

**Workarounds practiced by South African clinical psychologists during
mandatory community service: Ethical implications.**

Delia Miranda (BSocSc Hons)

Student number: 212542109

Supervisor: Professor Douglas Wassenaar

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Humanities, University of KwaZulu-Natal


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Plagiarism Declaration

This research has not been previously accepted for any degree and is not being currently considered for any other degree at any other university.

I declare that this research contains my own work except where specifically acknowledged.

Delia Miranda
Student number: 212542109

Signed.....

Date.. 14 March 2019.....

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Abstract

Workarounds are goal-driven activities that change the standard way of working in order to overcome an obstacle. There is an abundance of research into workarounds implemented in public healthcare settings by nurses; however there is little or no research into the implementation of workarounds by clinical psychologists. The current study aimed to explore the use of workarounds by South African clinical psychologists during their community service year and applied ethical codes of practice to understand the decision making and the ethical implications of implemented workarounds. The data was organised into quantitative descriptive statistics and analysed qualitatively using a framework method of analysis with the ethical code of practice as the analytical frame. The results of this research reveal that clinical psychologists in public healthcare settings do implement workarounds as ways to manage obstacles in their working environment. The data revealed a small number of obvious violations of ethical codes of practice. Additional research into the use of workarounds by clinical psychologists would be beneficial, particularly into further understanding the nature of obstacles encountered and the motivation for the particular choice of workaround.

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Chapter 1: INTRODUCTION

1.1 Background to the research problem

The term ‘workaround’ is a computing term and has, for many years, been linked with computer technology and software problems (Halbesleben, Wakefield, & Wakefield, 2008; Vestal, 2008). Workarounds in the world of computers, technology and software are common practice. When a computer program is faulty or does not allow the user to perform a certain function, a workaround enables the user to overcome the fault or restriction and continue working.

Workarounds are also associated with healthcare, most notably in hospital settings. A workaround is used in an instance where a healthcare provider, for example a nurse, encounters an obstacle, in the form of faulty equipment or a resource constraint or a conflict between their goal and the institution’s goals or policies, and they choose to find a way around the obstacle in order to reach their goal of caring for their patient (Alter, 2014). Nurses are often praised for their ingenuity in devising ways to work around a system that hinders or delays their ability to best care for their patients (Vestal, 2008). There is however a dark side to workarounds in that they are breaches of institutional policy and in some instances could lead to dangerous consequences for patients as well as questionable ethical practice (Berlinger, 2016; Halbesleben et al., 2008).

At the time of writing, no research conducted to investigate the use of workarounds by clinical psychologists could be accessed and to the writer’s knowledge, research into the use of workarounds by clinical psychologists has not been conducted to date. This research aims to investigate the nature of workarounds used in community service sites in South Africa where resource constraints in the form of personnel shortages, inadequate funding and problematic infrastructure have been reported (Marais & Petersen, 2015). This study will focus on the nature

of workarounds employed by clinical psychologists and will consider the ethical implications of these workarounds.

1.2 Chapter outline

A literature review in chapter 2 will review previous research which focussed on workarounds in public healthcare settings and will outline obstacles encountered, workarounds implemented and potential consequences for healthcare. A conceptualisation of the term and a working definition for workarounds in healthcare will be discussed. In addition the chapter will focus on ethical decision-making and some of the previous research into ethical dilemmas encountered in healthcare decision-making. The South African and Canadian ethical principles for psychologists will be highlighted as they will be the basis for evaluating the ethical implications of descriptions of workarounds in the data.

Chapter 3 will outline the rationale and aims of the study and will include the research questions.

The methodology used in this study will be discussed in chapter 4. A detailed description of the data collection process and the method used to evaluate the data will be presented and discussed in this chapter.

Chapter 5 will present the results of the study. The data collected will be collated and presented as descriptive statistics and qualitative descriptions of obstacles encountered, workarounds implemented and the consequences and outcomes of using these workarounds. A section on the ethical implications will be included in the results.

A discussion of the results will be presented in chapter 6. This chapter will aim to answer the research question. The workaround stories in the data collected will be discussed in depth and compared to the contents of the literature review. The ethical implications of the workarounds

described in the data as well as the conflict between two or more ethical principles will be analysed.

The study will be concluded in chapter 7, highlighting the general findings of this research as well as the limitations and recommendations for future research.

Chapter 2: LITERATURE REVIEW

Workarounds are prevalent in the world of computers, technology and software (Halbesleben et al., 2008; Vestal, 2008) where ‘glitches’ are bypassed (Campbell, 2011; Vestal, 2008). Computers are used in innovative ways or in some cases using a computer is simply avoided altogether to escape software and other problems (Halbesleben et al., 2008). Workarounds have also been noted in industrial and electrical engineering (Halbesleben et al., 2008) as well as in the military where improvising on orders given in battle situations becomes necessary for survival and victory (Campbell, 2011). Workarounds in these settings are described and understood to be temporary solutions or alternative pathways which are used until permanent solutions or patches are available and the workaround is no longer needed (Campbell, 2011; Vestal, 2008).

Workarounds in healthcare settings are similar in many ways. They are a means of getting things done, practical fixes, and are at times even viewed as essential to the job (Alter, 2014; Berlinger, 2016; Vestal, 2008). Healthcare providers who develop workarounds are frequently praised for their ingenuity and resourcefulness (Dupret & Friberg, 2018; Lalley & Malloch, 2010; Vestal, 2008) and, unlike workarounds in computers, technology and software and the military which are temporary in nature, workarounds in healthcare that yield positive outcomes are often passed on to others resulting in the workaround becoming common practice (Berlinger, 2016). The adverse element of workarounds in healthcare is that they may be violations of the institution’s rules, regulations, protocols, guidelines and/or policy (Alter, 2014; Berlinger, 2016; Campbell, 2011; Halbesleben et al., 2008; Lalley & Malloch, 2010). The negative consequences of implementing workarounds could range from medical errors to a lack of consistency and reliability in practice and even legal and ethical violations (Alter, 2014; Berlinger, 2016; Lalley & Malloch, 2010; Rathert, Williams, Lawrence, & Halbesleben, 2012).

2.1 Conceptualization of workarounds

In order to gain a better understanding of the theory of workarounds and the implications associated with workarounds, the next few paragraphs will be dedicated to a working conceptualisation of the term. There is no dictionary definition of healthcare workarounds and writers on the subject differ in their conceptualisation of the term. As Halbesleben et al. (2008) note, workarounds are written about but no clear definition has been established.

After reviewing various articles that attempt to define workarounds, it is clear that there are four preconditions for workarounds to occur. These preconditions are an existing policy, a work related goal, a policy related obstacle to achieve the goal, and the ability to devise and implement a workaround (Alter, 2014; Campbell, 2011; Debono et al., 2013; Halbesleben, Savage, Wakefield, & Wakefield, 2010; Halbesleben et al., 2008; Rathert et al., 2012; Seaman & Erlen, 2015; Vassilakopoulou, Tsagkas, & Marmaras, 2012).

The first precondition of existing policy is commonly understood to mean institutional policy. Campbell (2011, p. 410) refers to it as “a specific policy procedure or rule enforceable by bureaucratic superiors” and Debono et al. (2013, p. 2) talk about “organisationally prescribed or intended procedure”. Similarly, Seaman and Erlen (2015, p. 235) refer to “protocol established by the organisation”. Alter (2014, p. 1042) however extends this idea to include “routines, instructions, expectations, requirements, software specifications and/or regulations”. Existing policy prescribes the standard expected workflow in a healthcare setting which healthcare professionals are expected to follow.

The second precondition is a work related goal (Alter, 2014; Campbell, 2011; Debono et al., 2013; Halbesleben et al., 2008; Seaman & Erlen, 2015). Alter (2014, pp. 1043-1044) described the goal as “doing work in a preferred manner” and “achieving a desired level of efficiency, effectiveness or other organisational or personal goals”. Timely achievement of a

specific work related goal is viewed as a goal in itself (Debono et al., 2013). In healthcare settings, and of particular interest in this study, work related goals refer to goals directed towards patient care and service delivery.

The next precondition is an obstacle. The obstacle to achieve the goal is often policy related (Alter, 2014; Campbell, 2011; Debono et al., 2013; Halbesleben et al., 2008; Rathert et al., 2012) and can create difficulties in various forms. Alter (2014) refers to two ways in which an obstacle can occur. The obstacle can either hinder the healthcare professional from achieving their goal in the way they would prefer to achieve it or the goal of the healthcare professional and the policy could be in conflict or misaligned. In many cases the obstacle is a resource constraint which affects the ability of the healthcare professional from achieving their goal (Alter, 2014; Halbesleben et al., 2010). The obstacles can be perceived or real (Alter, 2014; Campbell, 2011; Debono et al., 2013; Halbesleben et al., 2010) and result in a block, gap, hindrance or barrier to normal workflow (Alter, 2014; Campbell, 2011; Debono et al., 2013; Halbesleben et al., 2010; Halbesleben et al., 2008; Rathert et al., 2012; Seaman & Erlen, 2015). In essence the obstacle creates a “mismatch between expectations... and actual working practice” (Sobreperez, Ferneley & Wilson, 2015 in Alter, 2014, p. 1045) or makes it difficult to readily achieve a work related goal (Halbesleben et al., 2008).

The final precondition is the ability to devise and implement a workaround. A workaround is an intentional act devised to address the obstacle (Alter, 2014; Campbell, 2011; Debono et al., 2013; Halbesleben et al., 2010; Halbesleben et al., 2008; Rathert et al., 2012). The workaround is devised by a person who uses their knowledge and creativity (Alter, 2014; Campbell, 2011; Halbesleben et al., 2008) to improvise or adapt an existing policy (Alter, 2014), bypass the problem (Alter, 2014; Debono et al., 2013; Halbesleben et al., 2010; Seaman & Erlen, 2015), or temporarily fix the difficulty (Debono et al., 2013). The aim of the workaround is to

find an alternative path to achieve the original goal, making it a goal driven intentional act (Alter, 2014; Campbell, 2011; Debono et al., 2013; Halbesleben et al., 2010; Halbesleben et al., 2008; Seaman & Erlen, 2015; Vassilakopoulou et al., 2012). Although workarounds in healthcare settings are sometimes passed on to others, becoming common practice (Berlinger, 2016), they do not eliminate the obstacle or fully resolve the problem (Alter, 2014).

For the purpose of this study, workarounds will be conceptualised using the definition proposed by Alter (2014, p. 1044).

“A workaround is a goal-driven adaptation, improvisation, or other change to one or more aspects of an existing work system in order to overcome, bypass, or minimize the impact of obstacles, exceptions, anomalies, mishaps, established practices, management expectations, or structural constraints that are perceived as preventing that work system or its participants from achieving a desired level of efficiency, effectiveness, or other organizational or personal goals.”

Existing literature conducted internationally outlines some examples of workarounds that nurses in public healthcare implement, and include the following. Nurses store extra pillows and blankets in unused cupboards to ensure they are readily on hand when needed, rather than requesting them and having to wait for them to arrive in the ward (Berlinger, 2017). Another example of a workaround that has frequently been written about is when nurses make extra copies of patient wrist bands and scan the barcodes for medication dispensing purposes at the nurse's station rather than scanning at patient bedside as the policy states (Alter, 2014; Berlinger, 2017; Halbesleben et al., 2010; Lalley & Malloch, 2010; Seaman & Erlen, 2015; Vassilakopoulou et al., 2012). Working around this policy can result in errors in medication distribution. A workaround that occurred in an

Australian hospital was reported by Berlinger (2016) where nurses hid patients from a doctor who had a history of being incompetent, as a way to protect the patient.

2.2 Activities that are not workarounds

Not all instances where policy is adapted or bypassed constitute a workaround. Errors or mistakes, deviance, shortcuts, reengineering or redesigning and turfing are not the same as workarounds. Each is discussed briefly below.

2.2.1 Errors and mistakes

Halbesleben et al. (2008) refer to errors as instances where intended outcomes are not achieved. Errors are described as having some connection to workarounds because a workaround could result in a higher likelihood of an error occurring due to them being contrary to established policy. Mistakes are described as failures in the quality of the planning process which result in discrepancies between the objective and the outcome (Halbesleben et al., 2008). Workarounds are usually implemented in the moment which often requires quick thinking and planning. However, workarounds are not classified as poor quality interventions; rather workarounds in healthcare that are successful can become widely accepted practice (Berlinger, 2016). Errors and mistakes are specifically different to workarounds because they are not goal driven activities implemented to overcome an obstacle in workflow (Alter, 2014; Rathert et al., 2012).

2.2.2 Deviances

Halbesleben et al. (2008) describe deviances as similar to workarounds in that they are instances where the institutional policy or accepted practice is intentionally violated. Deviances differ from workarounds in their motive where the motive for the workaround in healthcare is patient care or service delivery and the motive for a deviance is self-serving (Halbesleben et al., 2008).

