice	8	56
Fidelity	8	37
Non-maleficence	6	24
Beneficence	6	13
Autonomy	6	9
Veracity	4	8
Trust	2	4
Total	8	151

The major significance of Table 8 is that it demonstrates that most participants demonstrate each of the principles or concepts, with the exception of trust. Trust, however, is actually a part of veracity.

Of note is that participants were not asked whether they supported individual principles and concepts. As Beauchamp and Childress' ethical principles and concepts are very close to many people's values, one cannot assume a participant does not support a particular principle or concept if she or he did not discuss or demonstrate it. Participants not coded for a particular principle or concept might not view the principle with the same degree of importance as those they discussed. They might also not have addressed their mind to the principle or concept during the interview.

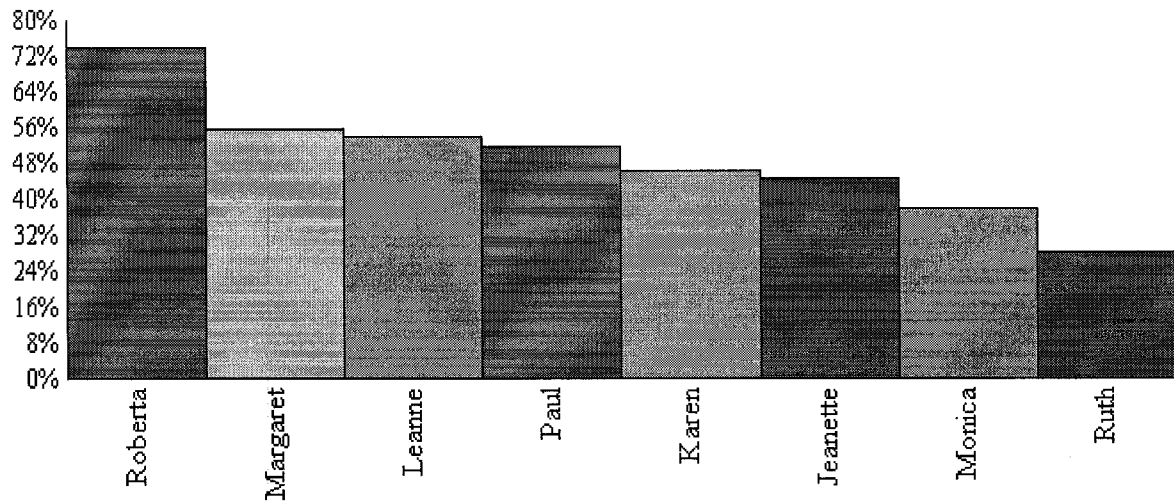


Figure 3: Evidence of Beauchamp and Childress' Ethical Principles

Figure 3 provides more evidence that participants demonstrate Beauchamp and Childress' ethical principles. It shows the percentage of the interview that each participant discussed topics categorized into one of Beauchamp and Childress' ethical principles or concepts. Participants' scores ranged from 28 to 74%.

Disability Management Coordinators Use Elements of the Kantian Ethics and Ethics of Justice, and the Ethics of Care and Feminist Ethics Theories to Guide Ethical Decision-Making

Participants were axial coded for the Ethics of Care and Feminist Ethics, and Kantian Ethics and the Ethics of Justice, if they spoke about one of the essential features of these theories or if their discussions of dilemmas demonstrated it.

A focus on individual needs of the worker is supported by 100% of participants. Topics included in this axial node are a focus on the individual needs of the worker, budget and profit pressures, and needs assessment.

One hundred percent of participants also support or demonstrate the concept that duty arises from the relationship between the care giver (i.e. DMC) and the cared for individual (i.e. worker). The topics of relationships, impact on the parties and care giving form this axial node.

All participants spoke about or demonstrate a focus on relationships, particularly in resolution, but not to the same degree as the previous two salient features. Relationships with the employer and the impact of decisions on parties are incorporated into this axial node.

Seven out of eight participants use emotion or intuition to identify the ethical situations, whereas only one participant uses emotion and intuition to aid in dilemma resolution.

Empathy and support for individuals is demonstrated by five participants. This salient feature was axial coded in a separate node.

Half of all participants support the use of a holistic approach, while only two participants demonstrate an awareness of power imbalances between the parties in the return to work process. Like the previous feature, a holistic approach and awareness of power imbalances are axial coded in a separate node.

Table 9

Evidence of the Ethics of Care and Feminist Ethics

	Number of participants	Number of references
Focus on individual needs	8	41
Duty from relationship, care-giving	8	39

	Number of participants	Number of references
relationship		
Focus on relationships (e.g. in resolution)	8	27
Use of emotion to identify ethical situations	7	9
Display empathy, support for individual	5	10
Holistic approach	4	4
Awareness of power imbalance between care giver, cared for	2	4
Use of emotion to resolve ethical situations	1	1
Total	8	135

Again, it should be noted that participants were not asked whether they supported the individual features of the Ethics of Care and Feminist Ethics, and Kantian Ethics and the Ethics of Justice. As with Beauchamp and Childress' ethical principles, participants were coded under a feature if they talked about or demonstrated it in their discussion of dilemmas. One cannot assume that a participant does not support a particular feature if he or she did not discuss or demonstrate it. Unlike Beauchamp and Childress' ethical principles, however, many of the salient features of both ethical theories do not share an obvious equivalency to societal values. While participants may not view the feature with the same degree of significance as the features they discussed, they may well not support it either. This area requires further research.

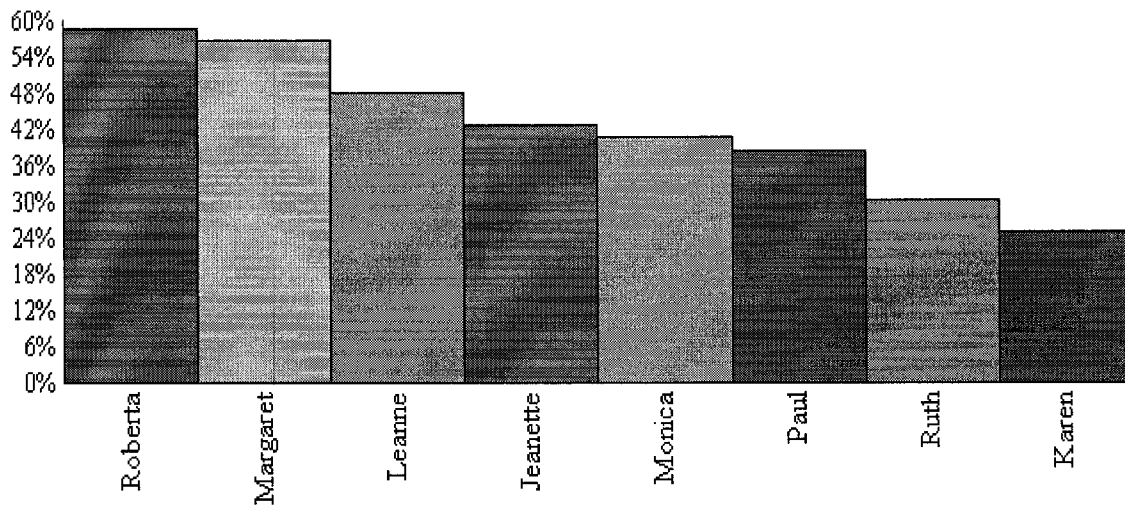


Figure 4: Evidence of Ethics of Care and Feminist Ethics

Figure 4 shows the percentage of the interview that each participant discussed topics categorized into one of the salient features of the Ethics of Care and Feminist Ethics. Participants' scores ranged from 25 to 59%. Figure 4 reinforces the evidence in Table 9 that participants demonstrate features of the Ethics of Care and Feminist Ethics in their interviews.

As Tables 9 and 10 reveal, some overlap exists between the features of Kantian Ethics and the Ethics of Justice, and the Ethics of Care and Feminist Ethics. Participants use both approaches in decision-making.

Six out of eight participants support the Kantian ethical features of autonomy, treating others as an end (i.e. respect for individuals), the use of reason, and a clearly defined decision-making process. Axial coding for treating others as an end incorporates topic nodes such as treating others as an end, autonomy, informed consent, worker as moral actor, confidentiality and privacy. The use of reason was coded separately, but

axial coding for the use of defined decision-making steps includes breaking down issues into components, and stages and steps in decision-making nodes.

Fairness, objectivity and equality, and the use of rules to identify ethical situations are supported by half of participants, whereas the use of verifiable and reliable decision-making is supported by three participants. Axial nodes for these features were coded on their own.

What is interesting is that universal rules and moral obligations arising from universal rules receive no support from the participants. It should be remembered, though, that participants were not asked from where they believed their moral duty arises. In addition, there is no support among participants for not considering the consequences or outcomes of dilemmas and potential resolutions. In fact two participants specifically contradicted this element.

Table 10

Evidence of Kantian Ethics and the Ethics of Justice

	Number of participants	Number of references
Use of rules to resolve ethical situations	7	31
Treat others as end (respect for individuals)	7	22
Use of reason	6	14
Use of a clearly defined process (e.g. steps, components)	6	10
Autonomy	6	8
Use of rules to identify ethical situations	4	9

	Number of participants	Number of references
Fairness, objectivity, impartiality, equality	4	6
Verifiable, reliable decision-making	3	3
Duty from rules	0	0
Universal rules (ascertained through reason)	0	0
Universal rules (applied to everyone)	0	0
Not consider outcomes	0	-2
Total	8	101

Figure 5 shows the percentage of the interview that each participant discussed salient features of Kantian Ethics and the Ethics of Justice. Participants' scores ranged from 20 – 66%.

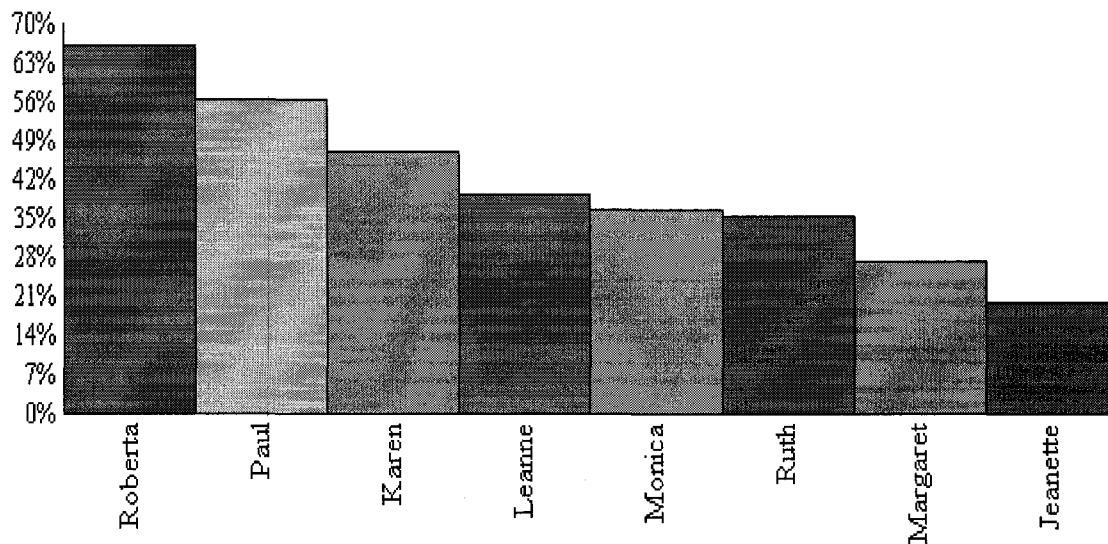


Figure 5: Evidence of Ethics of Justice and Kantian Ethics

Most Disability Management Coordinators Do Not Use Other Ethical Theories to Guide Ethical Decision-Making

In Chapter II's literature review, not all traditional ethical theories were found capable of providing satisfactory guidelines for professional or personal behaviour. I therefore did not analyze the participants' interviews for Social Contract Theory, Psychological Egoism, Ethical Egoism, the Ethics of Virtue, Ethical Subjectivism and Emotivism. Although Social Contract Theory can lead to the development of a system of moral guidance, it is fatally flawed because no moral obligation exists toward animals or persons not capable of participating in the social contract. On the other hand, Psychological Egoism and Ethical Egoism are not helpful because their basic premises are antithetical to the values of disability management. The Ethics of Virtue is unable to guide behaviour because its initial starting point is the question 'What is a good person?' The answer is a virtuous person, and so the theory digresses into an enumeration of essential virtues. Finally, Ethical Subjectivism and Emotivism cannot accommodate reason, nor do they guide behaviour.

