Decision-making processes in healthcare social work: training, ethics, and method in professional practice

Balma Soraya Hernández Moscoso[1]
ORCID: 0000-0002-7045-5233
Alba Giró Subirats[2]
ORCID: 0009-0009-0945-319X
Aida Gago Cornudella[3]
ORCID: 0009-0009-6921-1088
Tania González Sanchís[4]
ORCID: 0009-0009-9942-691X

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Abstract

As a specialised field within social work, healthcare social work addresses the psychosocial dimensions associated with processes of health and illness, and it plays a key role in supporting patients and families in highly complex contexts. Within healthcare settings, and as an inherent part of the experience of illness, decision-making processes are continuously present and permeate both clinical practice and social intervention.

The growing complexity of intervention contexts, the presence of ethical conflicts and tensions arising from institutional environments raise important questions regarding professionals' knowledge, training and use of tools for ethical decision-making in everyday practice.

The aim of this study is to analyse how healthcare social workers make decisions in professional practice, exploring their training in ethics and bioethics, the ethical perspectives informing their interventions and the use of decision-making methods or tools. Perceived difficulties and

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[1] Healthcare Social Worker. Paediatric Palliative Care and Complex Chronic Patient Service. Hospital Sant Joan de Déu. Barcelona. soraya.hernandez@sjd.es

[2] Hospital Sant Joan de Déu. Barcelona. alba.giro@sjd.es

[3] 01gagoaida@gmail.com

[4] Hospital Sant Joan de Déu. Barcelona. tania.gonzalez@sjd.es

expressed training needs are also detailed. An observational and descriptive study was conducted through the administration of questionnaires to healthcare social workers at Sant Joan de Déu hospital in Barcelona. The findings indicate that ethical conflicts are perceived as frequent and are associated with experiences of moral distress. Although most professionals report having received training in ethics, this is primarily acquired through informal learning pathways. The results also reveal the coexistence of various ethical perspectives without a homogeneous theoretical alignment.

Keywords: Healthcare social work, ethics, bioethics, decision-making, ethical conflict

1. Introduction

Social work contributes to the well-being of communities through intervention in human interactions and in individuals' relationships with their environment. Historically, the profession has been closely linked to the protection of people's health (Colom, 2010; Porcel, 2008), understood as a core element in the development of personal autonomy. Within healthcare settings, social work practice is structured in accordance with the principles of bioethics (Beauchamp and Childress, 1999), whilst remaining firmly grounded in the values inbuilt within the discipline, which are also reflected in professional codes of ethics (Banks, 1997).

Within healthcare contexts, decision-making processes constitute an inherent component of the experience of illness and may become particularly complex when ethical conflicts arise (Bertran et al., 2021). Nevertheless, bioethics education for healthcare professionals in Spain continues to be limited (Basagni, 2023). As members of the healthcare system, healthcare social workers undertake interventions characterised by a strong evaluative dimension, in which emotional factors play a significant role in supporting patients and families, thereby constituting an important element in decision-making processes (Cortina, 2007). In the same way as healthcare professionals, social workers may experience a lack of specific tools to support decision-making. This situation may be related to forms of training that focus primarily on the fulfilment of duties and obligations, to the detriment of the formation of moral reasoning and critical reflection (Cuenca and Román, 2023a).

The purpose of this study is to explore healthcare social workers' training in ethics, their personal theoretical perspectives and their use of decision-making methods in professional practice. At a time when the added value of social workers as healthcare professionals is increasingly being acknowledged, it is pertinent to analyse the host of competencies involved in their practice, including the support provided to patients and families in complex decision-making processes and in the resolution of ethical conflicts (Kangasniemi et al., 2021).

2. Objectives

The overall objective of this study is to analyse how healthcare social workers make decisions in their professional practice.

The specific goals of the study are:

- To examine healthcare social workers' training in ethics, bioethics and decision-making.
- To explore the ethical perspectives that inform their professional practice.
- To analyse the use of methods and tools for ethical decision-making.

- To identify the primary difficulties and perceived needs associated with decision-making processes.

3. Theoretical framework

3.1. Moral philosophy and ethical perspectives: an approach to the foundations of decision-making

Throughout history, societies have sought criteria to use as a basis to determine which decisions are morally appropriate and how action should be focused in complex situations. This field of knowledge has produced a wide range of theoretical frameworks that address specific historical, social and cultural contexts, without providing clear-cut or universally applicable answers to moral dilemmas (Idareta, 2023; Montero and Morlans, 2009).

Aristotle was the first to formulate ethics as a systematic theoretical discipline, structuring it around the concept of virtues, understood as those human qualities that are cultivated and which enable individuals to act appropriately. During the Middle Ages, philosophical reflection became intertwined with Christian religion, with moral judgement consequently subordinated to theological values. With the Renaissance, humanist thought revived the classical tradition and displaced God in favour of reason. In the 17th century, Descartes positioned ethics within the framework of rationalism, presenting it as the human capacity to analyse one's decisions objectively. Subsequently, Hobbes, Locke and Rousseau championed the need for a social contract capable of assuring individual rights and collective coexistence through agreed norms. During the Enlightenment, Hume argued that moral decisions are governed not by reason but by the passions, assigning emotions a determining role in human action. Within this Enlightenment tradition, Kant formulated the categorical imperative as a universal principle requiring individuals to act in accordance with norms that are valid for all humanity.

In contrast to deontological ethics, the teleological perspective emerged through the work of utilitarian thinkers such as Bentham and John Stuart Mill, who argued that morally correct action is that which produces the greatest level of well-being for the greatest number of people. From a critical perspective, Karl Marx focused on material and structural conditions and on power relations that restrict the opportunity of making decisions freely. Nietzsche broke with traditional moral structures and posited the need for each individual to construct their own guiding principles. During the 20th century, this line of thought was further developed through the existentialism of authors such as Jean-Paul Sartre and Simone de Beauvoir, who addressed decision-making in a world devoid of absolute truths.

In the 20th century, authors such as Nozick and Rawls revisited the social contract tradition, combining respect for individual liberties with the requirement for norms directed towards the common good. From a different standpoint, discourse ethics, developed by Karl-Otto Apel and

Jürgen Habermas, put forward a conception of morality based on consensus achieved through dialogue. Hans Jonas (2004) extended this approach by incorporating consideration of the consequences of human decisions for the environment and for future generations. Along similar lines, Emmanuel Levinas placed responsibility towards the Other at the heart of all moral decision-making. At the same time, Lawrence Kohlberg proposed a theory of moral development based on the progressive internalisation of universal ethical principles centred on justice and formal logical reasoning.