2.2.3 Shortcuts

The term “shortcuts” has on occasion been used interchangeably with workarounds and can be viewed as a specific type of workaround (Halbesleben et al., 2008). Shortcuts are ways to work around the obstacle of time when “workers believe that following the correct process will take too much time” (Halbesleben et al., 2008, p. 5).

2.2.4 Redesigning or reengineering

Redesigning or reengineering projects that create major system changes are not workarounds because the redesigns or reengineering would cause changes to work systems at a high level and not just for the individual persons work (Alter, 2014). Changes of this magnitude would potentially create policy changes within an organisation.

2.2.5 Turfing

Berlinger (2016) refers to turfing as a technique that is related to workarounds in that both are problem avoidance techniques. “Turfing relocates the problem in space or time” (Berlinger, 2016, p. 64) whereas a workaround is a method of working around a problem to get the job done and deliver the service. A workaround is usually implemented by someone who does not have the authority to move the problem or challenge policy. On the other hand, turfing is usually implemented by a person with enough power to move the problem to another person or another time. Avoiding a problem by turfing it gives the illusion that it has disappeared. In contrast, a workaround acknowledges the problem but implements a fix to achieve the end goal in another way (Berlinger, 2016).

2.3 Understanding the elements of workarounds

This section will elaborate on the types of obstacles that could be encountered, the different kinds of workarounds that could be implemented and the various expected outcomes of workarounds.

2.3.1 Obstacles

Workarounds are conceptualised in terms of overcoming an obstacle which prevents the healthcare professional from achieving work related goals. The reality of getting a job done often involves navigating instances where existing rules or procedures do not match the reality of the work that needs to be done (Berlinger, 2017; Vassilakopoulou et al., 2012). These obstacles can be intentional or unintentional (Halbesleben et al., 2008) and can originate from a variety of sources. Intentional blocks are often put in place as a control measure and workarounds of these type of blocks can have potentially adverse consequences because standardised procedure is not being followed (Halbesleben et al., 2008). Unintentional blocks often come in the form of faulty equipment, outdated policies or resource constraints. Working around these blocks has the consequence of the underlying problem not being addressed making the need for continual workarounds and potentially dangerous and non-standard practice continuing (Halbesleben et al., 2008). Understanding the obstacles that lead to the implementation of workarounds is fundamental to our knowledge of why workarounds are implemented (Halbesleben et al., 2008). In healthcare settings, obstacles are more likely to lead to the implementation of workarounds due to the high workload and constantly changing nature of the work (Halbesleben et al., 2008).

Obstacles that lead to the implementation of workarounds can be divided into several different circumstances or challenges. In public healthcare workarounds usually fall into the following categories:

2.3.1.1 Rules, protocols, guidelines and policy

This refers to instructions or guidelines given to healthcare professionals who are expected to implement them. Protocols and guidelines are usually implemented to improve patient care and to protect both the patient and the healthcare professional from harm (Halbesleben et al., 2008). Policy, guidelines and instructions are often complex and at times they may contradict one other or fit poorly with work related goals (Campbell, 2011; Halbesleben et al., 2008). This creates a strain on healthcare professionals and the need for a workaround is produced (Campbell, 2011). At times a healthcare professional may perceive the policy as not being in the best interests of the patient and will then implement a workaround as a way to customise care to the needs of the patient (Debono et al., 2013; Halbesleben et al., 2008). When institutional changes to policies or guidelines are effected, partial acceptance of the changes and resistance to compliance can lead to workarounds (Halbesleben et al., 2010). Some of these changes are designed with intentional blocks in order ensure that every step of the expected way of performing a task is complied with to eradicate or reduce errors. Workarounds are often effected to avoid the intentional blocks (Halbesleben et al., 2008).

2.3.1.2 Operational failures, environmental challenges and work process design

Operational flaws result in disruptions to patient care. Berlinger (2016) suggests that these often preventable situations also have ethical implications for those most affected by them. Missing patient information or incomplete documentation are also noted as obstacles that elicit workarounds (Debono et al., 2013). Rathert et al. (2012) look at environmental factors in terms of crowding and suggests that a work environment that is crowded affects the ability to get things done quickly due to distractions and lack of work space. Working in a crowded environment demands more from an individual's personal resources, and could result in increased frustration

and exhaustion. A study by Rathert et al. (2012) concludes that frustration and exhaustion could lead to increased use of workarounds.

2.3.1.3 Technology and equipment failures

As already mentioned, the concept of workarounds began in the computer and technology field and it is therefore not surprising that workarounds in public healthcare are frequently associated with technology (Halbesleben et al., 2008). Alter (2014) and Debono et al. (2013) describe working around technology as instances in which the technology does not fit with the reality of the work environment. In pursuit of efficiency and goal achievement as well as responding to patient needs, workarounds emerge as a response to technology misfits. Unreliable or defective equipment can be frustrating and may leave healthcare professionals with the opinion that they have to find a way to work around equipment failures (Berlinger, 2016). The implementation of new technology or an upgrade of equipment does not always go smoothly creating a sense that what is new is not reliable (Halbesleben et al., 2010). Workarounds in these instances can be in the form of going back to what is perceived to be previously reliable ways of getting things done in order to avoid the extra steps required to manage teething problems associated with new technology or equipment.

2.3.1.4 Resource constraints

Resource constraints saturate public healthcare which creates morally challenging situations (Albee, 1969; Baum, Gollust, Goold, & Jacobson, 2007; Berlinger, 2016; Padfield, 2013; Rohleder, Miller, & Smith, 2006). Where there are resource constraints, healthcare professionals are forced to make do with what they have which creates more opportunities for the implementation of workarounds (Alter, 2014; Berlinger, 2016; Vestal, 2008). Workarounds of this nature can be short-term solutions or take place over long periods of time, depending on how long the resource constraint exists for (Alter, 2014).

2.3.1.5 Human resource shortages and personnel factors

Following the previous point, funding constraints in public healthcare also result in staff shortages. Staff shortages often result in exhaustion and burnout which, according to Rathert et al. (2012), are likely to lead to the implementation of workarounds. In instances of staff shortages, healthcare professionals perceive themselves as lacking the resources to manage productivity and comply with procedure and perceive the workaround as a time and energy saving practice (Debono et al., 2013; Rathert et al., 2012; Vassilakopoulou et al., 2012). Berlinger (2016) expands on this idea and suggests that a healthcare professional faced with a bad situation and who perceives themselves as powerless to effect change, may avoid a situation by implementing a workaround. Staff shortages are not the only catalyst for workarounds. The human factor involves personal preferences and although policies and guidelines attempt to restrict personal preferences from determining how a particular job gets done, people may have a tendency to work around guidelines when they are perceived as a block to their own preferences (Marais & Petersen, 2015). Yoes (2012) refers to instances where the core values of a healthcare professional appear to be in conflict with a specific aspect of their work and Berlinger (2016) refers to the moral distress experienced by healthcare professionals who have to manage institutional stress and productivity expectations. Both of these drivers create obstacles that can result in workarounds. Halbesleben et al. (2010) write about instances where other healthcare professionals' ineffective execution of or non-compliance with policy or guidelines can become the obstacle that prompts the use of a workaround. In addition, coordinating several different health care professionals can be challenging, and the associated demands can result in a workaround being implemented.

2.3.2 Workarounds

Berlinger (2016, p. 126) describes workarounds as “ways of behaving and thinking” which result in time saving and problem-solving fixes. The tension between adhering to the policy, standard procedure or rules of an organisation and finding unofficial ways of working, which respond to the reality of the obstacles that occur in public healthcare settings, places the healthcare professional in a potentially precarious position with supervisors and colleagues. (Berlinger, 2016) recognises that even the term ‘workarounds’ points towards situations in normal work that are challenging and often morally problematic. Berlinger describes healthcare systems that are under pressure because the policies and the reality of the work are either “slipping out of alignment or were never a good match” (Berlinger, 2016, p. 49). In some instances the expected procedure has been devised with additional steps to ensure that every possible problem has been accounted for. However, in reality the usual process of work does not include any of these problems and healthcare professionals work around these additional steps if they are perceived as inefficient (Vestal, 2008). Workarounds are often implemented when a healthcare professional can see no other way of getting the job done or providing care to their patients, and avoiding the obstacle in the form of a workaround is perceived as the only way to proceed (Berlinger, 2016). Debono et al. (2013) also acknowledge the complexity of the working environment of healthcare professionals who are often expected to learn on the job while being professionally independent. Workarounds are frequently thought about and devised in the moment that an obstacle presents itself leaving the healthcare professional with little time to consider all the consequences of their choice of workaround. Some workarounds involve multiple steps, some are less efficient in the long term and others leave colleagues in the same system uncertain of what has been done (Vestal, 2008). Halbesleben et al. (2010) and Berlinger (2016) refer to workarounds as deviations and highlight their inconsistent nature which creates both

ethical and safety concerns. Medication dispensing is the most written about workaround and Halbesleben et al. (2010) refers to inpatients who receive multiple medications throughout the day. Shift changes mean that different nurses will be dispensing medication for the same patient and if protocols for dispensing are not adhered to the patient could receive more medication than was prescribed (Halbesleben et al., 2010). This could result in significant safety concerns for the patient.

Finding unofficial ways of working as a response to obstacles are viewed by some healthcare professionals as pragmatic ways of dealing with the obstacles and “can also be a source of professional and psychological satisfaction, an opportunity to be creative and use one’s experience to manage problems” (Berlinger, 2017, p. 54). In some cases the workaround proves to be better than the prescribed way of getting the job done which can result in changes in policy or standard procedure because they draw attention towards the obstacle (Vestal, 2008). In other instances the workaround can give the healthcare professional a sense of having an advantage. Sharing a workaround with colleagues can be an opportunity to connect with other members of their team (Berlinger, 2016). Implementing a workaround can be viewed as simply an alternative way of doing the job because a workaround is implemented for the purpose of achieving a work related goal (Vestal, 2008). Although workarounds can put the healthcare professional at risk of disciplinary action for flouting the rules, implementing a workaround can have the opposite effect and the healthcare professional can be seen as efficient, effective and organised and as someone who does not complain about problems (Berlinger, 2016).

Addressing a concern in the moment with an adaptation or workaround is referred to as first-order problem solving (Stutzer & Hylton Rushton, 2015). Healthcare settings are complex systems with constantly changing situations and the healthcare professional is expected to adapt to these changes (Berlinger, 2016; Seaman & Erlen, 2015; Stutzer & Hylton Rushton, 2015).

These complex systems frequently leave healthcare professionals strapped for time and escalating an obstacle to second-order problem solving would require organisational involvement which is time consuming (Stutzer & Hylton Rushton, 2015). As a result, workarounds are increasingly becoming common practice and the obstacles remain unattended to (Berlinger, 2016). Vestal (2008) points out that when a temporary solution or workaround is implemented, the implication is that a more permanent solution to an obstacle is required. When the obstacles are not addressed with second-order problem solving, the workarounds can become the standard way of doing the job and the institutional policy or guidelines can be forgotten (Vestal, 2008). This does not imply that the workaround is a better way of working, to the contrary they have been described as less thorough, inconsistent, potentially harmful and ethically problematic because important checks or steps may be bypassed (Berlinger, 2016; Vestal, 2008).

Workarounds are therefore viewed as both positive and negative ways of working, especially in complex healthcare systems (Vestal, 2008). They get the job done and can highlight problems areas. However, they are also violations of expected procedure and can be potentially harmful.

Alter (2014) describes some of the different types of workarounds that healthcare professionals implement as responses to obstacles they encounter, and these are outlined briefly below.

2.3.2.1 Substitute

Substituting often occurs when the obstacle is a resource constraint or personnel shortage. At times a resource is inadequate whereas other instances involve the perception of inadequate or unavailable resources. Substituting involves using what is on hand rather than what the guidelines prescribe.

2.3.2.2 Bypass

A workaround in the form of a bypass is usually performed when the obstacle is integrated into the policy, guidelines or routines of usual work. When an aspect of a routine or the policy itself is the obstacle, healthcare professionals find ways to circumvent the policy or routines in order to get their job done.

2.3.2.3 Respond

When healthcare professionals respond to obstacles they usually devise quick fixes. This typically happens when an unusual situation presents itself and the healthcare worker needs to find a solution quickly. This solution becomes a workaround when it is not in line with the guidelines of the institution.

2.3.2.4 Supplement

Some routines are supplemented with new ways of doing things. This can happen when other healthcare professionals are busy and their part of the usual routine is supplemented with a workaround which enables other healthcare professional to continue working. Supplementing can also be used when there is a resource constraint and the healthcare professional finds an alternative resource to supplement the one that is unavailable.

2.3.2.5 Design

Designing new ways of doing things or modifying existing work routines or guidelines when obstacles are encountered is another way that workarounds are implemented. These are sometimes called shadow systems which exist to deal with the shortcomings of institutional systems.