I was able to find some evidence, albeit meagre, for Religion, Utilitarianism, and Ethical Relativism in participants' ethical decision-making. One participant refers to the use of the Golden Rule and prayer in her decision-making. The premise of Utilitarianism is demonstrated by the same participant. In addition, two participants spoke of the relative nature of ethics, one cautioning that sole reliance on individuals' values to guide ethical behaviour is risky given that people's values are diverse.

*Theoretical Constructs**A Model of the Formation and Resolution of Ethical Dilemmas in Disability Management*

During my analysis of the ethical dilemmas reported by the participants, it became clear that many dilemmas are related and that the relationships between them are complex. I realized that some of the dilemmas described by participants do not meet the definition of a dilemma, but are more correctly categorized as a precondition to a dilemma or a consequence of an unethical decision. For example, seven participants describe having dual clients as an ethical dilemma. Having both the worker and employer as clients does not necessarily represent a conflict between ethical principles, similarly inadequate options, or between equally convincing rationales for or against a specific option, or a decision point. Dual clients predispose the return to work process, however, to the formation of dilemmas.

In another example, Roberta described how an organization used its employee and family assistance program to procure psychological assessments of workers in the disability management program. She explained the practice has a potential for privacy breaches and compromises the credibility of both programs. In actuality the dilemma did not consist of the compromised credibility of the programs. It arose at the point the organization was faced with the choice of procuring psychological assessments from the employee and family assistance program or elsewhere. Compromised credibility and privacy breaches are negative consequences of the decision to use the employee and family assistance program, which she felt was unethical.

Examining the data, therefore, reveals that many preconditions are associated with the individual parties to the return to work process, while others are associated with the

environment within which the accommodation takes place. These I determined to be preconditions to the formation of an ethical situation or dilemma. As I attempted to make sense of the relationships between various preconditions and the consequences of dilemmas I developed a visual model showing how ethical dilemmas are formed, following them through the ethical decision-making process to the consequences. The model incorporates preconditions found in the disability management literature, or described by participants, that inhibit or facilitate ethical decision-making. It also permits the use of ethical theories and principles in the analysis of ethical situations in the return to work process.

The model is not the same as an ethical decision-making model, several examples of which were discussed in Chapter II. At its most basic level, the model illustrates how ethical dilemmas, as a phenomenon, are formed in disability management. The model is informed by phenomenologism and social constructionism. Through phenomenologism, people apply cognitive processes and assign meaning to the perception of their environment and their own behaviour (Palys, 2003). Part of phenomenologism, social constructionism differentiates the physical and social world (Best, 1995; and Loseke, 1999). As social creatures, individuals assign meanings to the physical environment (Best, 1995). In other words the social environment is constructed through language by labelling things and people (Loseke, 1999). Applying social constructionism to ethical decision-making in disability management shows us that dilemmas are social constructions of the parties to the return to work process.

I propose that dilemmas are formed by the interaction of the parties in the disability management environment in conjunction with professional imperatives, or

moral obligations and expectations, perceived by the DMC. The core elements of an ethical dilemma in disability management are therefore:

1. The parties to the return to work context process,
2. The disability management environment, and
3. Disability management professional imperatives.

Without one or more of the elements, the dilemma will not arise. Figure 6 is a visual representation of the model:

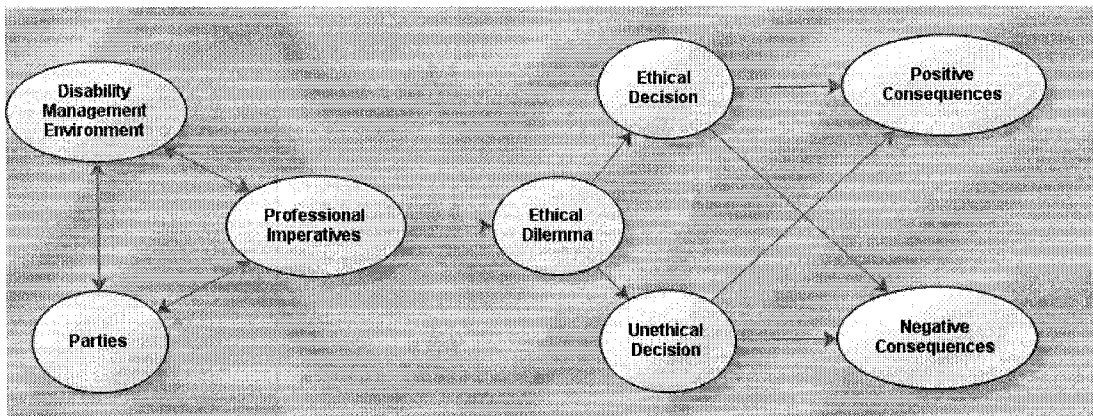


Figure 6: A model of the formation and resolution of ethical dilemmas in disability management, the core elements.

Due to limited space the model does not illustrate every conceivable factor or precondition that may affect an ethical dilemma or consequence. The major preconditions are highlighted, however, and the model accommodates additional preconditions and consequences readers may think of.

The connectors between the core elements flow two ways, reflecting the requirement of interaction between all three elements to create the dilemma. Although the model may be used by other parties to analyse ethical situations in the return to work context, it is depicted from the DMC's perspective as he or she is confronted by a

dilemma and makes a decision. The connectors between the dilemma and the decision represent the decision-making process, at which time the DMC applies her or his own strategy or one of the many ethical decision-making tools available.

Following the model's flow, the decision is defined as ethical or unethical. The decision may have positive or negative consequences, or both. As stated previously the model is conceptualized from the perspective of the DMC. Although other parties in the workplace may use the model to analyse ethical situations, for the purpose of this discussion the decision is the DMC's and it is the DMC who defines the decision as ethical or unethical.

A professional imperative under this model is defined as a personal or professional moral obligation, duty, or expectation to behave in a certain way that is perceived, acknowledged or felt by the DMC. When I brainstormed a list of all the obligations a DMC might have in a professional capacity, I found myself describing personal and professional values, and other abstracts that essentially amount to Beauchamp and Childress' ethical principles and concepts. Other sources of professional imperatives include the values, codes of ethics and professional standards of professional associations and organizations, and the occupational competencies of DMCs, OHNs or other professionals fulfilling the role of a DMC (National Institute of Disability Management and Research, 1999 and 2000).

Figure 7 represents the various professional imperatives at work in the model:

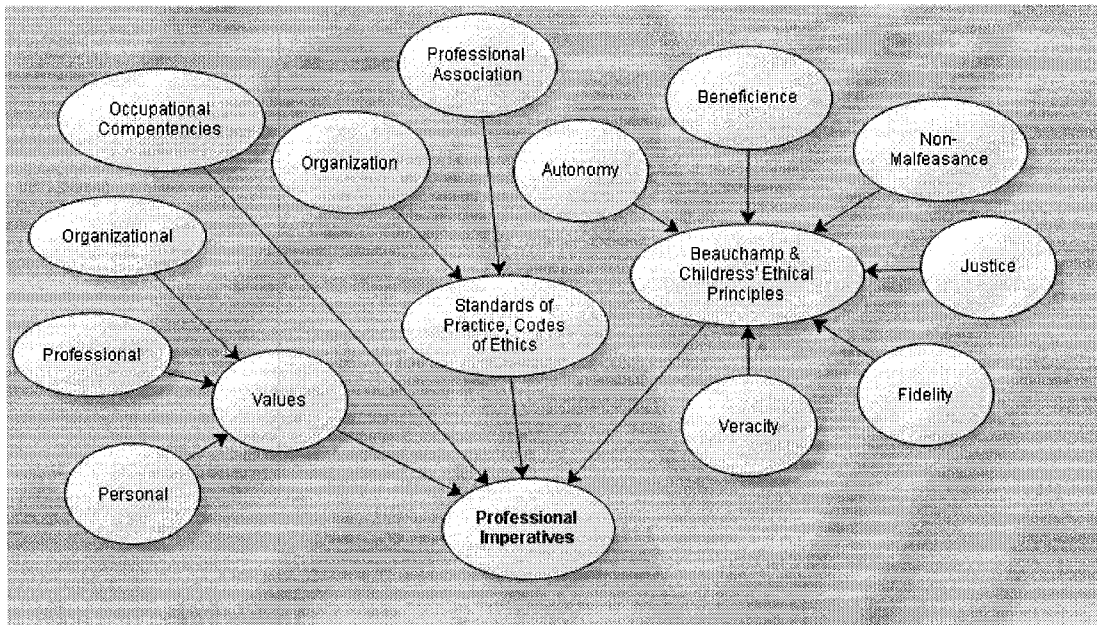


Figure 7: Professional imperatives.

If the DMC does not feel or perceive an obligation or duty, no dilemma arises.

Evidence of this is found in the study data. In response to the subject of workers working while receiving disability benefits, Leanne describes how there are some things outside the return to work process that are red herrings and are not properly part of a DMC's focus. She felt no obligation to share the information with the employer because she did not define the dilemma as hers, but the worker's.

The environment in which the return to work process takes place is complex and unusual. Numerous preconditions in the environment inhibit or facilitate ethical decision-making and return to work. The model incorporates preconditions described by participants and the disability management literature. For instance, the elements of an effective disability management program identified by Shrey and Dyck have a place in the model. I have not attempted to list all preconditions, but they may be categorized as inputs into one of three levels: a) the disability management program; b) the organization

in which the return to work process takes place; and c) the macro environment. Figure 8 illustrates the preconditions in the disability management environment:

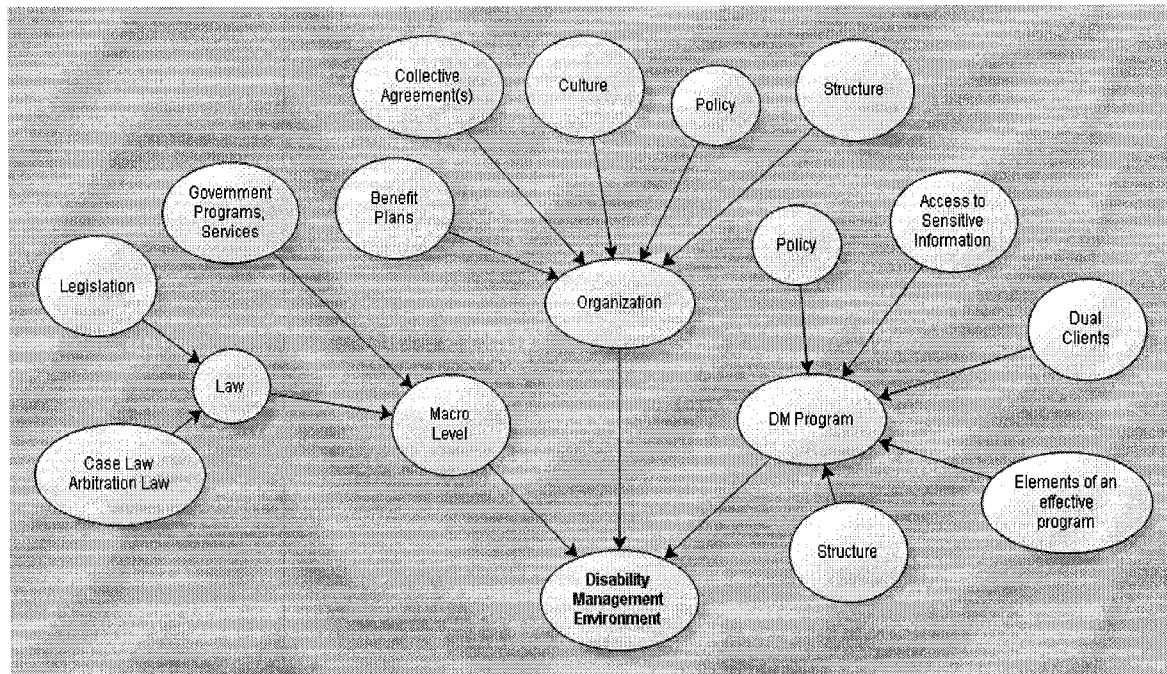


Figure 8: The disability management environment.