From a feminist critique of ethical theories centred on justice or context-dependent responsibility, authors such as Carol Gilligan and Joan Tronto developed what has become known as the ethics of care. This perspective maintains that moral deliberation cannot be separated from relational bonds or from the contexts of care through which human action is interpreted. In a similarly critical stance towards moral individualism, communitarianism –represented by authors such as MacIntyre (1993)– advocates a return to shared traditions as a source of ethical meaning. Hermeneutics, whose principal exponent is Gadamer, conceives ethics as an interpretive process that takes account of the historical and cultural context of each individual.

At the beginning of the 21st century, a number of contemporary philosophical currents became increasingly well established. Among these, two broad approaches may be distinguished: analytic philosophy and postmodern philosophy. Analytic philosophy, grounded in a scientific-rational tradition, focuses on the thorough analysis of concrete facts while avoiding the formulation of universal theories. By contrast, postmodern approaches challenge classical rationalism, questioning the existence of any absolute truth and advocating the recognition of diverse voices and perspectives.

Within the framework of contemporary ethical pluralism, classical debates such as that between determinism and indeterminism have regained prominence. Determinist positions maintain that human action is conditioned by factors such as the physical environment, human biology and social structures. Conversely, the indeterminist perspective champions the possibility of personal autonomy free from such determining influences.

From a critical perspective, it is necessary to acknowledge that the development of most of these intellectual traditions has been shaped by gender bias. Academic ethics has historically contributed to the exclusion of women from the sphere of moral deliberation. This exclusion is evident both in classical philosophical treatises and in Enlightenment texts, as illustrated, for example, by Rousseau's educational proposals for women and by discourses concerning female inferiority that were prevalent within the natural and medical sciences of the 19th century, as advanced by authors such as Darwin and Freud (De Miguel, 2021). The contemporary reassessment of this legacy, through the recovery of women's intellectual contributions and the incorporation of feminist approaches (Sorlí, 2023), constitutes an essential task for any theoretical framework seeking a critical understanding of moral deliberation.

For the purposes of clarifying the foregoing discussion and facilitating an understanding of the ethical pluralism described, the primary traditions examined may be grouped, for illustrative purposes, into the following broad approaches, which have historically informed reflection on decision-making:

- Approaches centred on virtue and moral character, which emphasise prudence and the ethical dispositions of the individual.
- Normative and deontological perspectives, grounded in duties, principles and universal norms.
- Teleological or consequentialist models, geared towards the evaluation of the consequences of action.
- Ethics of responsibility, care and alterity, which incorporate relationships, vulnerability and context into moral deliberation.
- Critical, feminist and postmodern approaches, which challenge assumptions of moral neutrality and draw attention to relations of power, gender and inequality.

This overview of the leading philosophical traditions provides a framework within which decision-making processes in healthcare social work (HSW) may be situated, namely that of ethical pluralism, from which both professional ethical analysis and practical deliberation in situations of clinical and social complexity are articulated.

3.2. Ethics in social work: from the code of ethics to practical tools

Within the field of social work, ethics has progressively become established as a significant component of the profession's historical and professional development.

Throughout its development as an ethical-professional framework, social work ethics has undergone a number of distinct phases. In its earliest formulations, professional ethics was associated with charitable practices rooted in religious and philanthropic traditions. As a critical response to these origins, professional ethics evolved towards an institutionalised and normative approach aimed at legitimising social work as both an academic discipline and a profession.

This approach was subsequently reinterpreted in order to incorporate growing social complexity, giving rise to a reflective and deliberative ethics without relinquishing the values that have historically characterised the profession. In more recent stages of its development, professional ethics has come to be conceptualised as a practical tool, shifting the emphasis towards operational principles and deliberative processes rather than abstract value-based formulations (Idareta, 2017).

It is within this context that codes of ethics have been developed, setting out the principles intended to guide professional practice (IFSW, 2018). These documents function as reference frameworks by providing guidance in situations of moral uncertainty and ethical conflict, as well as protection against institutional or political pressures. At the same time, codes of ethics constitute a safeguard for the public insofar as they contribute to the prevention of abusive or negligent practices.

Nevertheless, a number of authors have pointed out that their practical usefulness may be constrained by their normative nature and by general formulations that do not always provide clear guidance in relation to specific situations, thereby potentially placing social workers in contexts characterised by ambiguity (Rodríguez, 2017). Within this framework, the need has been identified to move towards a professional ethics that incorporates validated tools and processes of collective deliberation.

Among the tools for resolving ethical dilemmas described in the literature (Úriz et al., 2017; Úriz and Idareta, 2017) is Reamer's model, which proposes a structured sequence of steps designed to identify ethical conflicts, analyse the principles in tension and evaluate alternative courses of action.

Similarly, the aggregate model developed by Loewenberg and Dolgoff proposes a progressive eleven-step process intended to guide decision-making. Other proposals incorporate complementary dimensions into the main analytical framework. Accordingly, the model proposed by Congress (2000) introduces deliberation concerning the consequences of decisions, whilst Taylor's approach (2021) adopts a critical perspective that integrates risk management and the structural analysis of social inequalities.

Drawing upon both the historical development of professional ethics and the need to integrate multiple dimensions, Cuenca and Román (2023b) propose a renewed ethical framework that is not restricted to the listing of principles, but rather allows for their continuous adaptation and review through participatory processes, in response to the contemporary challenges facing professional practice. The authors emphasise the importance of a collective commitment to embedding ethics in a cross-disciplinary manner within education and training, organisational structures and professional culture, with the aim of creating a shared ethos that not only guides practice but also actively contributes to its transformation.

In conclusion, ethics in social work encompasses normative, deliberative and practical dimensions. Its stringent application is not limited to knowledge of the professional code of ethics; rather, it requires the incorporation of specific tools capable of facilitating ethical analysis in contexts characterised by uncertainty and conflict, together with the systematic integration of moral reflection into everyday professional practice.