2.3.2.6 Prevent

There are occasions when healthcare workers perceive a policy to be an obstacle and devise a workaround as a way to prevent potential mishaps from occurring. An actual obstacle

may not have been encountered. However, the perception that one could occur can prompt the healthcare worker to devise a workaround.

2.3.2.7 Pretend

Pretending to comply with institutional policy can be considered a workaround. In cases where personnel shortages or resource constraints put healthcare workers under pressure, pretending to comply with policy can provide the appearance of complying with policy. This type of workaround is done in order to satisfy management while trying to do their best for their patients.

2.3.2.8 Avoidance

Berlinger (2016) refers to situations of avoidance that are also ways to respond to obstacles. When healthcare professionals are faced with disordered situations they avoid them either physically, psychologically, with feelings of helplessness or through justification. Physically avoiding an obstacle would involve devising alternative ways of achieving a goal by staying away from an obstacle. Psychologically, avoiding would require that the healthcare professional change their perceptions about a situation which would involve a workaround of personal standards or organisational policy. Healthcare professionals who feel helpless in a situation can avoid taking action and devise a workaround which leaves the obstacle in place. Justification usually involves turning a blind eye to situations and learning to live with problematic conditions. Responding to an obstacle with avoidance is often a response to the complexity of healthcare environments which are continuously changing, requiring continual adaptations on the part of the healthcare professional.

2.3.3 The outcomes of workarounds

Implementing workarounds is not without consequences. At times these consequences are positive. However, there are many instances where workarounds have potentially harmful

outcomes as well as ethical consequences. Previous research into the use of workarounds in healthcare has described several positive and negative outcomes.

2.3.3.1 Work continues despite obstacles

The very nature of a workaround is finding a way around an obstacle in order to achieve a work related goal (Alter, 2014; Berlinger, 2016; Debono et al., 2013; Halbesleben et al., 2008). Healthcare professionals frequently encounter instances where obstacles cause a block in workflow and decisions on how to proceed need to be made. Healthcare professionals may need to choose between following institutional procedure to deal with the block, which could stop their work, or engaging in a workaround and allowing work to continue despite the obstacles (Alter, 2014).

2.3.3.2 Source of future improvements

When an obstacle is temporary and situational it is likely to pass and the workaround is no longer needed. Obstacles of a more permanent nature often create the need for a permanent workaround and one that is passed on to others. Permanently implemented workarounds have the opportunity to create more awareness of the obstacle. Alter (2014) suggests that policy makers should be aware of the workarounds and the way healthcare professionals choose to work as a source of information when making or changing policy. Berlinger (2016) refers to instances where workarounds are overtly practiced as opportunities for improvement if management is willing to explore the reason for the workaround as well as the effectiveness of the workaround in a problematic system.

2.3.3.3 Potential errors and inefficiencies are created

Workarounds involve ignoring, evading or adjusting policy or standard practice when there is an obstacle. The prescribed way of doing specific tasks in healthcare setting usually contain steps to avoid errors. When standard practice is worked around, the potential to create an

environment for errors to occur is higher which could impact negatively on patient safety (Debono et al., 2013; Halbesleben et al., 2008; Rathert et al., 2012). Halbesleben et al. (2008) refer to the lack of research providing empirical evidence that harm is in fact created. However they point out that when a policy or standard practice is not adhered to, the potential for errors and the risk of harm is increased.

2.3.3.4 Affects subsequent work

Some workarounds do not create errors or harm while they are being implemented, yet the impact of the workaround may be felt further down the line (Alter, 2014). The subsequent impact could be a result of insufficient or incorrect information which could later affect the healthcare professional who implemented the workaround or other healthcare professionals who attend to the same patient (Alter, 2014; Stutzer & Hylton Rushton, 2015). When obstacles are dealt with using unofficial fixes, variable conditions are created which could lead to confusion on how to proceed and possible harm in the future (Berlinger, 2017).

2.3.3.5 Obstacles are not addressed

Workarounds that may have been viewed as temporary fixes to overcome an obstacle can turn into permanent solutions if the obstacle is not dealt with (Alter, 2014). The obstacles are not always reported to management as this would create awareness of the workaround and the violations of policy which could result in punitive consequences (Berlinger, 2016). Failing to report the obstacles could conceal potentially dangerous conditions in the workplace (Berlinger, 2017; Stutzer & Hylton Rushton, 2015).

2.3.3.6 Development of interpretive flexibility and autonomy of practice

Healthcare professionals who are able to use their common sense and resourcefulness when faced with obstacles develop a flexibility that permits them to keep working in sometimes difficult situations (Alter, 2014). Debono et al. (2013) say that with the emphasis in public

healthcare settings being on efficiency, nurses, who may be familiar with the usual protocol of a particular doctor, may proceed before the doctor has given the order. By doing this the nurse is developing autonomy in her choice of workaround. Workarounds that do not endanger patients are at times justified through autonomy of practice and are therefore viewed as acceptable (Debono et al., 2013).

2.3.3.7 Ethical consequences

Although workarounds are not always obviously wrong or harmful, the ethical consequences may be more difficult to identify and could lead to potential harm. Berlinger (2017) suggests that in order to be ethically pragmatic, healthcare professions need to allow their workarounds to be scrutinised for any underlying ethical violations. In some cases the obstacle creates an ethical challenge and the workaround a different ethical challenge resulting in the healthcare professional having to decide which is more problematic (Berlinger, 2017). The ethical implications of workarounds should be investigated together with the motivation used by the healthcare professional to implement the workaround and the advantage they understood the workaround would create for themselves and their patient (Berlinger, 2016).

2.3.4 Ethical considerations

The ethical impacts and implications of implementing workarounds will be specifically explored in this research. Previous research has investigated the ethical dilemmas faced by healthcare professionals who work in complex systems and the ethical decision making that they employ. Berlinger (2016) describes complex systems that often operate 24 hours a day with frequent shift changes, as environments where the risk of harm is always present. Complex systems are also described as being notoriously under-resourced where less than ideal conditions become the norm. Healthcare professionals who work in complex systems are often faced with

situations in which they are uncertain on how to proceed. The trade-off between following the rules in a resource constrained environment, where the rules and the reality are often a mismatch, and doing the best for their patient can create uncertain and morally stressful situations (Berlinger, 2016). The uncertainty and moral stress can stem from conflict between multiple obligations that the healthcare professional deals with in terms of their obligation to the patient, to their superiors, and to their profession (Berlinger, 2016; Seitz & O'Neill, 1996).

The rules of the organisation and the ethical guidelines for practice are the overt guides for making ethical decisions in healthcare organisations. An individual's personal morals and ethical world view also play an important role in the process of ethical decision making (Baum et al., 2007; Berlinger, 2016). In addition, professional experience is often used as a benchmark for ethical decision making (Baum et al., 2007). Personal morals and an individual's ethical world view cultivate concepts of right and wrong or conscience. Morally stressful situations engage a person's conscience and decisions can be made when personal values and principles, together with the dynamics of the situation, and institutional guidelines are considered (Berlinger, 2016). When there is a conflict between competing obligations, compromises are often necessary and these can take the form of a workaround.

In public healthcare, the rules and regulations of the institution regulate and guide practice within the institution. Professional and ethical codes for the different healthcare professions provide the basis for professional responsibility to the specific profession and in turn to the patients (Berlinger, 2016). Working in complex systems involves discretion on how rules and codes are interpreted and wording in ethics codes such as "reasonable" and "appropriate" provide the latitude for professional judgment to be used when conflicts between competing rules arise (Knapp, Handelsman, Gottlieb, & VandeCreek, 2013). In addition to interpretive discretion, ethical principles can conflict with one another in the complexity of healthcare systems. In these

situations, the healthcare professional needs to carefully decide which principle has precedence (McCarron & Stewart, 2011; Urofsky, Engels, & Engebretson, 2008).

Relying solely on personal moral and ethical beliefs and professional experience is not sufficient when making ethical decisions. However being too rigid about institutional and professional rules and codes can create a barrier between the healthcare professional and the patient (Knapp et al., 2013). The process of ethical decision making is usually an integration of personal morals and values, professional codes and ethics and institutional rules (Knapp et al., 2013). Integrating personal, professional and institutional ethics in public healthcare may at times result in a conflict between these different aspects involved in decision making which can cause moral stress on the part of the healthcare professional (Berlinger, 2016). Facing morally stressful situations can lead to the implementation of a workaround.

As previously discussed, conceptualising workarounds includes a policy related obstacle. The workaround itself is a way to overcome the obstacle which frequently involves a modification or dismissal of the policy. The risk of repercussions to the healthcare provider for ignoring policy is a real threat (Campbell, 2011). Seaman and Erlen (2015) and Berlinger (2016) suggest that the organisation or healthcare institution should have a moral obligation to both support their healthcare professionals and to devise policy that reduces the risk of conflicts arising. Providing a safe, controlled setting for healthcare professionals to share their workaround stories could be an environment for policy makers to understand the pressures in these complex systems and learn from workaround stories. Successful workarounds could be integrated into policy or the policy could be changed to match the pressures on the ground (Campbell, 2011).

Professional ethics codes are developed to protect the patient and the professional from harm and have the resultant effect of contributing to standardised care. In addition to this, a code of ethics usually provides principles for dealing with problems that may arise in practice.

However, as Berlinger (2016) points out, the pressures that arise from working in environments that are constantly changing can result in ethical uncertainty on how to proceed. The response to these ethically challenging situations is often avoidance of the situation or avoidance of compliance with policy in the form of a workaround (Berlinger, 2016). Attempting to adhere to ethical standards and responding to the constantly changing challenges on the ground is a common occurrence in healthcare settings and working the system becomes part of the job (Berlinger, 2016). The workaround is also usually seen as ethically acceptable because it is devised to optimise patient care which is a recognisable good, However, the line between efficient performance and safe practice may become blurred in healthcare settings (Berlinger, 2016).

2.3.5 Professional ethics codes

Berlinger (2016) suggests that navigating ethically challenging situations requires confidence in the way professionals think about ethical matters and problematic situations in relation to the rules. A healthcare professional who is *au fait* with their profession's code of ethics is in a position to think and act with more confidence when faced with ethically problematic situations.

Psychology became an official profession in South Africa with the passing of Act 56 of 1974. However, it was not until 1985 that the first South African ethical principles were published (Wassenaar, 1998). Since then new ethics codes and subsequent revisions, which bear a close resemblance to the American Psychological Association (APA) code (Wassenaar, 1998), have been published, resulting in the current ethics code for psychologists in South Africa (HPCSA, 2006). The code gives guidance for ethical practice as well as resolving ethical issues and ethical decision making. The guiding ethical principles for South African Psychologists are

divided into 6 principles, namely competence, integrity, professional and scientific responsibility, respect for people's human rights and dignity, concern for other wellbeing and social responsibility (HPCSA, 2006). Confidentiality is a principle that is covered in depth separately from these 6 guiding principles. There is also a section dedicated to resolving ethical issues in the code.

The Canadian code of ethics for psychologists was originally an adoption of the principles established by the APA and the original standards developed in 1953 until the 1977 revision were used by Canadian psychologists (Sinclair, Poizner, Gilmour-Barrett, & Randall, 1987). In 1979 the Canadian Psychological Association (CPA) began work on their own code of ethics and the first Canadian Code of Ethics for Psychologists was adopted in 1986 and revised in 1991 (Seitz & O'Neill, 1996). In the development of the Canadian Code of Ethics for Psychologists, the APA Code of Ethics was evaluated and a decision was made to develop a new ethics code that would be conceptually more cohesive, more inclusive, give more explicit guidelines than the APA code, and provide rules for ethical decision making (Sinclair et al., 1987). This code was developed with the use of vignettes which allowed the developers to access the collective wisdom of the psychologists who participated (Sinclair et al., 1987). The resulting code has clear overarching ethical principles and is easy to use.

The Canadian code of ethics for psychologists has 4 guiding principles, namely respect for the dignity of persons and peoples, responsible caring, integrity in relationships and responsibility to society (Canadian Psychological Association, 2017; Seitz & O'Neill, 1996; Sinclair et al., 1987). Confidentiality is incorporated into the first principle of respect for the dignity of persons and peoples. Although the CPA code is quite different to the APA code, the underlying principles are the same (Seitz & O'Neill, 1996). What makes the CPA code distinctively different is the emphasis on ethical decision making with the principles ranked in

order of the weight they should be given when making ethical decisions (Seitz & O'Neill, 1996). The code was designed to be used as a practical tool to use when faced with ethical dilemmas to aid in ethical decision making (CPA, 1991 in Seitz & O'Neill, 1996).