The disability management program level includes preconditions such as the program's structure and policy. It includes, as well, other preconditions that represent unusual or unique characteristics in the return to work context such as dual clients and access to sensitive information.

The organizational level includes preconditions in the organization outside of the disability management program. It includes the structure of the organization, policies (e.g. human resources, occupational health and safety, and wellness), organizational climate or culture, collective agreements, and the structure of employee wages, remuneration packages, and sickness or disability benefit plans.

The macro environment consists of those preconditions at the municipal, provincial, territorial, national and even international level that may impact the disability

management environment. For example Canadian federal, provincial and territorial legislation in the areas of human rights, occupational health and safety, workers' compensation, and privacy places certain legal obligations upon employers and workers. Moreover, DMCs operate against a background of case law and arbitration law in the human rights and privacy arenas. DMCs must be aware of these obligations.

DMCs must also be aware of eligibility criteria for various government income support programs in the federal and provincial spheres. As mentioned by some participants, knowledge of workers engaged in activities that jeopardize their eligibility for these programs may precipitate an ethical dilemma for a DMC.

The preconditions or factors incorporated from the participants' interviews include:

1. Disability management program level: access to sensitive information; dual clients; elements of an effective program; policy; and structure,
2. Organization level: benefit plan structure; collective agreements; corporate culture or climate; policy and structure; and
3. Macro level: legislation; case law and arbitration law; and government programs and services.

The last and certainly not least important core element is the parties to the return to work process. The interaction of these individuals (i.e. worker, employer, DMC, union representative, co-worker, health care professional, or insurer) in their roles leads to the creation of dilemmas. The majority of dilemmas are created through the interaction of the worker, employer, and DMC because this is the central relationship required for the

fulfillment of the return to work plan. The relationship is represented by the blue connectors in Figure 9.

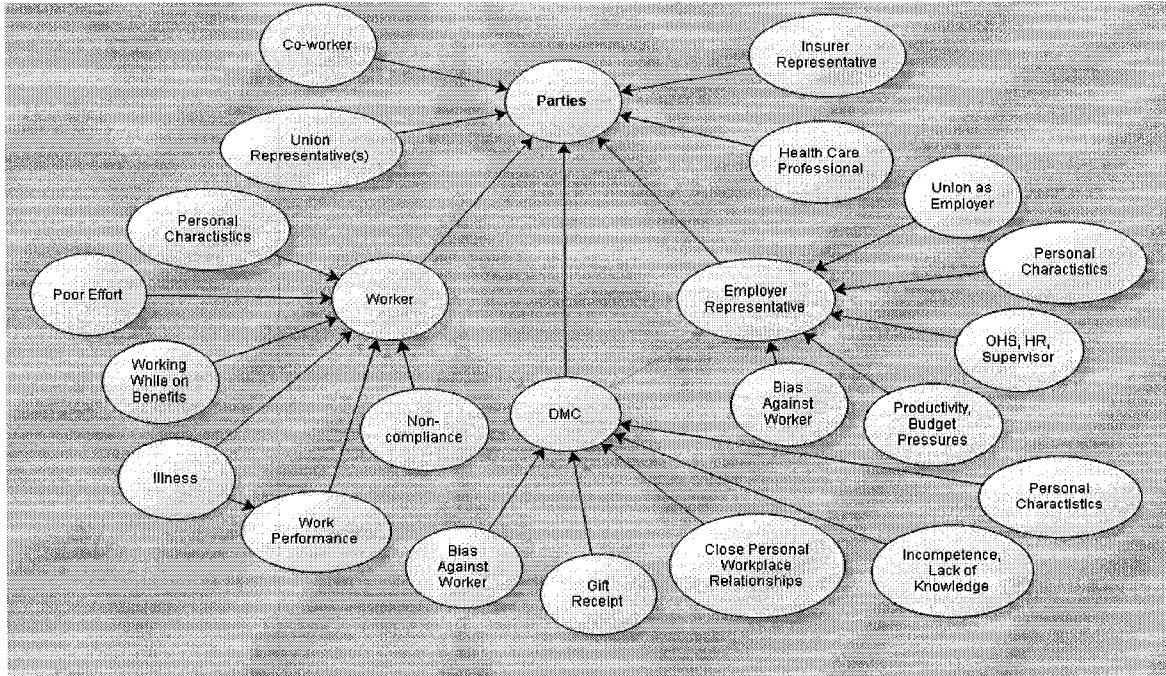


Figure 9: The parties to the return to work process.

The DMC is placed between the worker and employer, because he or she must continually balance the interests of both parties, and is often caught in a conflict between competing interests.

In addition to the worker's supervisor, employer representatives potentially involved in return to work include human resources, wellness, or occupational health and safety personnel.

The model incorporates preconditions related to the parties and reported by participants as challenges or barriers to return to work and ethical decision-making.

An observer might note that the majority of preconditions in Figure 9 are negative and assume that workers, DMCs and employers are generally uncooperative in return to work planning. This would be incorrect. The overwhelming majority of workers,

employers and DMCs put forward their best efforts to make the return to work successful. Appropriate behaviour is less likely to precipitate a dilemma, but the model must reflect those preconditions that do. It should also be noted that some worker preconditions may be caused or exacerbated by the illness or injury requiring accommodation. For example illness or injury was mentioned by half of participants as a potential cause of poor work performance. In addition non-compliance with treatment or the return to work plan may be due to the injury or illness; denial and lapses, for instance, are common in addictions and many mental illnesses.

Union representatives, coworkers, health care professionals, and insurers are involved in the return to work process to a lesser degree, but may also precipitate an ethical dilemma.

The preconditions described by the participants in Chapter IV as facilitating or obstructing ethical decision-making fit into the model's core elements, particularly the disability management environment and the parties to the return to work. Preconditions incorporated into the model from the participants' interviews include:

1. Worker preconditions: illness; noncompliance with treatment or the return to work plan; personal characteristics; work performance; and working while receiving disability benefits,
2. Employer preconditions: a bias against the worker; personal characteristics; productivity and budget pressures; and the union in the role of an employer to a union DMC, and

3. DMC preconditions: a bias against the worker; inappropriate or close personal relationships in the workplace; incompetence and lack of knowledge; personal characteristics; and receiving gifts from workers.

The model also describes the consequences arising from the decision. Positive consequences, negative consequences, or both may result from ethical decisions or unethical decisions. Furthermore, the model accounts for situations in which people are motivated to make unethical decisions. For example people sometimes make unethical decisions because: a) they do not anticipate positive consequences from an ethical decision; b) the negative consequences of an unethical decision will not be felt immediately; or c) the negative consequences will be unclear to others. Figure 10 illustrates the consequences.

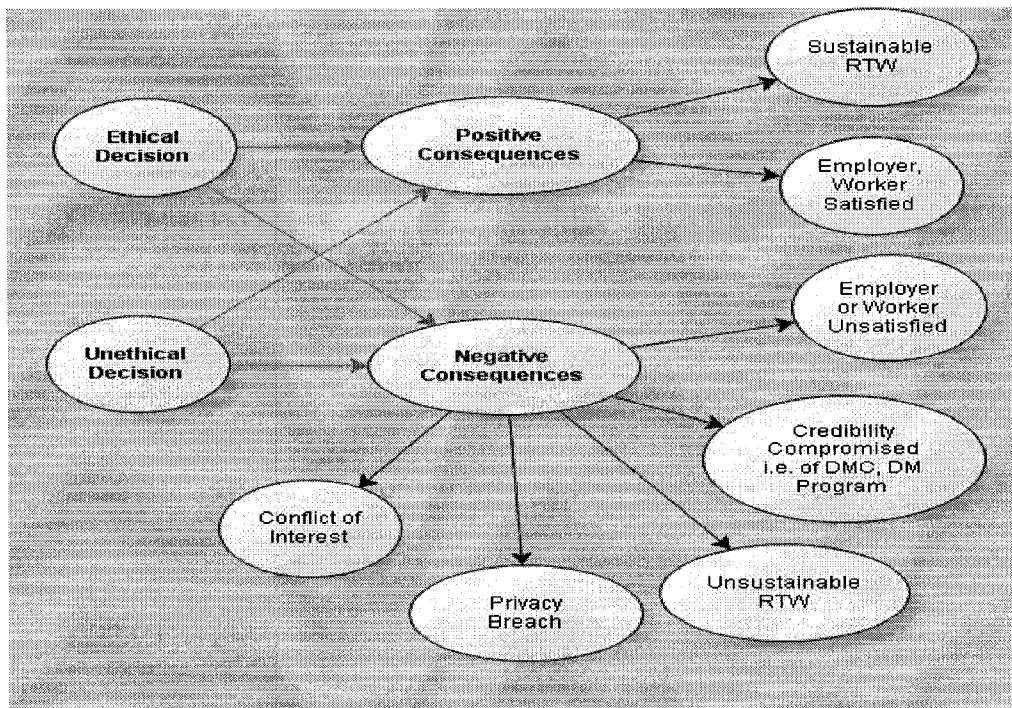


Figure 10: The consequences of an ethical or an unethical decision.

Finally, ethical concepts have a place in the model too. As we have seen, values and Beauchamp and Childress' ethical principles fit into the professional imperatives.

Ethical theories can be used in the model to:

- Identify an ethical situation or dilemma,
- Assist in the ethical decision-making process, and
- Assess or define whether the decision is ethical.

Individual ethical situations and dilemmas contained in the research data may be analyzed by identifying preconditions related to the core elements (i.e. disability management environment, the parties to the return to work process, and professional imperatives), the dilemma, the decision (ethical or unethical as assessed by the DMC), and the consequences (positive, negative, or both as assessed by the DMC). Karen provided a typical example of a dilemma in her interview:

Situation	Karen received a gift from worker.
Disability management environment	Dual clients.
Professional imperatives	Impartiality, the appearance of transparency.
Worker preconditions	Providing a well-intentioned gift.
Employer preconditions	Possible perception that the DMC's impartiality is compromised if the gift is accepted.
Dilemma	Should Karen accept the gift?
Decision	Karen shared the gift with co-workers, and assessed the decision as ethical.

Consequences	Positive, as assessed by the DMC. Karen did not compromise any professional imperatives and the worker was satisfied.
--------------	---

Another participant, Paul, described how he resolved a dilemma when he first encountered it:

Situation	Paul knows a worker may be terminated due to work performance issues upon return to work.
Disability management environment	Dual clients, access to sensitive information.
Professional imperatives	Privacy, avoidance of conflict of interest, beneficence, non-maleficence.
Worker preconditions	Poor work performance.
Employer preconditions	A desire to proceed with disciplinary action (including possible termination) for work performance issues during the return to work process.
Dilemma	Should Paul tell the worker about the possible termination?
Decision	Yes. Paul told the worker, and assessed the decision as the most ethical in the circumstances.
Consequences	Negative, as Paul felt he had compromised his ethical responsibility toward the employer. Neither Paul nor the worker felt good about the outcome.

On a subsequent occasion when the same dilemma arose, Paul made a different decision and used an interesting resolution strategy:

Decision	No. Paul did not disclose the possible termination to the worker, but advised the employer to give the worker a second chance, keeping in mind the performance issues were related to the worker's illness and setting out performance expectations up front. He prepared the worker to deal with potential performance issues upon her return, and counselled her in assertiveness. He assessed the decision as ethical.
Consequences	Positive. Paul felt much more satisfied with the outcome.