3.3. Clinical ethics: origin and consolidation of bioethics

Healthcare practice has historically been characterised by decisions carrying a significant moral dimension. However, it was not until the 20th century that such decisions began to be subject to systematic analysis.

From the 1960s onwards, the development of techniques such as dialysis, mechanical ventilation and parenteral nutrition substantially transformed medical practice. At the same time, serious concerns relating to biomedical research came to light, including the Tuskegee study in the United States, in which treatment was withheld from African American men with syphilis; experiments involving children from disadvantaged families at Willowbrook Hospital; and the non-consensual acquisition of Henrietta Lacks's HeLa cells, which were used for decades without recognition of, or compensation for, her family (Montero and Morlans, 2009). Among other cases, these episodes demonstrated that in the absence of appropriate regulation and ethical reflection, scientific developments could contribute to the perpetuation of abuses affecting particularly vulnerable groups.

Debates concerning the definition of life and death in patients in a coma or a persistent vegetative state, together with those relating to the voluntary termination of pregnancy, likewise highlighted the need to clarify who makes decisions, how such decisions are made and on the basis of which criteria.

It was within this context that bioethics emerged as a form of applied ethics. Although the term had already been used by Fritz Jahr in 1927, it was Van Rensselaer Potter who, in 1970, established it as a framework for reflecting upon the impact of new technologies on both human beings and the environment. Through normative milestones such as the Belmont Report (Observatori de Bioètica i Dret, 1979), focused on research involving human subjects, and through the creation of academic institutions such as the Hastings Center and the Kennedy Institute of Ethics, bioethics became established as a distinct field of knowledge.

Within this context, various models were developed to guide decision-making in situations of considerable clinical complexity. Principlism (Beauchamp and Childress, 1999) proposes four principles –autonomy, beneficence, non-maleficence and justice– which must be weighed and balanced in each individual case. Casuistry (Jonsen et al., 2022) advances a form of reasoning based on the analysis of cases, avoiding the rigid application of abstract theoretical frameworks. The deliberative method (Gracia, 2019) structures an orderly, rational and shared process aimed at prudent decision-making and at recognising the plurality of values and perspectives involved.

The development of bioethics in Catalonia did not simply replicate international trends; rather, it responded to a distinct process linked to the progressive institutionalisation of ethical reflection within healthcare. Within this outlook, the Jesuit physician Francesc Abel played a central role as a driving force behind the first clinical ethics committees and as a promoter of specialised training through the Institut Borja de Bioètica, which became established as a leading institution at national level (Montero and Morlans, 2009).

During the 1990s, bioethics continued to develop in Catalonia through the contribution of professionals from a range of disciplinary backgrounds, among whom Marc Antoni Broggi, Lídia Buisán, Jordi Camí, Joan Viñas, Màrius Morlans and Francesc Abel himself were particularly prominent. In 1991, the Catalan Bioethics Society was founded, an organisation that played a key role in the drafting of the first accreditation provisions for ethics committees in both research and clinical practice. In that same year, an Advisory Bioethics Commission was established, regarded as the direct precursor of the present-day Bioethics Committee of Catalonia, formally constituted in 2004 under the presidency of Victoria Camps.

This process was characterised by a conception of clinical ethics as an integral component of healthcare practice, distinguishing itself from other more normative or strictly principlist approaches by positioning ethical reflection as a structural component of both care and health-related decision-making.

This historical development of bioethics provides a basis for understanding the institutional and deliberative framework within which decision-making processes in healthcare are currently situated. Within this context, healthcare social workers are becoming increasingly involved in settings such as clinical ethics committees, contributing to interdisciplinary deliberation and ethical-professional analysis through their consideration of social determinants, vulnerability and the relational dimension of care.

3.4. Ethics in healthcare social work: a proposal for "socialprudence"

As a specialised field within social work, HSW addresses the psychosocial aspects associated with processes of health and illness (Colom, 2010). Its practice falls within the domain of healthcare ethics, insofar as professional decisions have a direct impact on the quality of life and well-being of those receiving care. Within this framework, a range of contemporary ethical perspectives have progressively been incorporated into healthcare settings, particularly those that are sensitive to the relational, emotional and contextual dimensions of intervention, such as the ethics of care, the ethics of compassion and constructionist approaches (Úriz, Ballestero and Idareta, 2013).

Building upon this framework, Martin (2019) proposes a reformulation of the classical principles of bioethics, adapting them to the healthcare context and its relational dimension. This ethical reformulation is structured around the following principles:

- Dignity: the intrinsic value of every person as a subject of rights and responsibilities. This principle refers to the professional recognition of both individual and collective rights, as well as the creation of spaces that enable their expression.
- Autonomy: the functional and practical dimension of individuals' capacities and competencies to make decisions concerning their own lives. Ethical support involves ensuring access to appropriate information and avoiding undue external influences.
- Vulnerability: a condition inherent to the human experience, which may manifest itself in the form of fragility and loss of autonomy (whether temporary or permanent, actual or self-perceived), potentially generating dependence on others.

- Justice and equality: the promotion of well-being through the guarantee of equality of opportunity, treatment and rights. This entails ensuring equity in the distribution of resources, taking into consideration objective needs and indeed material living conditions.
- Solidarity and collaboration: the expression of collective responsibility in response to vulnerability, sustained through the relationships and support networks that make shared responses of support and care possible.
- Beneficence: the orientation of professional action towards achieving the greatest possible well-being for those receiving care, integrating the foregoing principles coherently within decision-making processes.

From this perspective, a number of authors have proposed the development of a social bioethics (Busquets, 2009; Canimas, 2009) as a critical extension of the traditional biomedical conception, incorporating the social dimension as a central element in understanding both human behaviour and decision-making processes. This perspective incorporates recognition of the sociocultural, historical and political context as a factor that shapes processes of care and support (Pellicer and Hernández, 2022).

At present, HSW practice unfolds within an environment largely conditioned by clinical parameters. Although social workers have access to established theoretical frameworks, codes of ethics and professional methodologies, decision-making within multidisciplinary teams tends to prioritise biomedical criteria. This dynamic may give rise to processes of tokenisation of the social worker's role, understood as forms of participation that are delayed, limited or instrumental in nature, and frequently confined to the management of material resources. In contexts characterised by immediacy, service pressures and a professional role centred on administrative tasks, practitioners more frequently rely upon informal exchanges with colleagues in order to address the ethical dilemmas that arise within decision-making processes (Idareta and Iturralde, 2018). Although such practices may be functional in the short term, they may also contribute to reducing the visibility of the specific contribution that HSW can make to ethical analysis within multidisciplinary teams.