The data for this research will be elicited from clinical psychologists and will be in the form of short accounts of workarounds implemented in their community service year. The data will then be evaluated using a code of ethics which will allow for a neutral analysis of the workarounds. In light of the fact that the APA code, the South African code and the CPA code all share a strong similarity to each other in terms of the ethical principles they uphold, and given that the CPA code is designed specifically with ethical decision-making at the heart of the code, the CPA code will be used to assess the ethical value of the workarounds described in the data for this research. The similarity of the CPA code to the South African code will enable the results of the analysis to be relevant to the South African context. The results of this analysis will hopefully be helpful to South African clinical psychologists in their future decision making on how best to be efficient while still keeping patient safety and ethical practice as the goal.

2.3.5.1 The Canadian code of ethics for psychologists

In the preamble of the CPA code, a section is dedicated to ethical decision-making, with reference to instances where conflict may occur between the ethical principles themselves. This section goes on to state that the four principles are weighted in the order of priority they should be given when making ethical decisions (Canadian Psychological Association, 2017).

2.3.5.1.1 Respect for the dignity of persons and peoples

The principle with the highest weighting is the first principle, respect for the dignity of persons and peoples. The only time this principle is not afforded the highest weighting is when the safety of an individual is in danger (Canadian Psychological Association, 2017; Seitz & O'Neill, 1996). This first principle states that individuals should be respected for their innate

worth as human beings irrespective of personal attributes or circumstances (Canadian Psychological Association, 2017). This principle includes non-discrimination, fair treatment, informed un-coerced consent, protection of vulnerable persons, privacy and confidentiality (Canadian Psychological Association, 2017).

2.3.5.1.2 Responsible caring

The next principle is responsible caring which is weighted second most important and requires the psychologist to maximise benefit and minimise harm whilst respecting the dignity of persons and peoples (Canadian Psychological Association, 2017; Seitz & O'Neill, 1996). A psychologist who works to maximise benefit should be mindful of the context in which individuals have grown up in and lives in and should promote the well-being of the individual directly involved with the psychologist as well as those indirectly involved (Canadian Psychological Association, 2017). In order to successfully achieve this, the psychologist also has the responsibility to ensure their own competence and self-knowledge (Canadian Psychological Association, 2017).

2.3.5.1.3 Integrity in relationships

The third principle is integrity in relationships and should be weighted after responsible caring. Integrity in relationships is usually demonstrated with openness and straightforwardness. However, in some instances respect for the dignity of people and persons and responsible caring might have greater importance, meaning that openness and straightforwardness may need to be moderated (Canadian Psychological Association, 2017). The decision to be less open or straightforward should however always be justified by higher order values and that informed consent is upheld. Integrity in relationships also covers conflicts of interest. The wording of the code acknowledges that not all conflicts of interest can be avoided. However, the psychologist should always ensure they are acting in the best interests of the patient and the public and that

their dignity, well-being and best interests are maintained (Canadian Psychological Association, 2017). The principle includes honesty, objectivity, openness, avoidance of deception and conflict of interests and reliance on the discipline (Canadian Psychological Association, 2017).

2.3.5.1.4 *Responsibility to society*

The final principle is responsibility to society and should be weighted fourth highest when conflicts arise. Responsibility to society should always be considered in ethical decision-making, however the interests of the individual should not be sacrificed for the interests of society (Canadian Psychological Association, 2017). Acknowledging and respecting existing social structures is important. However, if these same structures deny persons or peoples respect and dignity, the psychologist could advocate for changes to these structures (Canadian Psychological Association, 2017). Advocating for change can have an impact on the ongoing development and growth of social structures and should be done in collaborative partnerships. This principle includes development of knowledge, beneficial activities, respect for society and development of society (Canadian Psychological Association, 2017).

2.3.6 *Eliciting stories*

Eliciting the stories of workarounds that are implemented in public healthcare has been reported to be difficult (Berlinger, 2016; Campbell, 2011; Halbesleben et al., 2008). The secrecy associated with workarounds often protects the healthcare professional from retribution and can also protect patient confidentiality (Berlinger, 2016; Campbell, 2011). A healthcare professional who is open about the workarounds they implement could be reprimanded and the option to continue using the workaround could be removed (Campbell, 2011). In resource constrained environments the healthcare professional might be of the view that they have no choice other than

to implement workarounds (Berlinger, 2016; Campbell, 2011). However, secrecy can lead to corruption (Berlinger, 2016) and deviations from policy can result in increased risk of harm to patients and non-standardised, unreliable care, as well as potential legal and ethical violations (Alter, 2014; Berlinger, 2016; Campbell, 2011; Halbesleben et al., 2008). Keeping workarounds secret removes the opportunity to examine them as either problematic in terms of harm or a worthwhile practice that should be shared and could potentially inform new policies (Berlinger, 2016). Understanding why healthcare providers implement workarounds, where policy fails and instances where workarounds improve patient care are important as this could result in revising policy to incorporate the creative thinking of workarounds while reducing the risk (Campbell, 2011).

Berlinger (2016) contends that workarounds are worth discussing in an open manner, free from punitive consequences. She further suggests that a contradiction exists in public healthcare settings where the workaround is the way that work gets done and at the same time is a violation of the policies and guidelines. Discussing workarounds in an open manner could result in better understanding and collective scrutiny of the advantages and challenges associated with any given workaround (Berlinger, 2016). When opportunities to share workaround stories are denied to healthcare professionals, secrecy and potentially harmful practices will continue.

Whistleblowing, which is the process of reporting peers who engage in work processes that are against policy (including workarounds), can be difficult in public healthcare institutions as all healthcare workers are affected by the same policy and resource related obstacles (Rice, 2015). Reporting peers who work around obstacles would potentially highlight the obstacle. However Rice (2015) suggests that professional relationships could be damaged by whistleblowing, which is not the kind of constructive discussion of workarounds that Berlinger (2016) seems to be advocating.

Campbell (2011) describes instances where workaround stories were shared and noted some of the reasons that contributed to healthcare professionals feeling comfortable to share their stories. The first reason he cited was frustration associated with many aspects of the work environment. The second reason related to individuals' pride in their innovative solutions to blocks in workflow. The final reason was the way his team developed an empathic, understanding and trusting relationship with the disclosing healthcare workers. Although the first two reasons were beyond their control, the third reason is in line with the views of Berlinger (2016) on the environment in which workaround stories should be told.

2.3.7 Clinical psychology

Although workarounds are widely recognised and many studies have described them, as Alter (2014) points out, workarounds remain under-studied and under-investigated. Workarounds in the field of clinical psychology appear to be a particularly neglected area of research. The challenges that clinical psychologists working in public health settings in South Africa face include resource constraints, large numbers of patients and procedural conflicts between the psychologist and the institution (Marais & Petersen, 2015; Pillay, Kramers-Olen, Kritzing, & Matshazi, 2012) resulting in a high probability of the development of workarounds.

Community service was first implemented in South Africa in 1998 for doctors, dentists and pharmacists (Reid, 2003). Since 2003 clinical psychologists, and six other healthcare professions in South Africa, have also had to register for compulsory community service (Pillay & Harvey, 2006; Reid, 2003). Community service is a one-year contract in a state healthcare facility, and since 2005 has included correctional facilities (Rohleder et al., 2006). The Department of Health stated that community service had a two-fold objective; firstly to provide services to underserved areas in the country; and secondly to provide healthcare professionals

with opportunities for professional development (Reid, 2003). As stated above, the placement sites for community service are prime locations for the implementation of workarounds are the focus of this research.

Although no research into workarounds implemented by clinical psychologists could be accessed at the time of doing this research, some papers have been written that describe conditions in public healthcare settings where clinical psychologists have had to be creative in order to keep service delivery and patient care the priority Padfield (2013) described her difficulty in maintaining the therapeutic frame in underserviced community service environments. Having access to the same room was a difficulty she experienced and her need to be creative in securing a space to see her patients sometimes proved difficult. These sentiments were shared by psychologists in correctional services who were constantly shifted to available spaces, many of which were inappropriate for psychotherapy (Rohleder et al., 2006). At times sessions were cancelled by the psychologist due to a lack of available space to conduct a session (Padfield, 2013; Rohleder et al., 2006). Research conducted into the experiences of the first community service psychologists also cited appropriate and private therapeutic space as a significant difficulty (Pillay & Harvey, 2006). The creativeness associated with accessing appropriate therapeutic spaces are workarounds of institutional policy and professional guidelines and ethics. Compromising on privacy and confidentiality has been reported as an ongoing difficulty in public healthcare settings (Padfield, 2013; Pillay & Harvey, 2006; Rohleder et al., 2006).

Psychologists who conducted their community service within the Department of Correctional Services reported that due to staff shortages the policy to have a guard present outside the door when therapy was being conducted was not always upheld (Rohleder et al., 2006). The workaround implemented in this case was to continue to see the offender without a

guard present which was against policy. In this way the psychologists found a way to work past an obstacle to meet their goal of continuing the session with the inmate, but compromised the rules and their own safety.

Resource constraints also affected the availability of correct psychometric tests and play therapy equipment in community service sites (Pillay & Harvey, 2006). Although specific workarounds were not documented for these types of shortages in equipment, this highlights the types of difficulties that community service psychologists have had to contend with.

Another issue that has been documented is the language barrier between psychologists and patients (Pillay & Harvey, 2006) given the diversity of the South African population. Language is a core means of communication and in mental healthcare, language is vital in obtaining information relevant for diagnosis and psychotherapy (Elkington & Talbot, 2016). The national Human Rights Charter states that in healthcare patients have the right to receive care in their language of choice (Health Professions Council of South Africa [HPCSA] in Elkington & Talbot, 2016). When the psychologist is not proficient in the patient's mother tongue, the services of a translator are required in order to act in accordance with legislation. Consistent with other research, Elkington and Talbot (2016) refer to the resource constrained healthcare system in South Africa and report that the services of translators are often unavailable in most healthcare settings. The lack of this vital service results in psychologists needing to be creative when working with patients with whom they are language discordant. The workaround used is to enlist the help of nurses, cleaners, data capturers and sometimes even family members to assist in the translation in order for the psychologist to still attend to the patient. The benefit of this workaround is that patient care is prioritised. However, in doing so confidentiality is often compromised (Elkington & Talbot, 2016).

2.4 Summary

This research aims to describe and provide insight into the nature and use of workarounds by clinical psychologists in public healthcare settings. Workarounds are goal-driven activities implemented to overcome obstacles in normal workflow. The elements of a workaround are the obstacle encountered, the ability to devise and implement a workaround, and the outcome or consequence of the workaround. Although there are numerous possible outcomes to workarounds, of particular interest to this research are the ethical consequences and the ethical decision making process. Professional ethics codes are ratified to guide healthcare professionals and regulate professional practice in terms of ethical conduct. The Canadian code of ethics for psychologists (Canadian Psychological Association, 2017) has its focus on ethical decision making and will be used to assess the ethical value and implications of workaround stories obtained in the data. The importance of eliciting accounts of implemented workarounds cannot be undervalued (Berlinger, 2016; Campbell, 2011). Sharing accounts of workarounds can open the discussion on the struggle of dealing with obstacles and can highlight any potential harmful or unethical ways of working.

Chapter 3: RATIONALE AND AIMS

3.1 Research aims and rationale

This research was inspired by Berlinger's (2016) book *Are workarounds ethical? Managing moral problems in health care systems*. Although the book addresses workarounds in healthcare as a whole, the primary reference is to nursing and no specific reference to workarounds with psychologists was made. Documenting workarounds used by clinical psychologists became an area of interest. However, the question of ethical practice was as important. Understanding workarounds from an ethical frame, as Berlinger (2016) did in her book, provided a more robust and meaningful analysis which will hopefully allow this research to inform clinical psychologists in the future when they are faced with obstacles and the need to work around them.

The general aims of this study were exploratory and descriptive in nature. Exploratory research aims to investigate unknown areas of research making initial inquiries and providing new insights (Durrheim, 2006). Descriptive research is useful when a phenomenon requires explanation (Durrheim, 2006). Both of these types of study methods were appropriate for this research. Although workarounds have been extensively researched, the specific professional group in this study, being clinical psychologists, are a neglected focus of workaround research with little or no data available. An exploratory investigation of the workarounds implemented by clinical psychologists will be the initial part of the research. Describing the ethical implications of the workarounds and providing explanations of the implications of these practices will be the second part of this research.

The specific aims of the study were:

- Identify whether workarounds were used by clinical psychologists during community service in public health settings;

- To describe and understand the nature of workarounds used by clinical psychologists in public health settings;
- To evaluate the ethical implications of these workarounds.

3.2 Research questions

The research questions explored in this study were:

- Have clinical psychologists used workarounds during community service?
- How do clinical psychologists write about workarounds?
- Using ethical principles for practice, how can the ethical challenges found in the descriptions of workarounds be understood?