Dilemmas may also be analysed by applying ethical theories to the model. The dilemma described by Margaret, a union DMC, is notable because it illustrates how applying different ethical theories, such as Utilitarianism and Kantian Ethics and the Ethics of Justice, produce different assessments of a decision and different consequences. Here is the ethical situation and Margaret's resolution strategy:

Situation	The worker was willing to return to work, but the employer did not want the worker back. The worker knew of the employer's antipathy, but was unwilling to leave his employment without a severance package. The DMC knew that letting the
-----------	--

	employer think the worker was anxious to return would encourage the employer to offer a generous severance.
Disability management environment	Severance policies.
Professional imperatives	Veracity, non-maleficence, beneficence.
Employer preconditions	No desire to see the worker return to work.
Dilemma	Should Margaret tell the employer the worker is willing to return to work, knowing this will encourage the employer to offer the worker severance?
Decision	Margaret let the employer think the worker was anxious to return to work. She assessed the decision as ethical and stated she would do the same thing again.
Consequences	Positive, as assessed by the DMC. Both the worker and employer were satisfied.

Margaret's decision may be assessed differently according to Kantian Ethics and the Ethics of Justice, or Utilitarianism. For discussion purposes, I will adopt a universal principle of absolute veracity under Kantian Ethics and the Ethics of Justice requiring telling truth at all times, in all places and cultures with no omissions or exceptions.

Margaret's decision may therefore be analysed as follows:

Decision	Margaret let the employer think the worker was anxious to return to work. The decision is unethical because it compromises the universal moral duty to tell the truth.
Consequences	Kantian Ethics and Ethics of Justice do not permit consideration of the consequences of a moral action, therefore worker and employer satisfaction is irrelevant.

According to Utilitarianism, however, the decision may be analysed much differently:

Decision	Margaret let the employer think the worker was anxious to return to work. The decision is ethical because in Utilitarianism the end justifies the means, and ethical decisions are those that create the most good for the most number of people. Here everyone was happy with the outcome.
Consequences	Positive, both the worker and employer got what they wanted.

I would like to emphasize that characterizing Margaret's dilemma as ethical or unethical is for the purpose of illustrating how ethical theories fit into the model only, and does not represent my personal assessment of the situation. During the interviews and analysis process I did not impose any personal assessments of participants' resolutions as ethical or unethical out of respect for their candour and because ethical dilemmas, by

their very nature, involve difficult decisions. In similar circumstances I might well have made the same decision.

To develop the visual model, I applied the general principles of grounded theory. First, all ethical situations and dilemmas described by participants were assigned into categories. This step occurred during the topic and axial coding of the data. Next, I plotted the categories on paper and drew connectors between them as I discerned interrelationships. Gradually I perceived that certain categories of dilemmas or ethical situations could be grouped together and it was from these groups that I developed the preconditions, core elements (consisting of broad categories of preconditions), dilemma, decision, and consequence components of the model. The definition of a dilemma was clarified as a decision point at this stage to distinguish it from the preconditions, decision and consequences. At each phase in the model's development I returned to the data to ensure all dilemmas and ethical situations described by participants and all factors obstructing and facilitating ethical decision-making described by participants fit into the model. I also ensured that facilitators of ethical decision-making found in the disability management best practices literature had a place in the model. I then solicited feedback from two senior OHNs, a labour representative, two colleagues from my workplace, and a participant (an OHN with nearly three decades of experience in disability management, including management of disability management programs). Based on their comments, new constituent parts and connectors were added.

Once complete, I tested the model by reviewing the ethical situations or dilemmas described by the participants. For each situation I was able to successfully identify preconditions related to the core elements (i.e. disability management environment, the

parties to the return to work process, and professional imperatives), the dilemma, the decision (ethical or unethical as assessed by the DMC), and positive or negative consequences.

In conclusion the model is a synthesis of the academic literature and research in disability management and moral philosophy, as well as the participants' experiences, and was developed using grounded theory.

A Combined Theoretical Approach for Ethical Decision-Making in Disability Management

Like other health care and rehabilitation professions the power imbalance between the worker and the DMC, or employer, requires ethical considerations and behavioural guidelines in return to work coordination. As a new field, no research has been done nor has any thought been given in the literature to a theoretical ethical approach in disability management that takes into account its professional values and the return to work process.

DMCs need a theoretical approach for managing preconditions to ethical dilemmas. While most DMCs are well intentioned, they may not know what resources and guidelines are available to aid ethical decision-making. New and inexperienced DMCs, in particular, would benefit from ethical guidelines.

I therefore propose a theoretical approach for ethical decision-making in disability management that combines Kantian Ethics and the Ethics of Justice with the Ethics of Care and Feminist Ethics. As discussed in Chapter II both ethical theories have strengths

yet neither theory has all the answers. Combining their strengths, however, produces a theoretical ethical approach with considerable potential.

Several reasons exist for combining the two theoretical approaches in disability management. Neither is a complete theory (Rachels, 2003). The strengths of one theory complement the weaknesses of the other. The Ethics of Care and Feminist Ethics is able to account for consequences and outcomes, individual needs, power imbalances, cultural values and decisions made within relationships, weaknesses of Kantian Ethics and the Ethics of Justice. On the other hand Kantian Ethics and the Ethics of Justice compensates for the inability of the Ethics of Care and Feminist Ethics to assist in the equitable distribution of resources within programs by applying principles of fairness and equality, and by balancing the use of emotion in decision-making with reason.

Precedent exists in the academic literature for combining the two theories. Supported by Botes (2000a), Gilligan asserts that care in the health care sector should integrate the holistic approach and empathy found in the Ethics of Care blended with the features of impartiality, equality, and fairness from Ethics of Justice. Furthermore Gilligan argues that “both justice and care have a place in the process of ethical decision-making, as these two aspects are [inextricably] linked and in constant interaction” (Botes, 2000a, p. 1073). Based on evidence that health care professionals approach ethical situations from different ethical perspectives, Botes (2000b) recommends combining the two approaches to create a common means of communication on ethical issues within a health care team. A combined approach enhances cooperation and patient care, avoids conflict, and resolves dilemmas that might otherwise remain unsolved if just one theory is applied:

Both the fair and equitable treatment of all people (from the ethics of justice) and the holistic, contextual and need-centred nature of such treatment (from the ethics of care), ought to be retained in the integrated application of the ethics of justice and the ethics of care (Botes, 2000a, p. 1071).

Gilligan (1980) concurs. Kohlberg himself acknowledges the inability of the Ethics of Justice to address all ethical situations and that it must be informed by a care perspective (Botes, 2000a). Buckley suggests that feminism would benefit from the concept of justice provided that the application of distributive justice and the concept of equality do not result in same treatment for all people where differences require different treatment (Buckley, 1999). Finally Kroeger-Mappes (1994) suggests that the two theories are really a single moral system, with the Ethics of Care providing the foundation for the Ethics of Justice.

Ethical decision-making in disability management is an interesting amalgam of the Ethics of Care and Feminist Ethics, and Kantian Ethics and the Ethics of Justice. Disability management embodies the values of collaboration and cooperation. Satisfactory relationships between the worker, disability management coordinator, supervisor, occupational health and safety representative, human resource personnel, and the union representative are critical to ensure the sustainability of the return to work. Collaboration and cooperation are expressed within these relationships, and are the means by which return to work is accomplished. These qualities are clearly compatible with the Ethics of Care and Feminist Ethics.

On the other hand, the disability management environment is highly structured and circumscribed by rules, a feature of Kantian Ethics and the Ethics of Justice. The list

of relevant rules is lengthy, comprised of policies, protocols, legislation, law, and collective agreements. The prevalence of rules in disability management may be explained by the predominance of Kantian Ethics and the Ethics of Justice in the last couple of centuries. Kantian Ethics and the Ethics of Justice became the ethical foundation upon which many Western institutions are based (e.g. workers' compensation, disability benefit plans, and other social and income support program eligibility). Furthermore the accommodation process takes place within organizations, most of which possess a hierarchical structure of decision-making. Finally disability management program managers must make decisions about resource distribution, selecting options for individual accommodations based on availability and need. These types of decisions mean that the disability management environment readily lends itself to guidance from Kantian Ethics and the Ethics of Justice, particularly its emphasis upon fairness, equity and impartiality. In the study, DMCs strongly supported these qualities.

The two theories are not mutually exclusive. Tables 8 and 9, and Figures 3 and 4 demonstrate that all participants use features of both the Ethics of Care and Feminist Ethics, and Kantian Ethics and the Ethics of Justice. Interestingly the participant scoring the highest percentage for interview coverage of Kantian Ethics and the Ethics of Justice also scored the highest in the Ethics of Care and Feminist Ethics, with scores of 59% and 66% respectively.

Although the ethical principles and concepts of Beauchamp and Childress are demonstrated by the majority of study's participants, the guidance these provide in ethical dilemmas is limited. Essentially, Beauchamp and Childress' approach is stymied in ethical dilemmas consisting of conflicts between ethical principles. For this reason

then, I have not integrated Beauchamp and Childress' ethical principles into the proposed theoretical approach, although they are integrated into my visual model of dilemma formation and resolution.

As noted in the key findings, elements from other theories are largely missing from the study data. Limited evidence is found in participants' interviews for Utilitarianism, Cultural Relativism, Ethical Relativism and moral systems based on religion.

The duty to accommodate, which is the expression of disability management in law, requires decision-making processes that incorporate elements from both the Ethics of Care and Feminist Ethics, and Kantian Ethics and the Ethics of Justice. The duty to accommodate is a legal obligation placed on employers and unions to accommodate workers in employment situations. Courts and arbitrators have derived the duty from antidiscrimination clauses contained in collective agreements, and in federal, provincial and territorial human rights statutes. Employers are prohibited from discriminating against employees on the basis of certain protected grounds (i.e. disability, religious beliefs, age, gender, ethnicity, race, skin colour, marital status, sexual orientation, marital or family status, and income source). The duty to accommodate obliges employers and unions to accommodate a worker's differences in the workplace to the point of undue hardship.

In the duty to accommodate non-discrimination or equality requires more than providing equal access to opportunities. Sometimes equal treatment results in discrimination, and sometimes equality necessitates differential treatment to produce equal outcomes (Vickers, 1997). Workers with disabilities must be treated differently

and according to their individual needs, therefore, to ensure they are able to participate in the workplace to the same degree as workers without disabilities. Application of the principles of justice and equality from the Kantian Ethics and the Ethics of Justice must therefore be tempered in disability management by attention to individual needs from the Ethics of Care and Feminist Ethics.

The duty to accommodate, in summary, lends itself to Kantian Ethics and the Ethics of Justice because it is a rule arising out of legislation and collective agreements, and because the accommodation process requires reasoning and judgment. Furthermore, in cases of disability the duty to accommodate requires:

- Collaboration in relationships between the employer, union and worker for the purpose of accommodating the worker's illness or injury in the workplace,
- Balancing the interests of all the parties, and
- A focus on the worker's individual needs by tailoring the accommodation to his or her functional abilities,

all of which are elements of the Ethics of Care and Feminist Ethics. Although the duty to accommodate is a rule, and therefore demonstrative of the Kantian Ethics and the Ethics of Justice, the means by which the duty to accommodate is accomplished is through the Ethics of Care and Feminist Ethics.

Finally, during my analysis of the study data, it was often difficult to classify topics as belonging exclusively to the Ethics of Care and Feminist Ethics, or Kantian Ethics and the Ethics of Justice. Balancing the interests of the parties demonstrates this conundrum. As a decision-making process, it may be broken down into three components: a) a balancing process; b) the interests of the parties; and c) the impact of

ethical decision-making on the parties. The 'balancing process' component is compatible with Kantian Ethics and the Ethics of Justice, whereas the 'interests of the parties' and the 'impact upon the parties' components are compatible with the Ethics of Care and Feminist Ethics. Balancing the interests of the parties therefore necessarily requires the moral actor to use elements of the Ethics of Care and Feminist Ethics, and Kantian Ethics and the Ethics of Justice. In addition, we should not forget Leanne's point that the best way to balance the interests of the parties is to get objective facts, an approach which necessitates objectivity from Kantian Ethics and the Ethics of Justice. In reality applying any kind of ethical decision-making process, even one that has features of the Ethics of Care and Feminist Ethics, requires reason and necessitates the use of Kantian Ethics and the Ethics of Justice.