Accordingly, deliberation constitutes the process through which the social worker may weigh and balance a range of factors prior to intervention, considering "the arguments supporting one option and another, hence the image traditionally associated with justice, in order to determine which constitutes the best alternative or, where this is not possible, the least harmful" (Montero and Morlans, 2009, p. 153). Deliberation also provides a framework for dialogue that fosters a climate of mutual respect among professionals whose axiological perspectives may differ and who operate within the parameters of their respective codes of ethics.

The virtue that guides deliberation is prudence, understood as the capacity to assess risks and benefits in each specific situation while maintaining the perspective necessary to moderate the influence of emotional factors and safeguard human rights (Montero and Morlans, 2009). Within this framework, the prudent decision does not seek absolute certainty but rather reasonableness; different decisions may be regarded as equally prudent when they are grounded in a thorough process of reflection.

When applied to HSW, prudence is not conceived solely as an individual moral virtue, but rather as a guiding principle of professional practice as well, understood as a form of situated practical wisdom (Idareta, 2021). This approach is grounded in specific competencies, including respect for human rights and for the professional code of ethics, together with the adoption of a secular, democratic and feminist perspective. Within this agenda, the concept of socialprudence is proposed as a basis for professional deliberation aimed at integrating social factors into decision-making processes. In doing so, it seeks to avoid both cultural relativism and the forms of subordination associated with welfare paternalism, while reinforcing the distinctive contribution of HSW within healthcare teams.

Socialprudence refers not merely to prudence understood as an individual moral virtue, but to a specific form of professional practical wisdom constructed at the intersection of ethical reflection and the analysis of the social factors that shape intervention. This form of prudence is particularly relevant in situations frequently encountered in healthcare practice, such as decisions concerning the hospital discharge of individuals who lack a support network capable of ensuring their care; the management of end-of-life processes shaped by diverse beliefs and traditions; or the assessment of social risk in contexts of heightened vulnerability. In such circumstances, when HSW intervention occurs late or is relegated to an instrumental role, decision-making tends to be reduced to clinical or organisational criteria, thereby rendering the relational dimension invisible. Socialprudence therefore makes it possible to anticipate social intervention, legitimise its contribution within interdisciplinary teams, and contribute to more comprehensive decisions that do not artificially separate the clinical dimension from the social one.

4. Method and participants

The research was designed as a single-centre, prospective, observational and descriptive study conducted within the Social Work Department of Sant Joan de Déu Maternal and Children's Hospital in Barcelona.

This design was selected in accordance with the objectives of the study. The approach makes it possible to describe the phenomenon within a homogeneous institutional framework, thereby avoiding the introduction of variability that could hinder the interpretation of the findings at this exploratory stage. Furthermore, the prospective and observational nature of the study was considered appropriate for gathering current information regarding practices, perceptions and training needs without intervening in them.

Although alternative methodological approaches would have been of considerable interest, they would have responded to different objectives, such as comparing organisational cultures or analysing deliberative processes in specific cases. In this study, a descriptive design was selected with the aim of generating an initial empirical foundation.

In light of the existing literature on the subject under investigation, the following research hypotheses were formulated, to be confirmed or refuted by the results:

- Decision-making processes in HSW intervention tend to be carried out in an automated manner, in some cases overlooking the available scientific evidence.
- Specific training in decision-making and in bioethics or applied ethics among healthcare social workers is limited and, where it exists, is primarily focused on classical ethical principles, with only limited knowledge of structured decision-making methods.
- Decision-making processes are strongly shaped by the personal values and beliefs of practitioners.

4.1. Sample selection

The target study population consisted of all healthcare social workers (n = 19) employed within the Social Work Department, including the professional holding the position of Head of Department. Given the small and clearly defined nature of the population, and considering that the principal investigator was herself a member of the department, all eligible individuals were invited to participate. No specific sample size calculation was therefore undertaken, resulting in a purposive non-probability sample.

The inclusion criteria were: being a healthcare social worker affiliated with the Social Work Department or with the management structure under which the department operates, irrespective of the role performed (direct practice, coordination or management), and explicitly expressing a willingness to participate in the study. This decision was intended to capture the widest possible range of perspectives while seeking to include diversity in terms of age, years of professional experience and organisational position, whilst maintaining a constant structural context.

The exclusion criteria were: being a student on placement or explicitly expressing a wish not to participate.

The final sample comprised 14 professionals. The responses of each participant are identified by an integer in parentheses.

4.2. Data collection

Two complementary strategies were employed for data collection: a literature review and the self-administration of two questionnaires.

The literature review was conducted during the first quarter of 2025 through a narrative search of scientific databases (PubMed, Web of Science, Scopus and Dialnet). Relevant articles and documents were selected on the basis of their subject-oriented relevance to the objectives of the study. The inclusion criteria comprised academic publications and specialised literature relating to healthcare settings, with priority given to material concerning moral philosophy, the ethics of social intervention, bioethics and decision-making in HSW. Documents unrelated to the topic and non-academic materials were excluded. The purpose of this review was contextual, providing a framework within which to situate the empirical findings in relation to the existing body of knowledge (Bowen, 2009).

With regard to empirical data collection, two questionnaires were used. Both questionnaires were administered at a single point in time (April 2025), following participants' voluntary agreement to take part in the study.

The first instrument was the Ethical Self-Assessment Questionnaire (C-AE) (Idareta, 2023), a validated instrument designed to identify professionals' ethical-theoretical orientations through items measured on Likert-type response scales. Sociodemographic questions were added to this questionnaire in order to facilitate description of the sample. The second instrument was an ad hoc questionnaire administered through the Google Forms platform, which included sociodemographic variables, questions relating to training in ethics and bioethics, and questions concerning the use of methods or tools for decision-making. This questionnaire combined closed multiple-response and Likert-type questions with open-ended descriptive questions designed to collect examples and commonly used strategies within professional practice. The sociodemographic variables collected were sex, age and years of professional experience.