3.3 Pilot study

Once the questionnaire was developed, a pilot study was conducted to refine the research instrument (not to generate data). The researcher wanted the participants to be clear about what they are being asked to report. In order to achieve this, as a piloting exercise, ten fellow masters students and a senior clinical psychology lecturer were asked to read the conceptualisation of workarounds in the questionnaire to ensure that what is being asked is clearly understood. A debriefing session was held to discuss their experience of the questionnaire. Both the senior lecturer and the fellow masters students reported clear understanding of the questions asked. As a result, no changes were made to the questionnaire.

Chapter 4: RESEARCH METHODOLOGY

This chapter provides a discussion of the research methodology that was used in this study. In addition, a detailed description of the steps taken to conduct the current study is included. The chapter contains the research design, sampling techniques and recruitment, data collection method, data analysis approach, a section on the reliability and validity of the study as well as the ethical issues that were considered in this study.

4.1 Research design

The research design being used combined both quantitative and qualitative methods (Durrheim, 2006).

Participants were invited to write a brief story describing a workaround they used during their community service. Demographic information from these stories, as well as additional information requested from the participants, was quantified for descriptive statistics (Durrheim, 2006).

A qualitative analysis of the experiences of the participants was conducted using a framework analysis approach to analyse the descriptions of workarounds. Bradley, Curry, and Devers (2007, p. 1758) state that “qualitative research is increasingly common in health services research” because it is useful for understanding a phenomenon in the context in which it occurs as well as uncovering links between behaviours and concepts.

4.2 Sample – techniques and recruitment

The list of all registered psychologists was ordered from the HPCSA. This list provides names, postal addresses, professional registration, year of community service and year registered

for clinical practice. Clinical psychologists who registered for their community service in 2012, 2013 or 2014 were chosen through purposive sampling. The value of this method of nonprobability sampling for this particular research is that clinical psychologists who are recently qualified will hopefully not have used workarounds to the point that they have become common practice. The sample would also have conducted their community service fairly recently (in the past 3 years) and should still have a good memory of any workarounds used. All the psychologists on the HPCSA register who completed their community service in 2012, 2013 and 2014 comprised approximately 380 psychologists. This entire sample was used to make provision for the expected poor response rate predicted in using the mail to distribute the questionnaires. Average response rates for mailed questionnaires have been reported to range between 25.6% and 37% (Slack & Wassenaar, 1999; Wassenaar, 2002). This initial sample was extended to all clinical psychologists who have ever done community service. The reason for this extension was a lower than expected response rate after a dedicated attempt to elicit participation in the research.

The initial sample was contacted through the use of posted letters and emails. The email addresses of 180 members of the initial sample of 380 were sourced using online databases and search engines for psychologists. These 180 members were sent an email containing a letter explaining the nature of the research, informed consent and a link to the online questionnaire. (See appendix A.) Of the 180 emails sent, 11 were returned marked 'failed delivery'. The remaining 200 members of the initial sample were sent the same information by posted letter, the addresses for which were obtained from the HPCSA register. Of the 200 letters sent, 17 were returned with a failed delivery due to post office boxes being closed, marked unclaimed or marked return to sender.

After a period of 5 months only 8 responses were captured on the online questionnaire. The researcher then sourced contact telephone numbers for 58 members of the initial sample and made telephonic contact with 13 members requesting participation. Further emails were sent to 7 new email addresses, one of which was returned with a failed delivery. One more response was captured following the additional 7 new emails being sent.

The collected data was still insufficient which led to the extension of the sample to include all clinical psychologists who have ever completed community service. A snowball sampling method was used in the KwaZulu-Natal region by personal conversations with clinical psychologists known to the researcher. A further 8 responses were captured following the snowball sampling.

4.3 Data collection

Data was collected through an online questionnaire on Survey Monkey. The link to the Survey Monkey questionnaire was sent to the participants with the informed consent and covering letter. The online questionnaire was developed by the researcher in consultation with a senior clinical psychology lecturer. The questions in the questionnaire were designed to provide data that would address the research questions proposed for this study.

The questionnaire (Appendix A) required respondents to supply some basic demographic information (excluding personal identifiers) and to write a vignette, which was guided by prompt questions, describing their experience of using a workaround during their community service as well as any consequences or benefits experienced. Many studies which focus on ethics in psychology have made use of vignettes as a way to elicit stories about conduct or opinions on ethical decision making (Pope & Vetter, 1992; Sinclair et al., 1987; Slack & Wassenaar, 1999). A copy of the questionnaire is attached as Appendix A.

The initial sample produced 8 replies. Telephonic contact and subsequent email produced a further 1 reply. Widening the sample and using snowball sampling produced another 8 replies. In total 17 participants responded. However, only 14 participants completed the questionnaire making 3 of the responses unusable, yielding a sample of 14 usable responses.

4.4 Data analysis

The demographic and information relating to masters studies, community service placement and implementation of workarounds used for quantitative analysis was manually counted due to the small size of the data set. This information was tabulated for descriptive statistical purposes.

The workaround stories and relevant information were analysed qualitatively using the framework method. The framework method of analysis is a qualitative method which identifies similarities and differences in qualitative data and then allows the researcher to draw conclusions of a descriptive or explanatory nature (Gale, Heath, Cameron, Rashid, & Redwood, 2013). This method was initially developed in the 1980's for use in applied policy research (Smith & Firth, 2011) and has also become a popular method of analysing data in health research (Gale et al., 2013; Parkinson, Eatough, Holmes, Stapley, & Midgley, 2016; Smith & Firth, 2011). The framework method appeared to fit well with the current research which used an ethical code of conduct to analyse the workaround descriptions.

The data set was however too small to strictly and fully utilise the framework method of analysis. The framework method is often used for collaboration by multiple researchers and it's defining feature is the use of a matrix (Gale et al., 2013) to sort and order large data sets (Parkinson et al., 2016; Ward, Furber, Tierney, & Swallow, 2013). The small sample available to the current study precluded the possibility of multiple researchers and data analysts. However,

other features of the framework method were still appropriate this this study and were modified to fit the small data set. The framework approach has various stages which were modified for the current data set. These are discussed below:

4.4.1 Stage 1: Transcription

In qualitative research, transcription of audio recordings is often necessary (Gale et al., 2013). This step was however not necessary in the current research as the workaround stories were already in typed format as they were obtained in the form of an online questionnaire, not recorded interviews.

4.4.2 Stage 2: Familiarisation

The point of this stage is to become familiar with the data contained in the workaround accounts. Familiarisation involves becoming familiar with the content and the feel of the data (Gale et al., 2013; Parkinson et al., 2016; Ward et al., 2013). The questionnaire responses were read through as entire entries and again by reading all the responses for each question. This allowed the researcher to get a sense of the obstacle encountered, the workaround used and the outcomes for each story as well as the links between stories and common themes. The benefit of becoming familiar with the data by simply reviewing it without coding is that links between the content and context of the stories and the consequences are not lost allowing for emergent themes to be easier to identify (Bradley et al., 2007).

4.4.3 Stage 3: Identifying a framework

The themes identified during the familiarisation stage can now be put together to form the framework for analysis (Ward et al., 2013). The current research used the CPA code of ethics as the framework for analysis. The four ethical principles identified in the CPA code of ethics were used as *a priori* codes. However, the researcher was also open to identifying emergent codes.

Emergent codes (Parkinson et al., 2016) ensure that data which did not fit with the ethics code, but which were relevant to the research, were not lost.

4.4.4 Stage 4: Initial coding

Large data sets often require several researchers to analyse the data. When an analytical framework is developed the researchers all meet after coding just a few transcripts to identify common codes which will then be applied to all subsequent transcripts (Gale et al., 2013). In the case of the current research, the small data set meant that there was no need to enlist the assistance of more coders. This stage was therefore omitted from the current research.

4.4.5 Stage 5: Indexing / coding

Coding the data helps to organise it in a formal way, categorising significant ideas while still maintaining the integrity of the data (Bradley et al., 2007). The framework was applied to the workaround stories, which was done in NVivo. The four *a priori* codes were applied to each workaround story and each ethical principle was considered for each story allowing for multiple principles being applied to each story.

4.4.6 Stage 6: Charting the data into a framework matrix

At this stage of the data analysis, the material is reduced into understandable, brief summaries which are then put into a framework matrix (Gale et al., 2013; Parkinson et al., 2016; Ward et al., 2013). Even though this data set was very small, the matrix was still used to organise the data and was generated in table format (see Tables 1-4) to view all the themes and how they interact. The words used by participants were put into the matrix so as to keep as close to the data as possible.

4.4.7 Stage 7: Mapping and interpreting

This stage of the framework analysis is characterised by understanding the data, not merely managing it (Parkinson et al., 2016; Ward et al., 2013). By going through the matrix,

initial and early interpretations of the data start to emerge (Gale et al., 2013). Once the data has been organised into the framework matrix, the themes and sub-themes can be compared against the original stories to ensure appropriate context (Parkinson et al., 2016). Patterns in the ethical behaviour of the participants started to emerge during this stage.

4.5 Reliability and validity / Credibility, dependability and transferability

4.5.1 Reliability

The reliability of the research refers to how dependable and repeatable the results are (Durrheim & Painter, 2006). Due to the nature of personal experience, the results may not be repeatable if the research were to be conducted with a different group of psychologists at a different time. However, the work environment in various healthcare facilities has many common elements including resource constraints and pressures of a challenging environment which would suggest that the results could be similar if repeated at another time, in a different setting or with a different sample. Consideration needs to be given to changing environments as new budgets and resources may improve these environments whereas bad governance and ageing resources could see deterioration in the environments. Due to the lack of any known research in the field of workarounds with clinical psychologists, it is not possible to compare previous results with the results of this study, but some comparisons with other health professionals will be made where possible.

4.5.2 Validity

The validity of the research refers to how sound the results and conclusions are (van der Riet & Durrheim, 2006). In order to ensure validity in the research, the conceptualisation of the term 'workarounds' needs to be very clear. The participants must be clear about what they are being asked to report. In order to achieve this, a piloting exercise was conducted to ensure that

what is being asked was clearly understood. In order to obtain results that will be generalizable to all areas of South Africa, a purposive sample from the current (2016) HPCSA-provided list of clinical psychologists in South Africa was used. The responses came from all areas in the country which reflects the diversity within different settings.

4.6 Ethical considerations

The elements of ethical research for social sciences outlined in Wassenaar and Mamotte (2012) were applied to the components of this study. The following were relevant to this research.

4.6.1 Collaborative partnership

The results of this research could be informative to clinical training institutions and current and future clinical psychologists. Being in a position to be more ethically aware could inform clinical psychologists' choices when the need to 'work around' systemic constraints arise. To maximise benefit from the research, a summary of the results will be made available to the participants after the research is complete if they request it on the questionnaire. Emanuel et al. in Wassenaar and Mamotte (2012) say that the questions asked in research should be of value to the target population and this research could be of social value to clinical psychologists.

4.6.2 Scientific validity

The scientific validity of this research will hopefully be strengthened by the use of existing ethical codes (CPA) as the frame of reference. In addition to this, the use of fellow Masters students to read and check the wording of the covering letter and questions will ensure any ambiguity and unclear statements are dealt with. This will add to the validity of the research as the participants will receive a clear idea of what the research is about and what is being asked of them. Methodological rigour is measured in all aspects of the research process and indicates

how accurate the research is (Marquart, 2017). The use of the framework method with the matrix containing the words that participants used will strengthen confidence in the methodological rigor in this study.

4.6.3 Fair selection of participants

Emanuel et al. in Wassenaar and Mamotte (2012, p. 15) state that “the population selected for study should be those to whom the research question applies”. This research applies directly to clinical psychologists in public health settings and the sample will be clinical psychologists who currently work or previously worked in public health settings.

4.6.4 Favourable risk / benefit ratio

The risk/benefit ratio of the research has been considered. In order to do this the chance of harm occurring and the severity of such harm need to be carefully thought through (Wassenaar & Mamotte, 2012). The risk of harm occurring in the process of this research is regret or emotional distress to the participants as they write about their use of workarounds. It is not possible to state the expected severity of this harm and the covering letter encourages any participant who experiences distress of any kind to seek help in the form of supervision or counselling. A further possible risk to the participants would be breach of confidentiality and could result in institutional discipline due to policy being disregarded when a workaround is implemented. No personal information or identifying information were collected or will be reported on in the results of this research to guard against this.

4.6.5 Independent ethics review

As stated by Emanuel et al. in Wassenaar and Mamotte (2012), independent ethics review should occur before any data is collected. The proposal for this research was submitted to the UKZN Humanities and Social Sciences Research Ethics Committee for ethics review and no data

was collected until ethics clearance was obtained. The ethical clearance certificate (reference number HSS/1246/016M) is attached marked appendix B.

4.6.6 Informed consent

The informed consent complies with the standard components as set out in Wassenaar and Mamotte (2012). The attached informed consent (Appendix C) has the legally required information and states that participants are under no obligation to participate in the research. Their participation should be completely voluntary and their understanding of this and the nature of the research will be formalised in writing by the return of the questionnaire. The consent will be integrated into the form of the questionnaire should the participant decide to join in the research.