The phenomenon of DMCs treating workers as separate and independent moral actors is another example from the study data of how the two ethical theoretical approaches are closely integrated. While the worker as moral actor phenomenon respects workers' autonomy and treats them as an end by letting them make their own moral decisions (characteristics of Kantian Ethics and the Ethics of Justice), there is an inherent conflict with veracity. If a DMC became aware of a worker receiving benefits while working, Kantian Ethics and the Ethics of Justice would not permit the worker to make the moral decision by allowing the DMC to distinguish the worker's ethical responsibilities from his or her own. Such a distinction is more easily achieved when the Ethics of Care and Feminist Ethics, with its focus on relationships, is applied to the decision-making process.

To summarize then, a theoretical ethical approach to decision-making in disability management that combines the Ethics of Care and Feminist Ethics, and Kantian Ethics and the Ethics of Justice, is warranted for several reasons:

- Neither theory has all the answers nor provides complete guidance in ethical decision-making,
- Each theory has strengths that compensate for the weaknesses of the other,
- Precedent for combining the two theories exists in the academic literature,
- Disability management is an amalgam of both the Ethics of Care and Feminist Ethics and Kantian Ethics and the Ethics of Justice. The disability management values of collaboration and cooperation, with their heavy reliance upon relationships, are compatible with the Ethics of Care and Feminist Ethics. The rule bound disability management environment and the necessity of fair resource distribution readily lends itself to Kantian Ethics and the Ethics of Justice,
- Participants use many elements of both theories in their ethical decision-making,
- Participants generally do not use elements of other ethical theories,
- The duty to accommodate, a rule and therefore characteristic of Kantian Ethics and the Ethics of Justice, is achieved through elements of Ethics of Care and Feminist Ethics, and
- In practice the theories of the Ethics of Care and Feminist Ethics, and Kantian Ethics and the Ethics of Justice are difficult to separate in disability management ethical decision-making.

A theoretical ethical approach is helpful as a foundation or perspective from which to approach ethical situations and return to work generally. DMCs, particularly inexperienced DMCs, nevertheless need practical tools and strategies which translate theory into practice, and which help them resolve real life dilemmas. Accordingly I would like to propose a framework for ethical decision-making.

A Framework for Ethical Decision-Making in Disability Management

As my analysis of the data proceeded, I was faced with the challenge of integrating participants' decision-making processes and the disability management best practices research with theoretical ethical concepts in a straight forward tool that DMCs can use in their practice. Despite much to recommend them, the ethical decision-making models reviewed in Chapter II have weaknesses; they do not incorporate all the features I believe should be present. I therefore developed a new ethical decision-making model specific to disability management. To distinguish it from the visual model of the origin and resolution of ethical dilemmas developed earlier in this chapter, I am labeling it a framework for ethical decision-making in disability management. The framework is built on a foundation that includes:

- Participants' experiences and ethical decision-making processes, incorporating common themes (e.g. rules, relationships, balancing interests), and
- The disability management best practices literature, thereby facilitating evidence based practice,
- The definition of an ethical dilemma offered in Chapter II, and

- The visual model of the formation and resolution of ethical dilemmas in disability management proposed in this chapter,

The framework:

- Aids in the translation of theory into practice; ethical concepts such as values, ethical principles and theories (including the combined theoretical approach for ethical decision-making proposed in the previous section) are integrated,
- Incorporates the strengths of the ethical decision-making models discussed in Chapter II, including:
 - Emotion and intuition. The framework follows the example of the ethical decision-making models of Hill, Glaser and Harden (1995) and Burkhardt and Nathaniel (2002) by acknowledging that many people use emotion in ethical decision-making, and assigns it an appropriate role,
 - An organizational context (Canadian Association of Rehabilitation Professionals, 2003), recognizing that DMCs do not make decisions in an organizational vacuum,
 - The WCB-AB's three ethics tests, the values test, the credit test and the reasonable person test (2008),
 - The rights, duties, values, interests of the parties to the return to work process (Burkhardt and Nathaniel, 2002), and
 - An evaluation component (Burkhardt and Nathaniel, 2002; the Canadian Association of Rehabilitation Professionals, 2003; and Hill, Glaser and Harden, 1995).

The decision-making stages in the framework are:

Stage 1: Identification

Stage 2: Assessment

Stage 3: Generation of options

Stage 4: Evaluation of options

Stage 5: Planning and implementation

Stage 6: Evaluation

Each stage contains a series of questions for the DMC. The stages refer the DMC to different resources, with examples, that may be helpful as she or he answers the questions. The resources may be internal to the DMC and his or her organization, or external. The inclusion of resources and examples was suggested by a participant, an OHN and occupational DMC, during our discussion of the visual model. The framework has several strengths:

- Identification of resources and examples,
- A structure for the DMC to document the decision-making process,
- Integration of the strengths of previous ethical decision-making models, filling in missing elements,
- Integration of ethical theories in Stages 1, 3 and 4, and
- Integration of the academic literature.

The framework's main weakness is its length. It is unsuitable for less complex ethical situations, in which case one of WCB-AB's three tests is more appropriate. When confronted with an ethical situation I recommend using the WCB-AB's tests first. If the situation is complicated or the three tests do not produce a satisfactory course of action

then the framework should be applied. The complete framework is set out in Appendix A.

Stage 1: Identify an ethical situation.

In this stage, something has alerted the DMC to the possible presence of an ethical situation and triggered the use of the framework. If the answer to any of the questions at this stage is yes, then the presence of an ethical dilemma is confirmed. The stage incorporates emotion (Burkhardt and Nathaniel, 2002; and Hill, Glaser, and Harden, 1995) and rules.

Stage 2: Assess the ethical situation.

Stage 2 consists of assessment. By collecting all the relevant facts, issues, and information about the parties' values, beliefs, needs and interests (Burkhardt and Nathaniel, 2002), DMCs are able to assess the relative significance of the dilemma to the parties involved. By the end of Stage 2, the DMC should be able to articulate the dilemma in the form of a question about the course of action to be taken, and whether she or he has the authority to make the decision.

Stage 3: Generate options.

At this stage DMCs generate potential courses of action, to be evaluated in the next stage. Collaboration is incorporated into this stage by determining what parties need to be involved in the decision, then consulting and involving them in the decision-making process. Potential courses of actions may become self-evident during discussion with the parties about desired outcomes. Consultation and collaboration is important, even if at the end of the day the DMC has the sole authority and responsibility for the decision.

Stage 4: Evaluate the options.

Stage 4 evaluates the courses of action generated in the previous stage. Different means of analysing the courses of action are suggested including: a) emotion and intuition (Burkhardt and Nathaniel, 2002; and Hill, Glaser, and Harden, 1995); b) balancing the needs and interests of the various parties to return to work process; c) reviewing the pros and cons; and d) a cost-benefit analysis. Moreover, this stage incorporates the WCB-AB's three ethical decision-making tests (i.e. the credit, values, and reasonable person tests), and the Golden Rule (i.e. is this how I would like to be treated?). At the end of Stage 4 a decision on a course of action will have been reached.

Stage 5: Plan and implement a course of action.

This stage involves working out the steps needed to implement the chosen option. A strategy, modelled after Roberta's 'begin with the end' approach, is suggested as a means of identification of the required steps. Responsibility for the decision or course of action is documented. At the end of this stage, the steps will have been determined and the plan implemented.

Stage 6: Evaluate the decision.

In Stage 6 the DMC is ready to evaluate the outcomes of the implemented course of action. A variety of measures are suggested for evaluation. Stage 6 recognizes that ethical decisions take place within an organizational context (Canadian Association of Rehabilitation Professionals, 2003). The DMC considers policies or processes that may have contributed to the dilemma, whether these may be changed, and what can be done differently to avoid similar ethical dilemmas in the future.

Implications of the Results

For DMCs generally the study:

- Gives a voice to their experiences in making ethical decisions during the return to work process, something not done before,
- Aids practice by:
 - Identifying common ethical situations and dilemmas,
 - Identifying strategies and tools for the resolution of dilemmas,
 - Creating a visual model intended to provide insight into how ethical dilemmas are formed and the preconditions to ethical dilemmas that obstruct and facilitate ethical decision-making,
 - Providing a theoretical context for ethical decision-making in disability management, something not previously suggested in the academic literature, and
 - Providing a framework for ethical decision-making, a practice tool that incorporates the disability management best practices literature, ethical theories and principles, and DMCs' experiences and values.

For organizations, the study:

- Provides insight into how ethical dilemmas are formed and resolved through the visual model,
- Identifies challenges and facilitators to ethical decision-making, particularly organizational factors, and
- Encourages employers to provide ethics training to DMCs, as well as to foster an organizational culture supportive of ethics generally and DMC autonomy.

With the insights provided by the visual model, organizations are able to identify and avoid many of the preconditions to ethical dilemmas, and to concentrate on implementing preconditions that facilitate ethical decision-making. For example, organizations wishing to reduce dual client issues should ensure the disability management program's mission statement gives clear priority to the worker's need for a safe return to work over organizational needs, and provide the program with sufficient funding.

Limitations of the Study and Recommendations for Future Research

The greatest limitation of the study is its sample size. A sample of eight participants means that while broad findings and conclusions are well-founded, the results may not be mined much further with any assurance of reliability or validity. In particular, nuances or differences in approaches and perspectives between different groups or subsets of DMCs cannot be teased out of the data.

Due to the exploratory nature of the study, more research is needed to test the key findings and theoretical constructs identified here. At this stage the framework and combined theoretical ethical approach are proposals only. The framework cannot be tested against the study data because participants' application of the framework to the ethical situations and dilemmas as described in the data cannot be predicted. Similarly, beyond demonstrating that participants use elements of Kantian Ethics and the Ethics of Justice and the Ethics of Care and Feminist Ethics, the combined theoretical approach cannot be tested against the study data. Both constructs need to be tested in the field by DMCs to determine their value in ethical decision-making.

In addition, the finding that a supportive organizational or professional culture is required for the use of formalized ethical decision-making processes must be tested because it is based on a single negative case.

The study assumes that participants make ethical decisions in the manner in which they say they make them. I did not use discourse analysis, nor did I design the study to test the validity of their statements. Modelled after Kohlberg's research, future research could elicit participants' responses to stipulated scenarios, then analyse and compare them against this study's proposed theoretical concepts.

Future studies might also interview or administer questionnaires to participants explore:

- Their agreement or disagreement with individual salient features of the Ethics of Care and Feminist Ethics, and Kantian Ethics and the Ethics of Justice,
- Their agreement or disagreement with individual Beauchamp' and Childress' ethical principles,
- Gender based differences in ethical decision-making among DMCs,
- The ranked importance of barriers to ethical decision-making,
- The ranked importance of facilitators of ethical decision-making, and
- The ranked importance of resolution tools and strategies.

I have not analyzed the data from the perspectives of labour relations, organizational theory, psychology (in particular cognitive processes), social constructionism, or sociology because I do not have academic credentials in these areas. An analysis from any of those perspectives would provide interesting insights and suggest areas of future research.

Summary and Conclusions

Eight DMCs living in Alberta were interviewed from February to April, 2006 about ethical decision-making in a phenomenological, qualitative study. No research has been done on ethical decision-making in disability-management, so the study is exploratory and uses an inductive approach. The purpose of the research is to explore ethical decision-making in disability-management, and to give a voice to the experiences of DMCs. My goal is to highlight the challenges DMCs face making ethical decisions, and discover how they overcome those barriers so that these experiences and insights may be shared with other DMCs and assist disability management praxis.

For the study, two key terms are defined. A dilemma is defined as a decision point to take or not take a certain course of action which arises from conflicting moral claims or ethical principles, equally unsatisfactory moral alternatives, or equally convincing rationales for or against a moral alternative. A DMC is defined as an individual who coordinates the return to work of employees absent due to injury or illness for a significant portion of her or his job. In addition to being DMCs the participants:

- Work for a private sector or public sector organization, a labour organization, or work as a private consultant,
- Live and work in Alberta,
- Are individuals with whom I have a prior professional relationship,
- Have a minimum of two years' experience in disability management, and
- Represent a variety of professional and educational backgrounds.