Given the exploratory and descriptive nature of the study, together with the brevity of the responses to the open-ended questions, double-coding procedures were not applied, as they were not considered likely to provide significant additional analytical value. Consistency within the analytical process was ensured through the use of clearly defined instruments aligned with the objectives of the research. The authors undertook an interpretive reading of the data, comparing participants' contributions with the theoretical frameworks identified in the literature review and discussing their interpretations in order to ensure coherence. The analysis was conducted by examining participants' contributions in relation to the key ethical approaches and decision-making models described in the specialised literature.

4.3. Data analysis

The bibliographic material was examined through an analytical review of the literature aimed at identifying the key topics and approaches relevant to ethics, bioethics and decision-making in HSW. This review provided the basis for contextualising the study, developing the theoretical framework and informing the discussion.

Responses to the open-ended questionnaire items were analysed using a descriptive and exploratory topic-based analysis (Labra et al., 2020;

Braun and Clarke, 2006; Cohen and Manion, 2002) aimed at identifying recurring patterns within the practices of social workers. The analytical process was based on a detailed and comparative reading of the responses, grouping content according to topic-based affinity and comparing it iteratively with the objectives of the study, without seeking to construct a formal system of categories or to develop theory. Atlas.ti software was used as a supporting tool for the organisation and management of the qualitative material.

The analysis was undertaken from a critical and feminist perspective (Kincheloe and McLaren, 2005; Amorós and De Miguel, 2005), paying particular attention to structural constraints.

Quantitative variables were analysed using descriptive statistics in R and Python. Using the sociodemographic data collected through the Ethical Self-Assessment Questionnaire, potential associations with the ethical perspectives identified were explored by means of chi-squared tests and analysis of variance (ANOVA), for descriptive and exploratory purposes. Results are presented as percentages.

4.4. Ethical considerations

In order to minimise the possibility of undue influence and ensure compliance with the principle of non-maleficence, the study was initially presented at a routine team meeting, during which the objectives of the research were explained clearly and particular emphasis was placed on the voluntary nature of participation. Participants were explicitly informed that the decision to participate, or not to participate, would have no professional consequences whatsoever. All social workers within the department were afforded the same opportunity to participate, thereby ensuring the principle of justice in participant selection and treatment, without discrimination or bias arising from their position or role within the team.

Respect for autonomy was ensured through the provision of complete and comprehensible information regarding the study, including the right not to participate and the right to withdraw at any time without providing justification. Participants were informed that the principal investigator might be able to identify them during the data collection phase. However, the subsequent anonymisation of the data and the impossibility of re-identification during analysis and dissemination of the findings were assured.

With regard to confidentiality and data protection, questionnaires were sent only to those professionals who had agreed to participate. The information sheet and informed consent form were included in the accompanying email. The data collected were stored securely, with access restricted to the principal investigator, and were used exclusively for research and scientific publication purposes. The data are expected to be retained for one year following publication of this article and will subsequently be destroyed. In order to ensure methodological rigour and compliance with the ethical principles governing research involving human participants, the project was reviewed and approved by the hospital's Research Ethics Committee [PIC-62-24].

4.5. Limitations of the study

It should be noted that, despite the existence of recent empirical studies addressing ethical decision-making in social work and healthcare contexts (for example, Úriz, Ballestero, Viscarret et al., 2013), the literature specifically focused on healthcare social workers and decision-making methods in hospital settings remains limited.

From a practical perspective, given that the principal investigator was a member of the department under study, some professionals may have perceived a reduced degree of freedom to express their views openly or may have been influenced by social desirability bias. Furthermore, the use of self-administered questionnaires limits the range of possible responses and constrains the exploration of nuance. At the same time, professionals with a broader familiarity with ethical issues may have been more inclined to participate, thereby influencing the profile of the responses obtained.

Lastly, although the sample employed is representative of the population under study, the findings may not be generalisable to other institutions or healthcare contexts. Consequently, the results should be interpreted as descriptive and context-specific, providing a useful basis for informing future lines of research, including comparative studies involving a broader diversity of institutional settings.

5. Results

The HSW Department under study forms part of Sant Joan de Déu Hospital in Barcelona (Catalonia) and falls under the Directorate of Quality and Patient Experience. The healthcare social workers, the majority of whom are women, specialise in child health and paediatrics, although each practitioner works across one or more hospital units, including mental health, oncology, neonatology, palliative care, emergency care and intensive care, among others.

Some professionals are permanently integrated within specific services, carrying out protocol-driven and/or proactive interventions, whilst others intervene on a reactive basis through interdepartmental referrals. This organisational structure results in varying levels of participation in the dynamics of different healthcare teams, with healthcare social workers frequently involved in clinical decision-making processes.

The department employs 20 social workers. One member of the team serves on the hospital's Clinical Ethics Committee.

5.1. *Ad hoc* questionnaire

The group of respondents (n = 14) consisted of 86% women with a mean age of 40 years. The responses reflect considerable variation in years of professional experience as social workers, with a mean of 12.5 years, as well as diversity in professional backgrounds prior to employment within the hospital setting (Table 1).

All social workers agreed that their professional practice involves complex decision-making and 64% considered ethical conflicts to be inherent to their work.

Table 1. Professional fields prior to employment in the hospital setting

Professional field	Percentage
Exclusively healthcare settings	21%
Social services	29%
Disability services	7%
Third sector	14%
Justice	21%
Older adults	7%

Source: compiled by the authors.

Training in ethics and philosophy had been acquired at different stages of participants' professional careers and through a variety of learning pathways. 79% of participants had acquired knowledge in this area through attendance at conferences and professional events, whilst 64% had received continuing professional development through specialised courses. Seven participants, representing half of the sample, identified undergraduate studies as the starting point of their learning in ethics, whilst four considered themselves self-taught in this area. A smaller proportion had completed specialised postgraduate studies (7%).

Table 2 illustrates participants' specific training in bioethics, showing that most had acquired such training through conferences and specialised courses.

Table 2. Participants' training in bioethics

Educational stage	Percentage
Undergraduate degree	36%
Specialised postgraduate qualification in bioethics	14%
Specific continuing professional development in bioethics	57%

Attendance at conferences and professional events (specialised or otherwise)	71%
Self-taught	29%
Teaching experience	7%
No training	14%

Source: compiled by the authors.