4.6.7 Ongoing respect for participants and study communities

Treating participants “with respect during and after the study” (Emanuel et al. in Wassenaar & Mamotte, 2012, p. 19) will be done by respecting the content of their vignette and the risk they have taken to disclose the information. This will be done by reporting on their experience truthfully, without embellishment and by applying the ethical code without judgment. In addition to this, the privacy of the participants will be respected by not revealing any information that could identify the participant or link any demographic information to the workaround story. The online questionnaire responses were printed out and stored under lock and key at UKZN once the research was completed and will be destroyed after five years. The online version was deleted.

Chapter 5: RESULTS

5.1 Overview of results

This chapter presents the results of the study. Both quantitative and qualitative results are included. The quantitative results are presented as descriptive statistics and the qualitative results are presented in terms of the key aspects that make up a workaround and the CPA ethical code of conduct. The letter and emailing to a sample of 395 yielded a response rate of 0.04% which is significantly below the expected response rate of between 25.6% and 37% reported in previous literature (Slack & Wassenaar, 1999; Wassenaar, 2002).

5.2 Quantitative results – descriptive statistics

All participants consented to participating in the research. Of the 17 responses, 3 were incomplete and will be excluded from the results. The descriptive statistical results are as follows.

5.2.1 Race

As shown in Figure 1, the questionnaire was answered by two black respondents and twelve white respondents. This is not disproportionate to the racial distribution of psychologists in South Africa. A national survey of all registered psychologists found that most psychologists in South Africa are white (HPCSA, 2017).

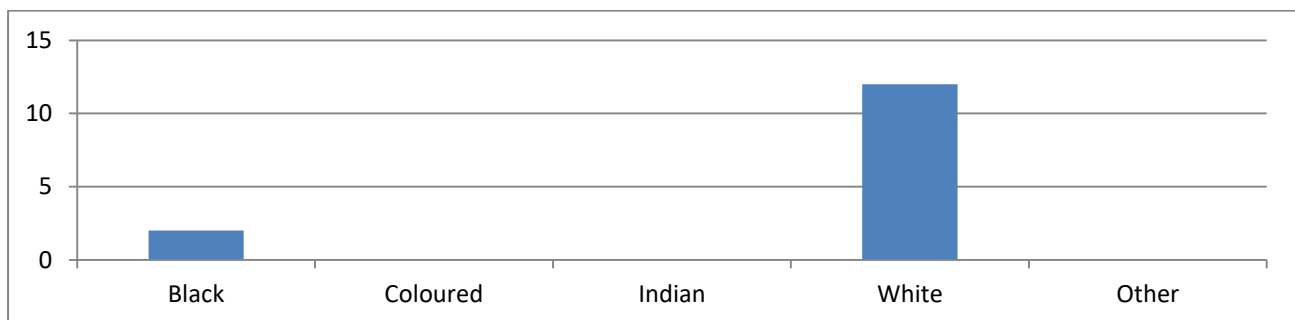


Figure 1 - Race

5.2.2 Age

None of the respondents fell into the below 25 year age range. One respondent was between the ages of 25 and 29 years. Five respondents fell into the 30-34 year range, three in the 35-39 year range and five respondents were over 40 years of age (see Figure 2). According to a national survey of all psychologists in South Africa, the average age of registered psychologists falls between 31 and 40 (HPCSA, 2017).

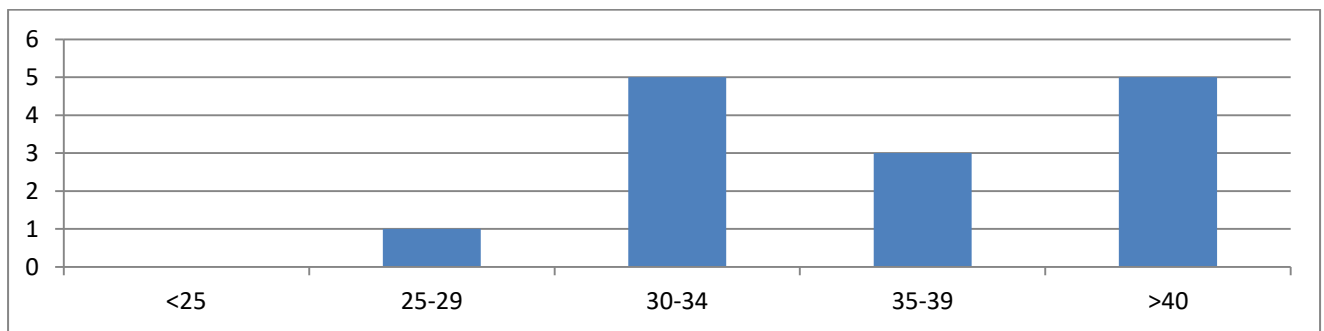


Figure 2 - Age

5.2.3 Gender

As shown in Figure 3, five of the respondents identified as male, eight as female and one identified as transgender/gender diverse. According to a survey conducted by the Health Professions Council of South Africa, this is not disproportionate to the gender distribution of psychologists in South Africa (HPCSA, 2017).

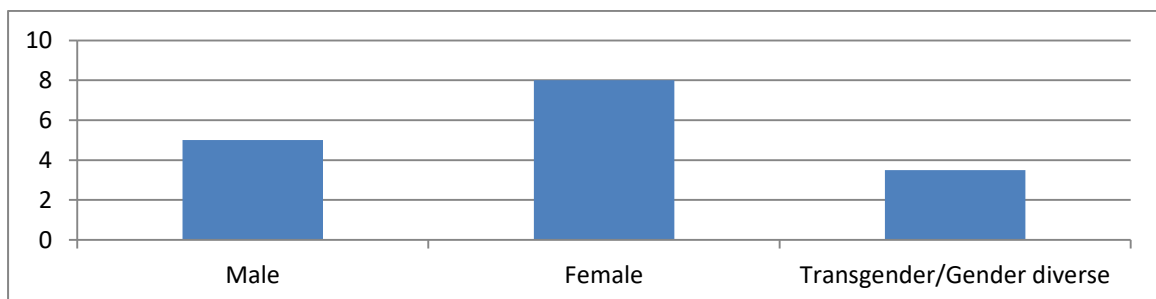


Figure 3 - Gender

5.2.4 University where Masters Degree was obtained

The respondents came from 6 of the possible 14 clinical psychology training universities in South Africa. Two were from the University of Cape Town, seven from UKZN, two from University of Limpopo, one from the Nelson Mandela Metropolitan University, one from the University of Western Cape and one from the University of the Witwatersrand (see Figure 4).

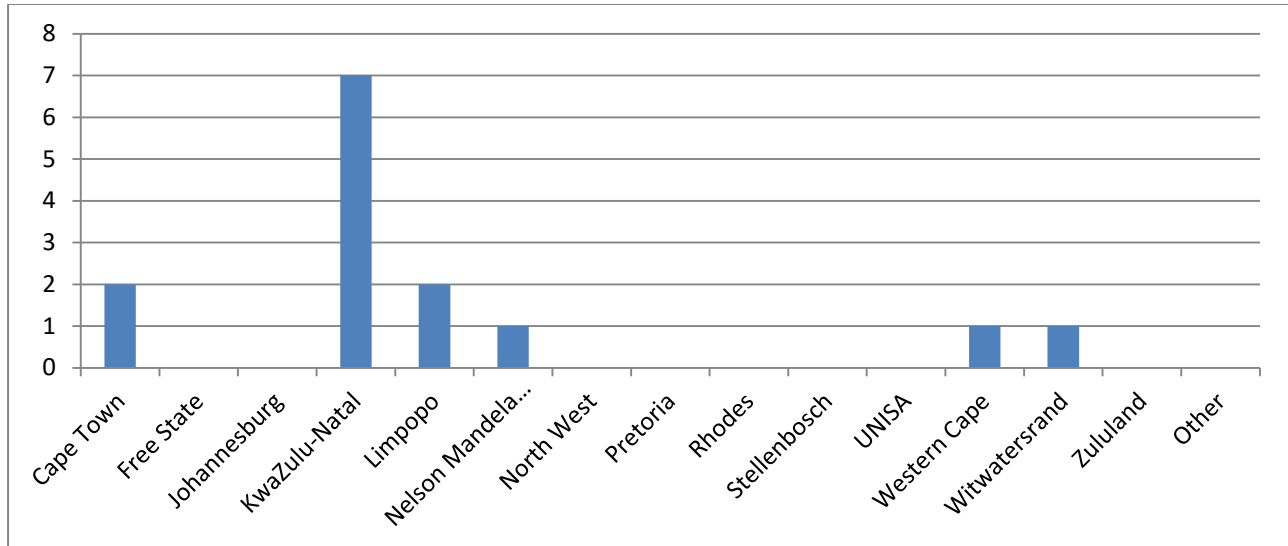


Figure 4 - University where Masters Degree was obtained

5.2.5 Year of community service

The respondents indicated that they completed their community service in the following years (see Figure 5). One in 2004, one in 2006, two in 2010, one in 2012, one in 2013, six in 2014, two in 2015 and one in 2016.

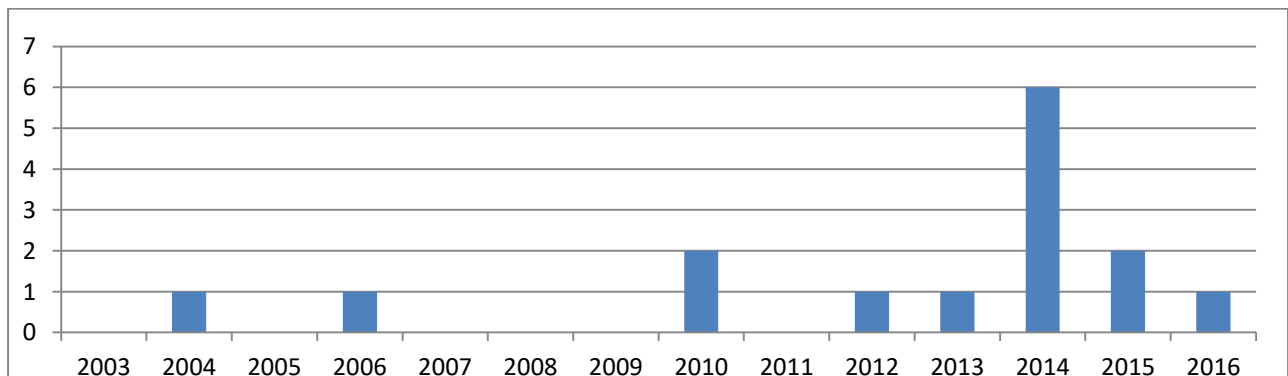


Figure 5 - Year of Community Service

5.2.6 Province where community service was conducted

As shown in Figure 6, the respondents indicated that they completed their community service in four of the nine provinces in South Africa. One was in the Eastern Cape, three in Gauteng, eight in KwaZulu-Natal and two in the Western Cape.

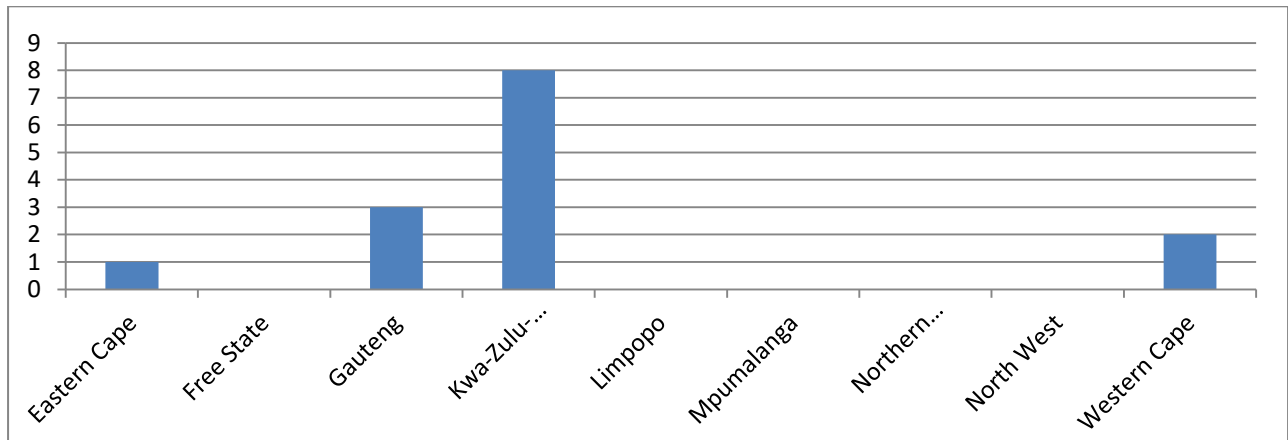


Figure 6 - Province where Community Service was conducted

5.2.7 Geographical location

Figure 7 shows that the geographical location of the respondents' community service was divided between rural and urban locations. There were four in a rural location and ten in an urban location.