Sampling was purposive and nonprobabilistic because the population of DMCs in

Alberta is small but unknown. Participants were assigned into one of two descriptive categories of DMCs. Occupational DMCs work for, or if an independent consultant, are contracted by the same employer that employs the injured or ill worker and generally do not perform other duties. Union DMCs are employed by the union that represents the worker and carry out functions in addition to return to work facilitation, such as collective agreement monitoring and enforcement. Participants consisted of six occupational DMCs and two union DMCs.

Participants' years of experience ranged from five to 27 years with an average of 14.75 years. During their disability management careers, participants worked in several private sector industries: disability insurance; industrial construction; manufacturing; meat-packing; mining; property management; oil and gas refining; steel manufacturing and recycling; and transportation. They also worked in several public sector industries: health care; municipal government; secondary and post-secondary institutions; telecommunications; transportation; and workers' compensation. Their diversity of experience, industries, occupations and educational backgrounds contributes to the richness of the study data.

In addition to questions designed to elicit demographic information, participants were asked a series of open ended questions:

- How do they identify ethical situations and dilemmas?
- What ethical situations and dilemmas do they experience?
- What challenges and barriers obstruct, and what factors facilitate ethical decision-making?

- How do they resolve ethical dilemmas and what ethical decision-making tools and strategies do they use?

From participants' voices common themes around the identification and resolution of ethical situations and dilemmas emerged. Participants generally use emotion and the contravention of rules to identify ethical situations and dilemmas. Strategies used to resolve ethical dilemmas are formal or informal. Formal strategies include the use of stages in decision-making (e.g. identifying relevant rules, ethical decision-making models, assessing consequences, and gathering facts). Informal strategies include viewing the worker as an independent moral actor, education and training in both occupational competencies and ethics, consulting with peers and mentors, balancing the interests of workers and employers, and collaboration in relationships with the parties to the return to work process.

DMCs face many challenges in the resolution of ethical situations. Challenges arise from factors related to the disability management environment and the parties to the return to work process, as well as from professional expectations, which I labelled as professional imperatives. Challenges related to the disability management environment were identified at the level of the disability management program (e.g. policy, access to sensitive information, dual clients), the organization (e.g. policies, structure, climate, collective agreements and benefit plans), and the macro level (e.g. government programs and services, legislation and law). These factors obstruct ethical decision-making. Ethical decision-making in disability management, though, is not always a negative experience. Participants identify similar factors at the three levels conducive to ethical

decision-making. Accordingly, factors that constitute preconditions to ethical decision-making may be negative or positive.

Common themes emerging from the study data include rules, relationships, dual clients, access to sensitive information, privacy and confidentiality, conflicts of interest, balancing the interests of workers and employers, viewing the worker as an independent moral actor, and competent practice as ethical practice. Interestingly, with the exception of the union DMCs, participants generally do not discuss unionized environments, nor do DMCs perceive that they lack decision-making autonomy.

Key findings from the data include:

1. The complex nature of ethical decision-making processes exhibited by participants,
2. Disability management best practices are synonymous with ethical decision-making,
3. Without ethics training participants develop their own decision-making strategies,
4. Ethics training by itself is not sufficient to ensure participants use the ethical decision-making strategies learned in the training; a supportive professional or organizational culture is required,
5. All participants use elements of Beauchamp and Childress' ethical principles, Kantian Ethics and the Ethics of Justice, and the Ethics of Care and Feminist Ethics.
6. Participants do not generally use features of other traditional ethical theories in their decision-making.

The exploration of how ethical dilemmas are identified and resolved reveals that dilemmas arise out of the interaction by the parties in the disability management environment, in conjunction with professional imperatives held by the DMC. From this insight a visual model of the formation and resolution of dilemmas was developed. The model accounts for preconditions in one of the three core elements of an ethical dilemma that facilitate or obstruct ethical decision-making. The core elements are:

1. The parties to the return to work process,
2. The disability management environment, and
3. A disability management professional imperative.

A professional imperative is defined as a personal or professional moral obligation, duty, or expectation to behave in a certain way perceived, acknowledged or felt by the DMC. Professional imperatives consist generally of personal, professional and organizational values, Beauchamp and Childress' ethical principles and concepts, occupational competencies, and the codes of ethics and standards of practice of professional associations.

The resulting dilemma represents a decision point by the DMC to take a course of action. It is at this stage that the DMC applies ethical decision-making strategies. The DMC's decision may be ethical or unethical. It may have positive consequences, negative consequences, or both.

In addition to the visual model, I proposed a theoretical ethical approach for decision-making in disability management that combines Kantian Ethics and the Ethics of Justice, and the Ethics of Care and Feminist Ethics. This combined approach is

supported by the study data, participants' experiences, academic literature, and a discussion of its suitability to disability management.

To facilitate disability management praxis I proposed an ethical decision-making framework for disability management that complements the visual model and combined theoretical ethical approach. The framework integrates participants' experiences and strategies, disability management best practices literature, ethical concepts (i.e. theories and principles), rules, relationships, and strengths from other ethical decision-making models.

In conclusion, the DMCs I talked to are able to resolve difficult ethical dilemmas equitably in the face of considerable challenges. As I listened to their stories, the participants inspired a deep appreciation for their thoughtful approach to ethical decision-making, and for their ingenuity and tenacity. For me their experiences and insights reinforce the symbiotic relationship between ethics, and best practices and competency in disability management. Without one the other cannot exist. Paul very clearly made this link, and so I will let him have the last word:

There is still relatively little time spent on ethical decision-making [in disability management training and education], and obviously ethics is not a, a tangible concrete topic. It is much . . . easier to speak about profit and cost benefit ratio and return to work planning and consistent documentation, but I think professional ethics cannot be avoided if we are aiming at sustainable resolutions rather than just a short-term return to work and go off again cycle.

References

- Alberta Association of Registered Nurses. *Professional Conduct: Code of Ethics*. Retrieved June 26, 2003 from <http://www.nurses.ab.ca/>.
- Alberta Government Services. (2005a). *Personal Employee Information: Personal Information Protection Act: PIPA Information Sheet 5*. Retrieved April 6, 2005 from <http://www.oipc.ab.ca/ims/client/upload/ImplementPIPA.pdf>
- Bailey, D. & Johnson, W. (2004). Protecting medical privacy rights. In Centre for Labour-Management Development, *Human Rights in the Unionized Workplace* Conference. Edmonton, AB.
- Bailey, S. (2002). Insight and Mental Illness: Legal and Ethical Issues Related to Psychiatric Treatment. [Electronic version]. *Clinical Research and Regulatory Affairs*. 19(1), 25-32.
- Beauchamp, T., & Childress, J. (2001). *Principles of Biomedical Ethics, Fifth Edition*, Oxford: Oxford University Press.
- Best, J. (1995). *Images of issues: Typifying contemporary social problems*. Second Edition. New York: Aldine de Gruyter.
- Beu, D., Buckley, M., & Harvey, M. (2003). Ethical decision-making: a multidimensional construct. *Business Ethics: A European Review*. (12)1, pp. 88-107.
- Botes, A. (2000a). A comparison between the ethics of justice and the ethics of care. [Electronic version]. *Journal of Advanced Nursing*, 32(5), pp. 1071-1075.
- Botes, A. (2000b). An integrated approach to ethical decision-making in the health team. [Electronic version]. *Journal of Advanced Nursing*, 32(5), pp. 1076-1082.
- Buckley, M. (1999). Citizenship and the ethics of care: feminist considerations on justice, morality and politics. *Canadian Women's Studies* 19(1-2), pp. 220-221. Retrieved June 9, 2003 from InfoTrac Web: CPI.Q.
- Burkhardt, M., & Nathaniel, A. (2002). *Ethics and Issues in Contemporary Nursing* (2nd ed.). Clifton Park, New York: Delmar, a division of Thompson Learning, Inc.
- Canadian Association of Disability Management Coordinators. (2003). *Code of Ethics*. Retrieved June 10, 2005 from <http://www.cadmc.com/code.htm>
- Canadian Association of Rehabilitation Professionals. (2003). *Guidelines for Using the Canadian Code of Ethics for Rehabilitation Professionals*, (1st. ed.).

Retrieved August 30, 2008 from
<http://www.carpnational.org/CARPCode2002.pdf>

Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, Social Sciences and Humanities Research Council of Canada, *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*. 1998 (with 2000, 2002 and 2005 amendments). Retrieved December 13, 2005 from <http://www.pre.ethics.gc.ca/english/policystatement/policystatement.cfm>

Canadian Standards Association. (2005). *Model Code for the Protection of Personal Information*. Retrieved March 29, 2005 from
<http://www.csa.ca/standards/privacy/code/Default.asp?articleID=5286&language=english>

Certification of Disability Management Specialists' Commission. (2005). *Code of Professional Conduct*. Retrieved June 10, 2005 from
http://www.cdms.org/CodeOfProfConduct_Aug04.pdf

Crowley, M. (2002). Office culture may determine how workers exercise ethics, experts say. *Las Vegas Review-Journal*. Retrieved May 28 from
http://www.reviewjournal.com/lvrj_home/2002/Nov-03-Sun-2002/business/19904318.html.

Davis, A., Aroskar, M., Liaschenko, J., & Drought, T. (1997) *Ethical Dilemmas and Nursing Practice* (4th ed.). Stamford, Connecticut: Appleton and Lange, a Simon and Schuster Company.

Dyck, D. (2002). *Disability Management: Theory, Strategy and Industry Practice, Second Edition*. Markham, Ontario: Butterworths Canada Ltd.

Foye, S., Kirschner, K., Wagner, L., Stocking, C. & Siegler, M. (2002). Ethical issues in rehabilitation: A qualitative analysis of dilemmas identified by occupational therapists. *Topics in Stroke Rehabilitation*. 9(3), pp. 89-101.

Freedom of Information and Protection of Privacy Act, R.S.A., 2000, c. F-25. Retrieved October 23, 2008 from <http://foip.alberta.ca/legislation/act/index.cfm>.

Giles V. & Khullar, R. (2004). *Alberta's New Privacy Law in the Unionized Workplace*. (pp. 1-12). Audio Conference: Centre for Labour-Management Development.

Gilligan, C. (1982). New maps of development: New visions of maturity. *American Journal of Orthopsychiatry*. 52(2), pp. 199-212.

Gilligan, C. (1980). The effects of social institutions on the moral development of children and adolescents. *Bulletin of the Menninger Clinic*. 44(3). pp. 498-523.

- Harder, H., & Scott, E. (2005). *Comprehensive Disability Management*. Edinburgh: Elsevier Churchill Livingstone.
- Health Information Act*, R.S.A. 2000, c. H-5. Retrieved April 3, 2005 from http://www.qp.gov.ab.ca/documents/Acts/H05.cfm?frm_isbn=0779719352
- Hill, H., Glaser, K., & Harden, J. (1995). A feminist model for ethical decision making. In E. Rave, & C. Larsen, (Eds.), *Ethical Decision Making in Therapy: Feminist Perspectives*. (pp. 18-37). New York: The Guilford Press.
- Josephson Institute of Ethics. (2002). *Groundwork for Making Effective Decisions*. Retrieved, May 28, 2003 from <http://www.josephsoninstitute.org/MED/MEDintro+toc.htm>.
- Jodoin, S. (2004). *Disability Management in the Workplace 110: Ethics and Professionalism in Disability Management*. Course, Edmonton, Alberta: Grant MacEwan College.
- Jodoin, S. (2005). *Privacy Policies for Disability Management Programs*. Unpublished manuscript, University of Northern British Columbia, Prince George, British Columbia, Canada.
- Keatings, M., & Smith, O. (2000). *Ethical and Legal Issues in Canadian Nursing, Second Edition*. Toronto: Elsevier Science Canada.
- Kozier, B., Erb, G., & Blais, K. (1997). *Professional Nursing Practice: Concepts and Perspectives* (3rd ed.). Menlo Park, California: Addison-Wesley Longman, Inc.
- Kroeger-Mappes, J. (1994). The ethic of care vis-a-vis the ethical rights: a problem for contemporary moral theory. *Hypatia* 9(3), p. 108-131. Retrieved June 9, 2003 from InfoTrac Web: Expanded Academic ASAP.
- LaFollette, H. (1990). The truth in ethical relativism. *The Journal of Social Philosophy*, retrieved May 6, 2005 from <http://stpt.usf.edu/hhl/papers/relative.htm>
- Loseke, D. (1999). *Thinking about social problems: An introduction to constructionist perspectives*. New York: Aldine de Gruyter.
- Luntley, M. (2003). Ethics in the face of uncertainty: judgment not rules. *Business Ethics: A European Review*. 12(4), pp. 325-333.
- McAuley, W., Teaster, P., & Safewright, M. (1999). Incorporating feminist ethics into case management programs. [Electronic version]. *The Journal of Applied Gerontology*, 18 (1), pp. 3-24.