Table 3 presents participants' specific training in ethical decision-making methods and tools. 57% had received specific continuing professional development, whilst 21% reported having received no specific training in methods and tools.

Table 3. Participants' training in specific decision-making models and/or tools

Educational stage	Percentage
Undergraduate degree	14%
Specialised postgraduate qualification in philosophy/ethics/bioethics	14%
Specific continuing professional development	57%
Attendance at conferences and professional events (specialised or otherwise)	50%
Self-taught	21%
Teaching experience	7%
No training	21%

Source: compiled by the authors.

In response to the question, "Do you use a decision-making method?", seven participants answered in the negative. When asked how they approached ethical decisions in the absence of a specific tool or method, responses varied: "Taking into account theoretical aspects and the characteristics of the family" (6); "Following workplace regulations and protocols" (10); "Identifying risks and benefits" (12); "I identify conflicting principles and determine the least harmful course of action" (5); and "I speak with the family" (7).

One social worker referred explicitly to principles associated with social work:

> Thinking about the patient's greatest well-being and protection, taking into account the principles of equality, justice, equity and responsibility. (5)

Another participant indicated that she discusses cases with professionals from other disciplines:

> We hold a weekly meeting in which each professional role presents its perspective and considerations. I formulate hypotheses and try to work from them in order to develop a joint plan together with the family. (4)

Six social workers indicated that they *sometimes* used a method. When asked to identify that method, three left the response blank and, of the remaining three, none referred to a recognised model, as shown in Table 4.

Table 4. Identification of the method used for decision-making and the resolution of ethical conflicts

Response
“I consider more than one alternative.” (2)
“I compare the situation with previous experiences. I rely on my own beliefs, values and principles.” (3)
“I act consistently and take the code of ethics into consideration.” (8)

Source: compiled by the authors.

One healthcare social worker reported using a decision-making method and identified it as follows: “Taylor’s method” (1).

When participants were also asked how they approached an ethical conflict that they had been unable to resolve independently or through case discussion, 79% reported consulting other social workers within the team, half discussed the issue informally and 29% raised it with the head of department. Other options considered are presented in Table 5.

Table 5. Responses to the question: “What do you do when faced with an ethical conflict that you cannot resolve individually or through case discussion?”

Action	Percentage
Consult a fellow social worker	79%
Consult or seek supervision from my coordinator	29%
Discuss the issue informally with the social work team	50%
Consult the social work team formally	29%
Seek supervision from a colleague with ethics training	14%
Consult a professional specialising in supervision	29%

Consult the hospital's Clinical Ethics Committee	57%
Consult the Professional Ethics Council	7%

Source: compiled by the authors.

When asked whether they had ever been required to undertake actions or accept decisions that caused them moral distress, 71% responded in the affirmative. Similarly, a further 71% reported having had to change their opinion as a result of external pressures, identifying disagreements with the institution as one of the main difficulties encountered (86%): "Working within an institution of this type (anonymised) inevitably influences certain decisions" (1); "On some occasions, I have had to comply with the majority decision" (14). In addition, 57% of participants indicated that conflict arose in relation to their own values, principles and beliefs.

To reduce the difficulties associated with resolving ethical conflicts and making decisions, 79% of social workers expressed a need for further training in ethics and bioethics, 64% requested more time for reflection and half called for additional opportunities to meet and discuss issues with the team: "I think there are too few opportunities to discuss situations that you do not know how to resolve" (8).

In relation to the objectives of the study, the data indicate that decision-making constitutes a structural dimension of professional practice within the hospital setting and that ethical conflicts are perceived as a frequent feature of everyday professional work.

Taken together, these findings make it possible to address the objectives relating to the analysis of everyday decision-making practice, the training received in ethics and bioethics, and the use of methods or strategies for resolving ethical conflicts. They also provide descriptive evidence through which the proposed hypotheses may be explored from an exploratory perspective.

5.2. Ethical self-assessment questionnaire

The questionnaire facilitates the identification of the ethical theories that inform professional practice. The respondents (n = 14) were 79% women, with a mean age of 38 years and between six and ten years of professional experience as social workers. 64% of participants had attended a state-funded independent secondary school and 36% completed their undergraduate studies at a private university. 50% worked part-time and 14% worked full-time while undertaking their university studies.

None of the participants reported involvement in community social action movements or social activism. Nevertheless, 36% made financial donations to third-sector organisations, a further 36% collaborated with such organisations on an occasional basis and 7% undertook voluntary work on a regular basis. Tables 6 and 7 present participants' self-reported political orientation and aspects relating to the spiritual dimension.

Table 6. Self-reported political orientation

Orientation	Percentage
Left-wing	51%
Centre-left	14%
Centre-right	14%
Depends on the prevailing social circumstances	14%
Prefer not to answer	7%

Source: compiled by the authors.

Table 7. Spiritual dimension

Spiritual dimension	Percentage
Christianity	14%
Cultural-religious traditions without underlying beliefs	36%
Spiritual orientations/philosophy of life	14%
Atheism	29%
Agnosticism	7%

Source: compiled by the authors.

The predominant ethical theories among healthcare social workers were compatibilist determinism and the ethics of responsibility, with a more limited presence of the ethics of care. 86% considered caring for others to be essential. Pure determinism was the least represented ethical perspective within the sample.

The proposition that the common good should always take precedence over individual interests divided the group exactly in half. Half of the participants endorsed the view that the exemplary ethical conduct consists of “being impartial and treating everyone equally”, whereas the other half favoured equity. 64% supported the idea that the same rights and responsibilities should be required of all individuals, compared with 29% who rejected this view and 7% who remained neutral.

Although almost all participants (86%) agreed that ethics entails taking on responsibility and combating injustice, this conviction was not reflected as broadly when it came to labour exploitation. Whilst 71% regarded ending the exploitation of the working class as a fundamental ethical obligation, almost 30% expressed reservations regarding this proposition. Lastly, 79% agreed that there is no absolute truth and that all perspectives are equally valid.

Application of the chi-squared and ANOVA statistical tests yielded p-values greater than 0.05. Consequently, no statistically significant relationships can be reported, although a number of descriptive trends were identified. From a descriptive perspective, the distributions observed between scores obtained on the various ethical perspectives and selected sociodemographic variables are presented. With regard to self-reported political orientation, participants identifying with left-wing or centre-left positions obtained higher scores in compatibilist determinism, whereas those identifying with centre-right positions exhibited higher scores in the ethics of responsibility.