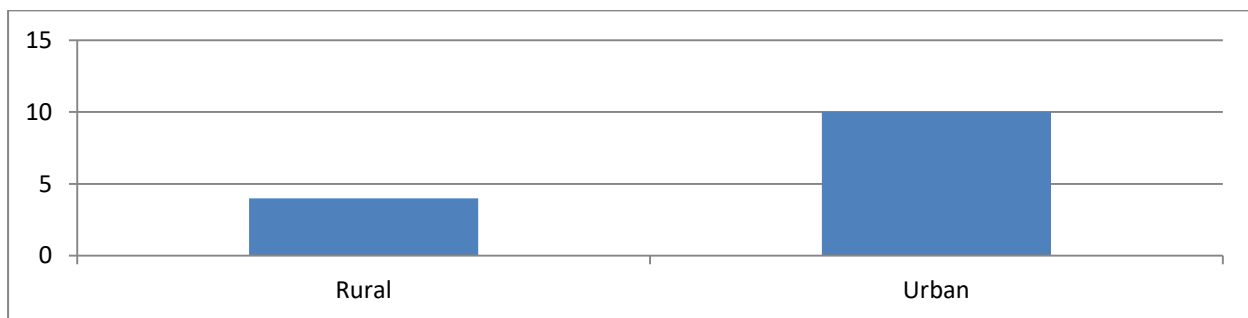


Figure 7 - Geographic location

5.2.8 Type of community service centre

Six of the respondents were placed in hospitals for their community service, two were split between a hospital and clinics. Two of the respondents were solely in community clinics. Three of the respondents were placed in specialised hospitals, one in a forensic hospital, one in a psychiatric hospital and one in a rehabilitation hospital. One of the respondents was placed in a correctional centre for their community service (see Figure 8).

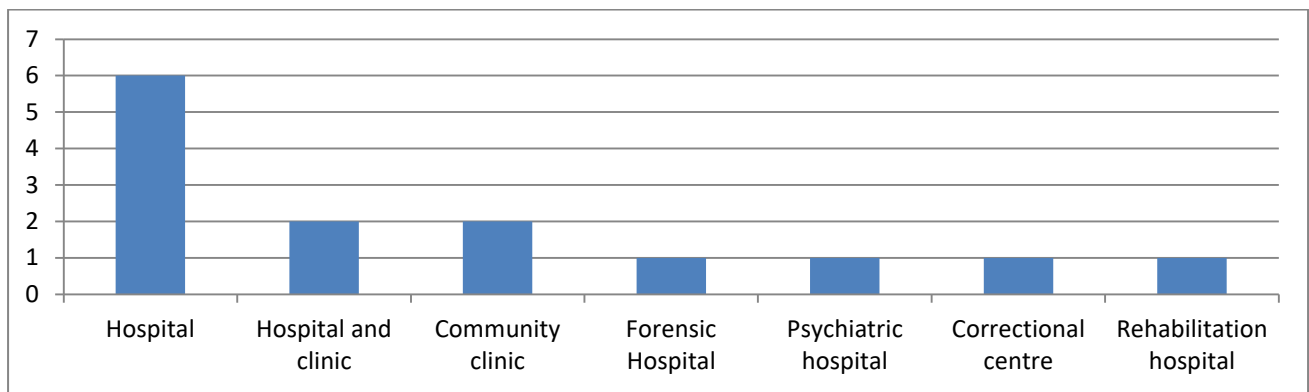


Figure 8 - Type of Community Service Centre

5.2.9 Engagement in a workaround

Of the 14 respondents, 5 reported that they did not engage in a workaround and nine responded that they did engage in a workaround during their community service year (see Figure 9)

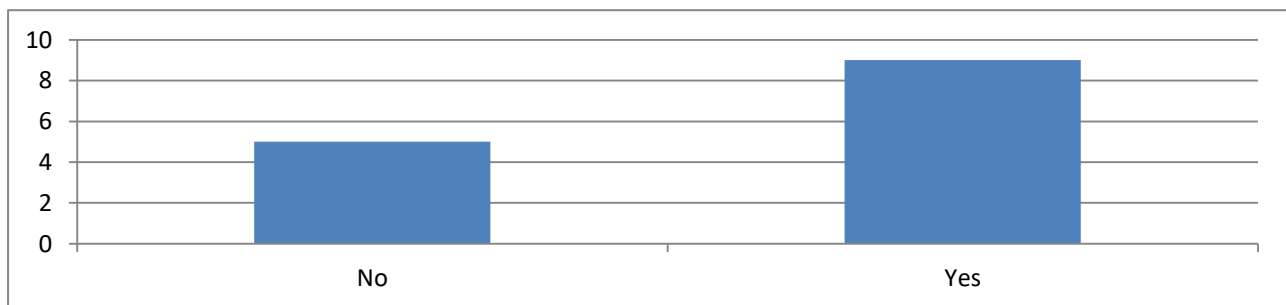


Figure 9 - Engagement in a Workaround

5.3 Qualitative results

The qualitative results are made up of the workaround stories described by the nine participants who indicated that they engaged in a workaround. The results are presented in a framework matrix, which been divided into sections (see Tables 1 – 4) for ease of reference, together with an explanation for each section.

5.3.1 Obstacles

The obstacles described by the participants were divided into four categories. The framework matrix (see Table 1) contains the words used by the participants to describe the obstacles they encountered.

5.3.1.1 Rules, protocols, guidelines and policy

Respondents 6, 7 and 8 encountered obstacles relating to rules, protocols, guidelines and policy. Respondent 6 described the policy of needing a written referral from a doctor in order to see a patient. The respondent reported that the doctors were at times busy and verbal requests to see patients were made. Respondent 7 used the word ‘bureaucracy’ to describe the obstacle of a patient being referred for one thing when they actually needed something different. Respondent 8 described the system in a clinic where the collection of patient files could be a time consuming process, often making patients late for appointments.

5.3.1.2 Operational failures, environmental challenges and work process design

Respondent 4 described an obstacle which fell into the ‘operational failures, environmental challenges and work process design category’. The obstacle fell specifically into the aspect of environmental challenges. The obstacle was described as a difficulty in obtaining necessary information from a minor when they attended the hospital without a parent or relative present.

Table 1

Obstacles matrix

	Described obstacle	Rules, protocols, guidelines and policy	Operational failures, environmental challenges and work process design	Resource constraint	Human resource shortages and personnel factors
Respondent 1	Lack of resources				✓
Respondent 2	Ordering psychological test material took long periods of time if you used the hospital procurement channels and often was rejected because of financial constraints.			✓	
Respondent 3	Not having the tools to do certain interventions			✓	
Respondent 4	I found working with kids difficult because at my hospital the patients came from all over KZN as it was a tertiary hospital. This often meant that kids had no parents available to talk with or even contact at all. If I needed background on a problem that was relatively urgent I could not always get it from a thorough intake.		✓		
Respondent 5	Correctional policy states that no offenders may be seen for psychotherapy without a security member (warden) present (stationed outside the office). However, due to scarcity of members this does not happen.				✓
Respondent 6	When I have seen a patient without a written referral. The doctor is busy and verbally tells the nurse to call me.	✓			
Respondent 7	Bureaucracy - An accused was sent for observation but it was clear that he'd really benefit in psychotherapy	✓			
Respondent 8	1) The clinic's system for registration of patients and issuing patient files is problematic, often resulting in patients being late for appointments. 2) There is limited access to telephones, no access to a fax machine or internet, resulting in difficulty in contacting patients and referral sites	✓ 1)		✓ 2)	
Respondent 9	The most obvious work around for me is when working with interpreters. Particularly in forensics, one should ensure that the interpreter is at least somewhat prepared and trained for the work ahead. Given the limited resources I have had to make do with student nurses, at times I have even had to use a family member.				✓

5.3.1.3 Resource constraints

A lack of resources was an obstacle described by respondents 2, 3 and 8. Respondent 2 described a shortage of psychological test material due to financial constraints. Respondent 3 described a shortage of tools to provide interventions and respondent 8 wrote about the lack of communication devices such as telephones and computers.

5.3.1.4 Human resource shortages and personnel factors

Respondents 1, 5 and 9 described obstacles relating to personnel shortages. Respondent 1 described a lack of resources and their workaround clarified this as a personnel shortage. Respondent 5 wrote about a situation in the Department of Correctional Services where a shortage of guards results in a policy of always having a guard present when seeing an offender difficult to adhere to. Respondent 9 described a shortage or lack of interpreters in forensic units.

5.3.2 Workaround

The workarounds described by participants were divided into four categories. The framework matrix in Table 2 contains the words used by the participants to describe the workarounds implemented. One of the workarounds described fell into multiple categories.

5.3.2.1 Substitute

Respondents 2, 3 and 9 described workarounds of substitution. The respondents described ways in which they had to use what was available when a resource constraint or personnel shortage was the obstacle. Respondent 2 reported that “I used photocopied test materials and answer sheets...”, while respondent 3 reported “Bringing own tools and materials”. Respondent 9 wrote that “Given the limited resources I have had to make do with student nurses, at times I have even had to use a family member” for translation in interviews.

5.3.2.2 Bypass

Respondents 1, 6 and 8 described workarounds that bypassed policy or guidelines. Respondent 1 wrote about institutional guidelines for an expected patient load which was described as being “unattainable and unethical for psychologists”. The bypass implemented was to engage in “strategic interpersonal interactions”. Respondent 6 wrote about a workaround of the policy where a referral from a doctor was needed before a patient can be seen. The workaround was described by the respondent as “the doctor is busy and verbally tells the nurse to call me. I will see the patient although it is required for the doctor to write the referral”. Respondent 8 wrote about a bypass workaround which described the policy of files that have to be stored in the filing section of the clinic. The workaround meant that “after their first appointments, I keep their files in my office as to ensure smoother service”.

5.3.2.3 Respond

Respondents 4, 5 and 7 wrote about workarounds that required a quick response to an obstacle. Respondent 4 described the need to gain “consent to contact nearest family/ guardian or sometimes failing that I’d have to hunt for a social worker or a medical practitioner from their referring hospital/clinic”. This workaround was in response to an environmental obstacle where minor children were sent to hospitals unaccompanied by a parent or legal guardian. Respondent 5 described a situation where “correctional policy states that no offenders may be seen for psychotherapy without a security member (warden) present (stationed outside the office). However, due to scarcity of members this does not happen. ...so you may cut corners with your safety and ignore policy in order to get the job done”. Respondent 7 described an instance where “an accused was sent for observation but it was clear that he'd really benefit in psychotherapy since he never received it, so I organised it”.

Table 2

Workaround matrix

	Workaround implemented	Substitute	Bypass	Respond	Design
Respondent 1	Required statistics which are unattainable and unethical for psychologists... strategic interpersonal interactions		✓		
Respondent 2	I used photocopied test materials and answer sheets in order to perform psychological assessments such as intellectual and personality assessments.	✓			
Respondent 3	Bringing own tools and material	✓			
Respondent 4	I had to often get consent to contact nearest family/ guardian or sometimes failing that I'd have to hunt for a social worker or a medical practitioner from their referring hospital/clinic.			✓	
Respondent 5	Correctional policy states that no offenders may be seen for psychotherapy without a security member (warden) present (stationed outside the office). However, due to scarcity of members this does not happen. So you have to decide: refuse to deliver services because you have no security, but that's not fair to offenders who need services, and adds to your stress because the referral list continues to grow. So you may cut corners with your safety and ignore policy in order to get the job done.			✓	
Respondent 6	The doctor is busy and verbally tells the nurse to call me. I will see the patient although it is required for the doctor to write the referral. Or I will see a patient even before a referral is made because I am in the ward and I know they will call me later to come see the patient.		✓		✓
Respondent 7	An accused was sent for observation but it was clear that he'd really benefit in psychotherapy since he never received it, so I organized it.			✓	
Respondent 8	1) After their first appointments, I keep their files in my office as to ensure smoother service. I also make the arrangement with them that as long as they are my patients and attend services with me, their files will be kept in my office. Should they need their file for use in a different section of the clinic, they can get it from my office via our Mental Health Nurse, and bring it back afterwards. 2) I use my personal computer, internet and cell-phone to communicate with patients and referral sites.		✓ 1)		✓ 2)
Respondent 9	Given the limited resources I have had to make do with student nurses, at times I have even had to use a family member. Having to make do with an inappropriate aid which affects the integrity of the information gathered. Particularly with regards to forensic interviews and psychometric assessment.	✓			

5.3.2.4 Design

The workarounds of respondents 6 and 9 were to design new work processes as ways to overcome or deal with obstacles. Respondent 6 designed a way of working where “I will see a patient even before a referral is made because I am in the ward and I know they will call me later to come see the patient” in order to deal with the obstacle of needing to wait for a written referral letter from the doctor. In addition the respondent described instances where the doctor “verbally tells the nurse to call me” when they are too busy to write a referral. This workaround was also classified as a bypass. Respondent 9 described a workaround that designed a new way of doing work wrote that they used their “personal computer, internet and cell-phone to communicate with patients and referral sites” as a way to overcome the obstacle of a shortage in communication devices in the clinic.