- National Institute of Disability Management and Research. (1999). *Occupational Standards in Disability Management*. Port Alberni, B.C.: Author.
- National Institute of Disability Management and Research. (2004). *Code of Practice for Disability Management Standards in Disability Management*. (2nd. ed.). Port Alberni, B.C.: Author.
- Norman, D., Murphy, J., Gilligan, C., & Vasudev, J. (1982). Sex Differences and interpersonal relationships: A cross-sectional sample in the U.S. and India. *International Journal of Aging & Human Development*. 14(4), pp. 291-306.
- Ottawa Citizen* (1996), 58 L.A.C. (4th) 209 (Dumoulin).
- Palys, T. (2003). *Research Decisions: Quantitative and qualitative perspectives* (3rd ed.). Scarborough: Nelson/Thompson.
- Patterson, J. (1989). Ethics and rehabilitation supervision. *Journal of Rehabilitation*. 55 (4), 44-49.
- Personal Health Information Protection Act*, S.O. 2004, c.3. Retrieved March 29, 2005 from http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/04p03_e.htm
- Personal Information Protection Act*, S.A. 2003, c. P-6.5. Retrieved March 29, 2005 from http://www.qp.gov.ab.ca/documents/Acts/P06P5.cfm?frm_isbn=0779726316
- Personal Information Protection and Electronic Documents Act*, S.C. 2000, c. 5. Retrieved January 12, 2005 from <http://www.privcom.gc.ca>
- Privacy Act*, R.S.C. 1985, c. P-21. Retrieved April 3, 2005 from http://www.privcom.gc.ca/legislation/02_07_01_01_e.asp.
- Peter, E., & Morgan, K. (2001). The rations of the trust approach for nursing ethics [Electronic version]. *Nursing Inquiry* 8, pp. 3-10. Retrieved June 12, 2003 from Academic Search Elite.
- Pinch, W. (1996). Feminism and bioethics. *Medical Surgical Nursing* 5(1), pp. 53-55. Retrieved May 28, 2003 from InfoTrac Web: Expanded Academic ASAP.
- Rachels, J. (2003). *The Elements of Moral Philosophy*. New York: McGraw Hill
- Rave, E., & Larsen, C., Eds. (1995). *Ethical Decision Making in Therapy: Feminist Perspectives*. New York: The Guilford Press.

- Rogers, B. (2002). Ethical considerations. In Dyck, D., *Disability Management: Theory, Strategy and Industry Practice, Second Edition*. Markham, Ontario: Butterworths Canada Ltd.
- Seale, C., Ed. (2004). *Researching society and culture*. (2nd ed.). London: Sage.
- Shrey, D., & Lacerte, M., Eds. (1995). *Principles & Practices of Disability Management in Industry*. Winter Park, FL.: GR Press.
- Shrey, D. (1998). Effective disability management programs. In P. King (Ed.), *Sourcebook of Occupational Rehabilitation* (pp. 287-322). New York: Plenum Press.
- Shrey, D. (1996). Disability management in industry: The new paradigm in injured worker rehabilitation. *Disability and Rehabilitation*, 18(8), 408-414.
- Stein, M. (2002). Utilitarianism and the disabled: distribution of resources. *Bioethics*, 16(1), pp. 1-19.
- Storch, L., Rodney, P., & Starzonski, R., Eds. (2004). *Toward a Moral Horizon: Nursing Ethics for Leadership and Practice*. Toronto: Pearson Prentice Hall.
- University of Northern British Columbia. (2005). *Research Ethics Board Approval Form*. Retrieved November 2, 2005 from http://www.unbc.ca/assets/graduatestudies/reb_approval_form.pdf
- Vickers, D. (1997). Equality. In W. Zimmermann, S. Riessner, & D. Shrey (Eds.), *Strategies for Success. Disability Management in the Workplace* (pp. 88-95). Port Alberni, B.C.: National Institute of Disability Management and Research.
- Vitell, S., & Paolillo, J. (2004). A cross-cultural study of the antecedents of the perceived role of ethics and social responsibility. *Business Ethics: A European Review*, 13(2/3), pp. 185-199.
- Vogel Smith, K. (1996). Ethical decision-making in Nursing: Implications for Continuing Education. *The Journal of Continuing Education in Nursing*, 27(1), pp. 42-45.
- Woods, C. (1996). Gender differences in moral development and acquisition: A review of Kohlberg's and Gilligan's models of justice and care. *Social Behavior and Personality*, 24(4), pp. 375-384.
- Workers' Compensation Board-Alberta. (2008). *WCB Statement of Ethics*. Edmonton, Alberta: Author.

Appendix A
A Framework for Ethical Decision Making in Disability Management

Stage	Questions	Resources (Internal and External)	Examples
1. Identify an ethical situation.	Does anything seem not right? Are my values compromised? Are there any competing or contradictory ethical principles, or moral obligations?	Your emotions and intuition. Your personal, professional, societal or cultural values. Ethical concepts: <ul style="list-style-type: none">• Beauchamp and Childress' ethical principles,• Ethical theories.	Autonomy, beneficence, fidelity, justice, non-maleficence, veracity. Religion, Utilitarianism, Kantian Ethics, Ethics of Care, a combined Ethics of Care/Feminist Ethics and Kantian

Stage	Questions	Resources	Examples
		(Internal and External)	
			Ethics/Ethics of Justice approach.
	Have any rules been contravened?	Rules: <ul style="list-style-type: none"> • Legislation, case law and arbitration law, • Collective agreement(s), • Policies, 	Human rights, privacy, workers' compensation. Accommodation, diversity and anti-discrimination, job competition, privacy, seniority, sick leave and benefit structure clauses. Disability management program, human resources, workers' compensation, disability insurance, or government

Stage	Questions	Resources	Examples
		(Internal and External)	
			program.
		<ul style="list-style-type: none"> Standards – corporate, organizational or professional associations. 	Codes of ethics, standards of practice.
2. Assess the ethical situation.	<p>What are the facts? Are there any gaps? Do I need to seek more information?</p> <p>What are the issues?</p> <p>Who is affected by the issues, and what are their beliefs, values, rights, interests, needs, and loyalties?</p>	<p>Case file, medical reports, the parties to the return to work process.</p> <p>Academic literature or research</p> <p>The parties to the return to work process.</p>	<p>Worker, employer representative(s), union representative(s), insurer (WCB or disability), co-worker(s), health care professional(s).</p>

Stage	Questions	Resources (Internal and External)	Examples
	<p>What are my values and beliefs? Do I have any interests or personal biases which may affect my perception or judgment of the situation?</p> <ul style="list-style-type: none"> Do a self assessment. 	<p>Your personal and professional values, and your societal or cultural values and beliefs.</p>	
	<p>Whose decision is this?</p> <p>Do I have the authority to make this decision?</p>	<p>Legislation.</p> <p>Policy – corporate and disability management program policies.</p> <p>Standards of practice - corporate and professional association.</p>	
	<p>What is the dilemma?</p> <ul style="list-style-type: none"> Articulate the dilemma as a question: What 		<p>Should I disclose the worker's personal health information to her</p>

Stage	Questions	Resources	Examples
		(Internal and External)	
	action should I take, having regard to all the circumstances?		supervisor? How can I accept this worker's gift while avoiding an appearance of favouritism? The supervisor wants to initiate disciplinary action for the worker's poor performance, what should I do?
3. Generate options.	What courses of action are available? What is the end result desired?	Academic literature or research. Peers, colleagues, mentors. Your past experience. Values: • Your personal and professional	Continuum of care models.

Stage	Questions	Resources	Examples
		(Internal and External)	
		values,	
		<ul style="list-style-type: none"> • The parties' values, and • The organization's values. 	Organization's mission statement, code of ethics, disability management program policies.
		Ethical concepts.	
		Rules.	
	Who needs to be involved in the decision and what do they suggest? What outcomes do the parties to the return to work process desire?	Your supervisor, the parties to the return to work process, interdisciplinary team members.	

Stage	Questions	Resources (Internal and External)	Examples
4. Evaluate the options.	<p>Which course of action is most advantageous, keeping in mind that a perfect resolution may not be possible?</p> <p>What are the consequences?</p> <p>Is this how I would want to be treated?</p> <p>Is the solution consistent with my values, the values of the parties, and the organization?</p> <p>Does the decision bring credit to me and my organization?</p> <p>Would a reasonable person believe that I acted with honour,</p>	<p>Academic literature or research.</p> <p>Peers, colleagues, mentors, professional associations.</p> <p>Your past experience.</p> <p>Your emotions, intuition.</p> <p>The parties to the return to work process.</p> <p>Values.</p>	<p>See previous stages.</p> <p>See previous stages.</p>

Stage	Questions	Resources	Examples
	(Internal and External)		
	fairness and reason?		
	Is it consistent with the ethical concepts that I find relevant and meaningful?	Ethical concepts.	See previous stages.
	Are any rules contravened?	Rules.	See previous stages.
	What are the advantages and disadvantages, costs and benefits?		
	Does it meet the needs of the parties to the return to work process?	The needs, rights, interests, and beliefs of the parties,	
	Does it balance the interests of the parties?	including yourself.	
	Would the likely outcomes be acceptable or unacceptable to the parties?		
	Does it feel right?	Your emotions and intuition.	

Stage	Questions	Resources (Internal and External)	Examples
5. Plan and implement a decision.	<p>What are the steps required to implement my decision?</p> <p>What is the end result desired?</p> <ul style="list-style-type: none"> • Work backwards. <p>Who needs to be involved in the decision?</p> <p>Who is responsible for the decision?</p>	<p>Rules.</p> <p>Your past experience.</p> <p>Peers, colleagues, mentors, professional associations.</p> <p>Your supervisor, the parties to the return to work process, interdisciplinary team members.</p> <p>Legislation.</p> <p>Policy – corporate and disability management program policies.</p> <p>Standards of practice - corporate and professional association.</p>	See previous stages.

Stage	Questions	Resources	Examples
	(Internal and External)		
6. Evaluate the decision.			
	<p>What happened and why? What was the outcome(s) of the decision or course of action?</p> <p>Did the outcome(s) have a positive or negative impact on the parties?</p> <p>Were any outcomes unanticipated?</p> <p>Were the parties to the return to work process satisfied?</p> <p>Did the worker achieve return to work? Was it sustainable?</p> <p>What can I do differently next time?</p>	<p>Corporate or organizational policies, procedures, guidelines, standards of</p>	<p>See previous stages.</p>

Stage	Questions	Resources	Examples
		(Internal and External)	
	practice, or collective	guidelines, or	
	agreement clauses	standards of practice,	
	contribute to the	standards of practice,	
	dilemma? Can these be	collective	
	changed and how?	agreement(s).	

Appendix B
Research Ethics Board Approval

UNIVERSITY OF NORTHERN BRITISH COLUMBIA

RESEARCH ETHICS BOARD

MEMORANDUM

To: Shelley Jodoin
CC: Henry Harder

From: Boris DeWiel, Acting Chair
Research Ethics Board

Date: January 30, 2006

Re: E2005.0112.009
Ethical decision making processes in disability management coordinators
practicing in Alberta

Thank you for submitting the above-noted research proposal and requested amendments to the Research Ethics Board. Your proposal has been approved.