According to the type of university attended, healthcare social workers who had studied at state universities obtained higher scores for dialogical and justice-based perspectives, whilst those who had studied at private universities exhibited higher scores in the ethics of responsibility. In relation to age, older healthcare social workers obtained lower scores when it came to items relating to the existence of universal ethical principles. Lastly, no relevant differences were observed between declared religious beliefs and the predominant ethical perspectives, and this is also true when it come to years of professional experience.

The data obtained through this questionnaire make it possible to address the objective of identifying the ethical perspectives that inform professional practice, revealing the coexistence of different ethical frameworks and the absence of any homogeneous theoretical alignment. At the same time, they provide relevant descriptive information for exploring the hypothesis concerning the influence of personal beliefs and values on decision-making processes.

6. Discussion

Although composed predominantly of women, the sample exhibits considerable diversity in terms of age, previous professional experience, political orientation and training in ethics. Despite this heterogeneity, all participants agreed that complex decision-making is an inherent component of HSW practice, with ethical conflicts occurring frequently. The findings also reveal what may be described as moral distress (Fantus et al., 2024), primarily associated with disagreements with the institution and with pressures that have, at some point, led the majority of participants to modify their opinion. Social workers repeatedly occupy intermediary positions between patients, families, clinical teams and the organisation, assuming ethical tensions associated with self-determination, confidentiality and shared decision-making (Weng, 2022). Within this context, accepting decisions imposed through hierarchical structures, relinquishing one's own professional judgement for "service-related reasons", or confronting structural limitations may add a significant emotional burden to the decision-making process.

With regard to the first hypothesis of the study, namely that decision-making constitutes a structural dimension of HSW intervention and may be conditioned by the institutional context, the findings confirm that ethical conflicts form part of everyday professional practice and bring about a significant emotional impact on practitioners.

With respect to training in ethics and bioethics, the findings demonstrate that such knowledge has been acquired predominantly outside formal education, principally through conferences and refresher courses, whilst university education provides only a limited initial foundation. This pattern becomes even more evident when examining training in decision-making methods, where formal preparation is exceptional and many professionals depend upon personal initiative to address gaps in their training. The absence of structured learning pathways may help to explain the heterogeneity observed in participants' educational trajectories (Ruiz, 2021).

These findings are directly related to the second hypothesis, according to which specific training in applied ethics and decision-making is limited and focuses primarily on general ethical principles, without the systematic development of practical tools.

With regard to specific training in decision-making tools, three social workers reported having received no training whatsoever, whilst the remainder indicated that they possessed some degree of knowledge. However, in practice, structured deliberative methods are rarely employed or, when they are used, they are not explicitly identified as such. This suggests that these tools have not been fully internalised and are not clearly distinguished from everyday reflection. Instead, improvised strategies tend to be employed, confirming observations already made by Banks (1997) and, more recently, by Cuenca and Román (2023, p. 50): "Many social workers act on the basis of practical wisdom or by drawing, in an unconnected manner, upon fragments of different theories associated with their learning." This situation reinforces the diagnosis found in the literature, which indicates that ethics education is often inconsistent, excessively theoretical or insufficiently applicable to professional realities (Basagni, 2023). In the specific case of social work, university degree programmes tend to prioritise the legal and historical dimensions of bioethics, relegating more practical components to a secondary position (Cuenca and Román, 2023). This situation points to a lack of systematic training and to the predominance of case-based approaches that depend heavily on individual judgement or organisational culture, potentially resulting in variability and inconsistency when confronting complex decisions.

The ethical dilemmas identified in this study are consistent with those described in the Spanish healthcare context, where social workers frequently encounter tensions relating to autonomy, confidentiality, informed consent and the management of sensitive information (Viscarret et al., 2022).

This context helps to explain the virtually automatic reliance on informal reflection with colleagues, the use of common sense or intuition, and even consultation with hierarchical superiors. Taken together, these findings suggest that social workers rely more frequently on informal exchanges than on formal channels, such as the professional ethics council, a specialised advisory body composed of social workers with training and experience in ethical consultation (Úriz, Ballestero, Viscarret et al., 2013). This preference for immediate professional exchange should not be interpreted solely as a lack of strictness, but also as an adaptive strategy within institutions where time for moral analysis is limited and service pressures hinder careful deliberation.

With regard to the third hypothesis, which posits that values, beliefs and personal ethical frameworks influence decision-making processes, the findings of the Ethical Self-Assessment Questionnaire provide a number of important nuances for discussion.

Rather than aligning rigidly with a single philosophical perspective, social workers appear to combine compatibilist approaches pragmatically with an ethics of responsibility inspired by Levinasian thought. The tendency towards compatibilist determinism (Dennett, 2003) is consistent with social work practice insofar as it recognises the influence of structural determinants and of axes of oppression and discrimination (Crenshaw, 1991), whilst simultaneously preserving the possibility of agency and transformation. This perspective calls for interventions directed towards emancipation, even within restrictive contexts (Lee, 2022). Likewise, the presence of an ethics of responsibility is consistent with proposals advocating a move beyond normative principles towards an ethics of compassion and responsiveness to suffering (Idareta, 2010), reinforcing both the case-based orientation identified in the ad hoc questionnaire and the widely held conviction that no absolute moral truth exists.

It might reasonably have been anticipated that the ethics of care would have a more prominent presence, given that social work is a highly feminised profession in which helping others has historically been naturalised as part of women's "traditional roles" (Fombuena, 2006). However, the ethics of care is not directed towards reinforcing gender prescriptions; rather, it advocates for democracy and substantive equality between the sexes, seeking to prevent women from being relegated to the role of primary caregivers (Gilligan, 1982). In this regard, the findings indicate that, although this perspective does not emerge as the principal theoretical point of reference, valuing care for others as an essential dimension of intervention is clearly present, consistent with a feminist perspective that recognises the structural oppression experienced by women (Sorlí, 2023).