Good luck with your research.

Sincerely,

Boris DeWiel

Appendix C
Information Sheet for Research Participants

Researcher: Shelley Jodoin

Address c/o Workers' Compensation Board--AB, P.O. Box 2415,
Edmonton, AB T5J 2S5

Phone # 780-498-7822 (bus.) 780-721-6642 (cell)

E-mail sdjodoin@shaw.ca

Supervisor's Name Dr. Henry Harder

Title of Project:

Ethical Decision-Making Processes in Disability Management Coordinators

Type of Project: Thesis

Purpose of Research:

To answer the research question: how do disability management coordinators in Alberta know when they are facing an ethical situation, and how do they make ethical decisions in their day to day practice?

Potential benefits and risks

Benefits: a) The advancement of knowledge about the manner in which disability management coordinators identify ethical situations and make decisions; b) the identification of factors (e.g. organizational, environmental, cultural, or personal) that facilitate or obstruct ethical decision-making; and c) the identification of ethical decision-making strategies and tools that may be used by other disability management coordinators.

Risks: The risks to the participant are low, and primarily flow from the risk that a participant, through information disclosed in the interview and published in the researcher's thesis, may be identified by a third party reading the thesis.

How the participant was chosen:

The participant is a person known to the researcher and practicing disability management in Alberta for more than two years.

What will respondent be asked to do:

Participate in an interview about ethical situations and decision-making in disability management.

Voluntary Participation

Participation in the research is voluntary and the participant has the right to withdraw at any time.

Remuneration

No remuneration for participation will be paid to the participant, although the researcher will pay for the bill if the interview is conducted in a restaurant.

Anonymity

The identity of participants will only be known to the researcher. If a transcriber is used, the researcher will ensure the tapes do not contain the participant's full name and that the transcriber signs a confidentiality agreement.

Confidentiality

The name and any personal identifiers of participants will not be incorporated into the final research report.

Data Storage

The data or information, consisting of interview tapes, field notes, and transcripts, data analysis will be stored at the researcher's residence, under lock and key. The information will be destroyed two years following the successful completion of the researcher's defense of her thesis .

Questions or Concerns

In case of questions about the interview and research, participants may contact the researcher, Shelley Jodoin, at the above address and telephone number. A copy of the final research report may also be obtained from the researcher.

- Any complaints about the project may be directed to the Vice President Research, University of Northern British Columbia at ph. 250-960-5820 reb@unbc.ca.

Finally, the participant may request a copy of his or her signed consent form from the researcher.

Appendix D
Research Study Informed Consent Form

Do you understand that you have been asked to be in a research study? Yes No

Have you read and received a copy of the attached information sheet? Yes No

Do you understand that the research interviews will be recorded? Yes No

Do you understand the benefits and risks involved in participating in
this study? Yes No

Have you had an opportunity to ask questions and discuss this study? Yes No

Do you understand that you are free to refuse to participate or to
withdraw from the study at any time? You do not have to give a reason. Yes No

Has the issue of confidentiality been explained to you? Do you
understand who will have access to the information you provide? Yes No

This study was explained by me by Shelley Jodoin.

I agree to take part in this study.

_____	_____	_____
Signature of Research Participant	Date	Witness

_____	_____
Printed Name	Shelley Jodoin

I believe that the person signing this form understands what is involved in the study and
voluntarily agrees to participate.

_____	_____
Signature of Investigator	Date

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM
AND A COPY GIVEN TO THE RESEARCH PARTICIPANTS.

Appendix E

Interview Topic Guide

I am going to ask you (the disability management coordinator and participant) a series of questions about ethical decision-making in disability management. The first set of questions will be open ended, followed by a number of demographic questions.

1 a) Identification of ethical situations or dilemmas

- How do you identify ethical situations or dilemmas? In other words, how do you know when you are facing an ethical situation or dilemma?

1 b) Examples of ethical situations

- Can you give me an example of an ethical situation or dilemma you have faced?

2 a) Resolution of Ethical situations and dilemmas

- How do you determine the right course of action, or the right thing to do when presented with an ethical situation or dilemma in the practice of disability management?

2 b) Ethical decision-making strategies or tools

- What strategies or tools do you use to help you make ethical decisions?

2 c) Examples of ethical situations w/ resolution

- Can you give me an example of how you resolved an ethical situation or dilemma?

3. Facilitators of ethical decision-making

- What organizational, environmental, cultural, or personal factors facilitate ethical decision-making?

4. Challenges and barriers to ethical decision-making

- What organizational, environmental, cultural, or personal factors obstruct or create barriers to ethical decision-making?

5. Other issues raised by participants

- Are there any other matters or issues on the subject of ethical decision-making in disability management that you would like to comment on or discuss?

Now I am going to ask you a series of closed questions to gather some demographic information:

1. What types of organizations and industries have you been employed in as a disability management coordinator?
2. What post-secondary education do you have?
3. How many years of work experience do you have in disability management?
4. What professional affiliations do you have?
5. Have you received any training in ethics?
6. What is your current occupation?

Appendix F Workers Compensation Board-Alberta Ethics Program

Program Components:

1. "In All fairness" video which describes the ethics program.
2. WCB Statement of Ethics booklet that defines ethics, the need for an ethics program, WCB corporate values, a process to resolve ethical dilemmas and example scenarios.
3. An Ethics Committee consisting of several WCB-AB employees, and chaired by the Secretary & General Counsel.
4. A five step process for resolving ethical dilemmas. The employee moves through the stages only if the previous stage fails to resolve the dilemma:
 - a. Apply one or more of the following tests:
 - "The Values Test: Are you clear about the values reflected in your decision and are they values you are proud to hold?" (Workers Compensation Board-Alberta, 2008, p. 6),
 - "The Reasonable Person Test: would a reasonable person in the community, having knowledge of all the facts, consider that you have acted fairly, honourably and rationally?" (Workers Compensation Board-Alberta, 2008, p. 6), and
 - "The Credit Test: If your action or decision became known to everyone, within either bring credit or discredit to you and the corporation?" (Workers Compensation Board-Alberta, 2008, p. 6).
 - b. Contact a supervisor,

- c. Contact Human Resources if the matter involves a supervisor or other management,
 - d. Contact an Ethics Committee member, and
 - e. Make a formal submission to the Ethics Committee.
- 5. Ethics training in new employee orientation, and refresher training to longer term employees.
- 6. Awareness activities throughout the year, including: a) annual Ethics Awareness Week activities; and b) quarterly ethics challenge question posted on the WCB-AB's internal website.

Appendix G
Canadian Code of Ethics for Rehabilitation Professionals Ethical Decision-Making Steps³

- Identify the individuals and groups potentially affected by the decision.
- Identify the ethically troubling issues, including the interests of persons who will be affected by the decisions, and the circumstances in which the dilemmas arose.
- Consider how your personal biases, stresses, or self-interest may influence the development of choices of action.
- Develop alternative courses of action remembering that you do not have to do this alone. (Where feasible, include interdisciplinary team members, clients, and others who may be affected by the decisions to share in the process. If the situation is difficult, consult with your professional association or other trusted professionals to maintain your objectivity and increase your options for action).
- Analyze the likely risks and benefits of each course of action on the persons likely to be affected.
- Choose a course of action, individually or collectively as deemed appropriate to the situation, after conscientious application of existing principles, values and standards.
- Act, with an individual or collective commitment, to assume responsibility for the consequences of the action. (A collective commitment, as may occur within an interdisciplinary team, requires that someone be assigned the responsibility for follow-up).

³ Reproduced with permission from the Vocational Rehabilitation Association of Canada, formerly the Canadian Association of Rehabilitation Professionals.

- Establish a plan to evaluate the results of the course of action, including responsibility for corrections of negative consequences, if any.
- Evaluate the organizational systems in which the issue arose in order to identify and remedy the circumstances which may facilitate and reward unethical practices.

(Canadian Association of Rehabilitation Professionals, 2003, p. 5)

Appendix H
Burkhardt and Nathaniel's A Guide for Decision Making⁴

Gather Data and Identify Conflicting Moral Claims

- What makes the situation an ethical problem? Are there conflicting obligations, duties, principles, rights, loyalties, values or beliefs?
- Where the issues?
- What facts seem most important?
- What emotions have an impact?
- What are the gaps in information at this time?

Identify Key Participants

- Who is legitimately empowered to make this decision?
- Who was affected and how?
- What is the level of competence of the person most affected in relation to the decision to be made?
- What are the rights, duties, authority, context and capabilities of participants?

Determine Moral Perspective and Phase of Moral Development of Key Participants

- Do participants think in terms of duties or rights?
- Do the parties involved exhibit similar or different moral perspectives?
- Where is the common ground? The differences?
- What principles are important to each person involved?
- What emotions are evident within the interaction and with each person involved?

⁴ From BURKHARDT/NATHANIEL. *Ethics And Issues In Contemporary Nursing*, 2E. © 2002 Delmar Learning, a part of Cengage Learning, Inc. Reproduced by permission. www.cengage.com/permissions

- What is the level of moral development of the participants?

Determine Desired Outcomes

- How does each party describe the circumstances of the outcome?
- What are the consequences of the desired outcomes?
- What outcomes are unacceptable to one or all involved?

Identify Options

- What options emerge through the assessment process?
- How do the alternatives that the lifestyle and values of the person(s) affected?
- What are the legal considerations of the various options?
- What alternatives are unacceptable to one or all involved?
- How are the alternatives weighed, ranked, and prioritized?

Act on the Choice

- Be empowered to make a difficult decision.
- Give yourself permission to set aside less acceptable alternatives.
- Be attentive to the emotions involved in this process.

Evaluate Outcomes of Action

- Has the ethical dilemma been resolved?
- Have other dilemmas emerged related to the action?
- How has the process affected those involved?
- Are further actions required? (Burkhardt and Nathaniel, 2002, pp. 102-103)

Appendix I
Hill, Glaser, and Harden's Feminist Ethical Decision-Making Model⁵

Rational-evaluative process	Feeling-intuitive process
<u>Recognizing a problem</u>	
Information from therapist's knowledge; advice from supervisor or colleague	Uncertainty about how to proceed in situation Identify what stands in the way of working through the problem: feelings about the nature of the issue, feelings about the consultant or about asking for help
(Decision to consult may occur here)	
<u>Defining the problem</u>	
What is the conflict? Who are the players?	What else is my discomfort about? What
What are the relevant standards? (rules, codes, principles)	do my feelings tell me about the situation? What am I worried about?
What personal characteristics and cultural values do I bring to this decision? How do these factors influence my definition of the problem?	
How does the client define the problem?	What are the client's feelings about the dilemma?

⁵ Reproduced with permission from The Guilford Press.

Rational-evaluative process	Feeling-intuitive process
(Decision to consult may occur here)	
What personal characteristics, values does the consultant bring to this process?	How do the consultant's characteristics affect me?
<u>Developing solutions</u>	
Brainstorm possibilities Cost-benefit analysis Prioritize values	What do my reactions to each choice tell me?
<u>Choosing a solution</u>	
What is the best fit both emotionally and rationally? Does this solution meet everyone's needs, including mine? Can I implement and live with the effects?	
<u>Reviewing process</u>	
Would I want to be treated in this way?	Does the decision feel right?
Is the decision universalizable? Would this decision withstand the scrutiny of others?	Have I given myself time to let reservations emerge?
How are my values, personal characteristics influencing my choice?	Does the manner in which I carry out this decision fit my style?
How am I using my power?	
Have I taken the client's perspective into account?	
<u>Implementing and evaluating the decision</u>	
Carry out the decision	Is this solution the best I can do?
Observe consequences	

Rational-evaluative process	Feeling-intuitive process
Reassess the decision	Does the outcome continue to feel right?
How has this decision affected the therapeutic process?	
<u>Continuing Reflection</u>	
What did I learn?	Have I changed as a result of this process?
	How?
What would I do differently?	How might this experience affect me in the future? (Hill, Glaser, and Harden, 1995, pp. 33-34)