The differences observed between the tendency towards compatibilist determinism among professionals identifying with left-wing or centre-left political orientations, the greater presence of the ethics of responsibility among those identifying with centre-right positions, and the distinctions observed between social workers educated at state and private universities were not statistically significant. Nevertheless, these distributions suggest that moral convictions may be shaped by political-ideological frameworks and educational pathways, at least in part. Similarly, the finding that older professionals tend to question the existence of universal ethical principles cannot be generalised. However, this phenomenon has been described in previous studies indicating that more experienced professionals are less likely to consult legislation and professional codes of ethics, relying instead upon personal learning and experience (Ballestero et al., 2011).

An unresolved tension between universalism and contextual equity can therefore be identified within the group. Whilst half of the participants considered prioritising the collective interest to be the highest expression of ethical conduct, the other half expressed reservations. Consistent with this tension, a substantial proportion rejected the idea that the same rights and responsibilities should be demanded of all individuals, reinforcing the relativist tendencies identified in other responses, such as the rejection of the existence of absolute moral truths.

These findings qualify any assumption of ethical homogeneity within the profession and highlight the extent to which each professional forms their own moral roadmap within a context characterised by the absence of shared points of reference. As Ballestero et al. (2011, p. 58) observe, "the absence of ethical 'standards' provided by the profession leaves social workers without points of reference", thereby placing the interpretation of ethical boundaries largely within the realm of individual judgement.

This gives rise to a recurring paradox: the greater the emphasis placed on respect for alterity –through compassion, contextualisation or relativism– the greater the risk of confusing such respect with an unrestricted freedom to make decisions without method or theoretical grounding. It is essential to clarify that diversity of responses to ethical complexity is not synonymous with arbitrariness, nor with decisions based solely on personal preferences. Intervention strategies may, and indeed should, be adapted to the circumstances of each case. However, they must be grounded in systematic deliberative processes, scientific evidence and human rights. In this respect, a key challenge for the profession lies in clearly distinguishing between adherence to different ethical perspectives and arbitrary practice, whilst fostering critical awareness of one's own biases and maintaining respect for professional codes of ethics as a collective safeguard (Gray, 2010).

Finally, the demands expressed by participants –namely, further training, more time for reflection and shared spaces in which to discuss cases– suggest a growing awareness of the ethical complexity inherent in professional practice. These findings highlight a gap between recognition of that complexity and the actual availability of the tools, time and institutional structures required to address it systematically.

The limited visibility and infrequent use of validated decision-making models, together with the relatively low level of consultation of professional ethics bodies, emphasise the need to develop a pedagogy of socialprudence, aimed not merely at *understanding* ethics but at *practising* ethics on the basis of a robust and contextually grounded philosophical foundation (Viscarret et al., 2022).

This should be translated into educational initiatives that integrate applied ethics into both undergraduate and postgraduate training, regular opportunities for ethical deliberation within healthcare teams, and supervision mechanisms that recognise moral reflection as an integral component of professional practice. Understood in this way, socialprudence would not only help to reduce moral distress, it would also strengthen the role of healthcare social workers in interdisciplinary decision-making, thereby contributing to more holistic and integrated care.

7. Conclusions

The findings reveal considerable diversity among healthcare social workers in relation to their training in ethics, which has been acquired predominantly through conferences and specialised courses rather than through formal education, where the provision of practical tools for decision-making and conflict resolution remains limited. This situation helps to explain why, although most professionals consider that they have received specific training in this area, such training is not translated into systematic application in everyday practice. Instead, informal discussions and common sense frequently emerge as the main strategies employed to address ethical challenges.

In response to ethical conflicts, identified as a frequent feature of intervention within healthcare settings, the study reveals significant moral distress arising from decisions shaped by external pressures and by the absence of structured institutional support. Healthcare social workers express a need for further training in ethics and bioethics, together with greater opportunities for reflection and additional spaces for engagement with interdisciplinary teams. These findings point towards a structural need to strengthen ethical support within healthcare settings.

Compatibilist determinism and the ethics of responsibility emerged as the predominant theoretical perspectives among the professionals surveyed, reflecting a position that seeks to reconcile external constraints with respect for patients' autonomy in decision-making processes and in social support interventions.

Future research should further examine the relationship between sociodemographic, educational and contextual variables and the predominant ethical theories identified, as well as the decision-making methods employed in practice. It would also be pertinent to investigate the extent to which the use of standardised ethical decision-making methods influences the quality of interventions in healthcare settings and contributes to reducing moral distress among healthcare social workers, with the aim of minimising bias and reducing reliance on unsystematic practices. In this regard, it is worth recalling, as Ballestero et al. (2011, p. 59) observe, that:

> Ethical practice must avoid the risks associated with bureaucratisation and with forms of action that are excessively impersonal, impartial and

> formal, characteristic of a rigid application of rules, whilst at the same time retaining the necessary flexibility. However, this flexibility must be accompanied by a shared and well-founded consensus that prevents a substantial proportion of professional ethical decisions from depending exclusively upon personal values.

The findings point to the value of strengthening ethics education for healthcare social workers through programmes that explicitly integrate moral philosophy, bioethics and the systematic use of decision-making methods, moving beyond approaches centred exclusively on abstract principles. Interdisciplinary clinical sessions, ethics supervision, and accessible ethics committees closely connected to everyday practice could also be established in order to address ethical conflicts in a structured and collaborative manner.

With regard to future lines of research, it would be valuable to extend the study to other hospital settings and to undertake multicentre comparative analyses capable of examining the consistency of the findings obtained. Likewise, research evaluating the impact of structured deliberative methods on the quality of decisions and on professionals' experiences of moral distress could provide relevant evidence for the development of more robust educational and organisational models. Lastly, exploring the institutional context through the lenses of the sociology or anthropology of the professions, both of which influence how social workers make decisions, represents another promising avenue for future research.

In conclusion, this study highlights the importance of ethical analysis within HSW, demonstrating both the challenges and the opportunities that characterise contemporary practice. The findings indicate that decision-making frequently relies upon unsystematic processes shaped by unequal educational backgrounds, personal values and institutional pressures, thereby reinforcing the need to move towards more structured frameworks. The diversity of ethical perspectives, educational pathways and decision-making dynamics reflects the complexity of the hospital environment and underlines the importance of continuing to develop practical tools, professional resources and a socialprudent approach capable of strengthening intervention. In this regard, the findings invite critical reflection on the integration of robust ethical principles into everyday practice, with the aim of avoiding both uncritical relativism and welfare paternalism, and of advancing from a merely professed ethics towards one that is genuinely deliberative.

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