5.3.3 Outcome

The Outcomes described by participants were divided into six categories. The framework matrix (see Table 3) contains the words used by the participants to describe the workaround and the outcomes. The data collection stage required the participants to indicate whether the outcome was negative or positive. Some participants had both negative and positive outcomes. An indication of the duration of the obstacles was required and three participants indicated that the obstacle was short-term while the remaining six participants indicated that the obstacle was a long-term phenomenon. Seven of the participants disclosed their workarounds while two indicated no disclosure. All of the outcomes described fell into multiple outcome categories.

5.3.3.1 Work continues despite obstacles

All of the respondents indicated that they were able to continue working once the workaround had been executed. The wording used to describe this was “work could get done and

clients could be assisted ethically” (respondent 1), “I was able to deliver the services that were needed by many of my needy clients” (respondent 2), “was able to do the interventions” (respondent 3), “sometimes I got really good information” (respondent 4), “offenders had access to psychological services” (respondent 5), “doctors and nurses appreciate me taking the initiative to see a patient before they realise the need to write a referral” (respondent 6), “the hospital I referred to implemented the recommendation” (respondent 7), “there is smoother flow in my service delivery as a whole. Patients are less anxious when coming for sessions. I feel less frustrated with the situation and thus more effective in my work as a psychotherapist” (respondent 8), “making use of informal interpreters has allowed me to get work done, and offer services to those who wouldn't normally have access to service” (respondent 9).

5.3.3.2 Potential errors and inefficiencies are created

Respondent 9 reported an outcome where the potential for errors and inefficiencies was created. The wording used to describe this “having to make do with an inappropriate aid which affects the integrity of the information gathered”.

5.3.3.3 Affects subsequent work

Respondents 4 and 9 indicated in the wording of the outcomes of the workarounds that subsequent work could be affected. Respondent 4 wrote about working around an environmental obstacle where information for minor patients was difficult to acquire. Attempts to source information “sometimes resulted in patchy information which didn't help the patient”.

Respondent 9 wrote about the use of informal interpreters. The respondent reported that they “do know of colleagues who have received incorrect information. Furthermore, they have had issues in a court setting when acting as an expert witness and their testimony has been questioned due to the use of an informal interpreter”.

5.3.3.4 Obstacles are not addressed

Respondents 3, 4, 5, 6, 8 and 9 wrote about obstacles that were not addressed and continued to be an obstacle for a significant length of time. Respondents 3, 4, 5, 8 and 9 described the duration of the obstacle as “long-term”. Respondent 6 described the obstacle as “short-term” even though the obstacle appears to have continued.

5.3.3.5 Development of interpretive flexibility and autonomy of practice

Respondents 2, 3, 6, 7 and 8 described outcomes where the respondent developed autonomy in their practice or the workaround was a flexible interpretation of institutional policy. Respondent 2 dealt with an obstacle of a resource constraint and reported that “I used photocopied test materials and answer sheets in order to perform psychological assessments such as intellectual and personality assessments” while respondent 3 reported “bringing own tools and material”. Respondent 6 responded autonomously when doctors were busy by stating that “I will see the patient although it is required for the doctor to write the referral. Or I will see a patient even before a referral is made because I am in the ward and I know they will call me later to come see the patient”. Respondent 7 recalled that “an accused was sent for observation but it was clear that he'd really benefit in psychotherapy since he never received it, so I organized it”. Respondent 8 reported that “I keep their files in my office as to ensure smoother service. I also make the arrangement with them that as long as they are my patients and attend services with me, their files will be kept in my office”.

5.3.3.6 Ethical implications

All of the workaround stories appeared to have ethical implications, either upholding ethical principles or resulting in questionable ethical practice and potential harm. The ethical implications are detailed in the next section with reference to the Canadian Psychological Association (2017) ethics guidelines.

Table 3

Outcomes matrix

	Workaround implemented, outcomes and duration of obstacle	Work continues despite obstacles	Potential errors and inefficiencies are created	Affects subsequent work	Obstacles are not addressed	Development of interpretive autonomy of practice	Ethical consequences
Respondent 1	<p>Workaround - Required statistics which are unattainable and unethical for psychologists... strategic interpersonal interactions</p> <p>Positive - work could get done and clients could be assisted ethically</p> <p>Duration of obstacle - Long-term</p> <p>Disclosed - No</p>	✓					✓
Respondent 2	<p>Workaround - For a period of about 8 months I used photocopied test materials and answer sheets in order to perform psychological assessments such as intellectual and personality assessments.</p> <p>Positive - I was able to deliver the services that were needed by many of my needy clients.</p> <p>Negative - I was aware that I was breaking copyright laws</p> <p>Duration of obstacle - Short-term</p> <p>Disclosed – Yes (Peers)</p>	✓				✓	✓
Respondent 3	<p>Workaround - Bringing own tools and material</p> <p>Positive - Was able to do the interventions</p> <p>Negative - leaving the interventions couldn't continue in the same way</p> <p>Duration of obstacle - Long-term</p> <p>Disclosed – Yes (Seniors / managers, peers)</p>	✓			✓	✓	✓
Respondent 4	<p>Workaround - I had to often get consent to contact nearest family/ guardian or sometimes failing that I'd have to hunt for a social worker or a medical practitioner from their referring hospital/clinic.</p> <p>Positive - sometimes I got really good information</p> <p>Negative - other times I got very little.</p> <p>Sometimes it resulted in patchy information which didn't help the patient</p> <p>Duration of obstacle - Long-term</p> <p>Disclosed – Yes (Seniors / managers, peers)</p>	✓		✓	✓		✓
Respondent 5	<p>Workaround - Correctional policy states that no offenders may be seen for psychotherapy without a security member (warden) present (stationed outside the office). However, due to scarcity of members this does not happen. So you have to decide: refuse to deliver services because you have no security, but that's not fair to offenders who need services, and adds to your stress because the referral list continues to grow. So you may cut corners with your safety and ignore policy in order to get the job done.</p> <p>Positive - offenders had access to psychological services</p> <p>Negative- psychologist compromised safety, own values and defied policy. Inevitably also became complicit in the system - allowing the practice to continue</p> <p>Duration of obstacle - Long-term</p> <p>Disclosed – Yes (Seniors / managers, peers, subordinates)</p> <p>All personnel know that this happens.</p>	✓			✓		✓

	Workaround implemented, outcomes and duration of obstacle	Work continues despite obstacles	Potential errors and inefficiencies are created	Affects subsequent work	Obstacles are not addressed	Development of interpretive autonomy of practice	Ethical consequences
Respondent 6	<p>Workaround - The doctor is busy and verbally tells the nurse to call me. I will see the patient although it is required for the doctor to write the referral. Or I will see a patient even before a referral is made because I am in the ward and I know they will call me later to come see the patient.</p> <p>Positive - doctors and nurses appreciate me taking the initiative to see a patient before the realise they need to write a referral.</p> <p>Duration of obstacle Short-term</p> <p>Disclosed - Yes (Seniors / managers, peers, subordinates)</p>	✓			✓	✓	✓
Respondent 7	<p>Workaround - An accused was sent for observation but it was clear that he'd really benefit in psychotherapy since he never received it, so I organized it.</p> <p>Positive - The hospital I referred to implemented the recommendation</p> <p>Duration of obstacle - Short-term</p> <p>Disclosed - No</p>	✓				✓	✓
Respondent 8	<p>Workaround - After their first appointments, I keep their files in my office as to ensure smoother service. I also make the arrangement with them that as long as they are my patients and attend services with me, their files will be kept in my office. Should they need their file for use in a different section of the clinic, they can get it from my office via our Mental Health Nurse, and bring it back afterwards.</p> <p>Positive - There is smoother flow in my service delivery as a whole. Patients are less anxious when coming for sessions. I feel less frustrated with the situation and thus more effective in my work as a psychotherapist</p> <p>Duration of obstacle - Long-term</p> <p>Disclosed - Yes (Seniors / managers, peers, subordinates)</p>	✓			✓	✓	✓
Respondent 9	<p>Workaround - Given the limited resources I have had to make do with student nurses, at times I have even had to use a family member. Having to make do with an inappropriate aid which affects the integrity of the information gathered. Particularly with regards to forensic interviews and psychometric assessment.</p> <p>Positive - I have to say that I have managed thus far without negative incident. And making use of informal interpreters has allowed me to get work done, and offer services to those who wouldn't normally have access to service.</p> <p>Negative - I do know of colleagues who have received incorrect information. Furthermore, they have had issues in a court setting when acting as an expert witness and their testimony has been questioned due to the use of an informal interpreter.</p> <p>Duration of obstacle - Long-term</p> <p>Disclosed - Yes (Seniors / managers, peers, subordinates)</p>	✓	✓	✓	✓		✓

5.3.4 Ethical Implications

The workaround stories were coded to the four ethical principles of the CPA code of ethics in order to understand the ethical implications of the workarounds implemented. The workaround stories were coded to each ethical principle if the principle was either upheld by the implementation of the workaround or the implementation of the workaround produced an actual or potential violation of the principle.

5.3.4.1 Respect for the dignity of persons and peoples

All of the workaround stories implied that the respondents upheld the principle of respect for the dignity of persons and peoples. Respondent 9 implied that confidentiality could be breached with the implementation of the workaround because the participant stated that “at times I have even had to use a family member” as an interpreter, which could affect the confidentiality of the intervention.

5.3.4.2 Responsible caring

Respondents 1-7 implemented workarounds that indicated attention to responsible caring. Respondent 8 did not specifically imply responsible caring; however there was also no indication that this principle was ignored. Respondent 9 implied that they attempted to uphold responsible caring when the respondent stated “making use of informal interpreters has allowed me to get work done, and offer services to those who wouldn't normally have access to service”. However, the possible foreseeable harm is mentioned when the respondent stated that some colleagues “received incorrect information” and “have had issues in a court setting when acting as an expert witness and their testimony has been questioned due to the use of an informal interpreter”.

5.3.4.3 Integrity in relationships

Integrity in relationships was not the focus of most of the workaround stories. It cannot be stated that the workarounds implemented either upheld this principle or ignored it. Respondent 4

Table 4

Ethical implications

	Workaround implemented	Respect for the dignity of persons and peoples	Responsible caring	Integrity in relationships	Responsibility to society
Respondent 1	Workaround of required statistics which are unattainable and unethical for psychologists (so that) work could get done and clients could be assisted ethically	✓	✓		✓
Respondent 2	Ordering psychological test material took long periods of time if you used the hospital procurement channels and often was rejected because of financial constraints. I used photocopied test materials and answer sheets in order to perform psychological assessments such as intellectual and personality assessments. I was able to deliver the services that were needed by many of my needy clients. I did not directly experience any negative consequences however I was aware that I was breaking copyright laws.	✓	✓		✗
Respondent 3	Not having the tools to do certain interventions. Bringing own tools and material. Was able to do the interventions.	✓	✓		
Respondent 4	I found working with kids difficult because at my hospital the patients came from all over KZN as it was a tertiary hospital. This often meant that kids had no parents available to talk with or even contact at all. If I needed back ground on a problem that was relatively urgent I could not always get it from a thorough intake. I had to often get consent to contact nearest family/ guardian or sometimes failing that I'd have to hunt for a social worker or a medical practitioner from their referring hospital/clinic. One thing that was useful that came out of it was that it increased the amount of energy devoted to the family system.	✓	✓	✓	✓
Respondent 5	Correctional policy states that no offenders may be seen for psychotherapy without a security member (warden) present (stationed outside the office). However, due to scarcity of members this does not happen. So you have to decide: refuse to deliver services because you have no security, but that's not fair to offenders who need services, and adds to your stress because the referral list continues to grow. So you may cut corners with your safety and ignore policy in order to get the job done - decided to conduct individual and group therapy sessions in spite of no security	✓	✓		✓
Respondent 6	The doctor is busy and verbally tells the nurse to call me. I will see the patient although it is required for the doctor to write the referral. Or I will see a patient (i.e. a mother who has given birth to a still born) even before a referral is made because I am in the labour ward and I know they will call me later to come see the patient.	✓	✓		

	Workaround implemented	Respect for the dignity of persons and peoples	Responsible caring	Integrity in relationships	Responsibility to society
Respondent 7	An accused was sent for observation but it was clear that he'd really benefit in psychotherapy since he never received it, so I organized it.	✓	✓		
Respondent 8	The clinic's system for registration of patients and issuing patient files is problematic, often resulting in patients being late for appointments. When patients are scheduled for their first appointment, I request them to come early enough in the day in order to get their files in time. After their first appointments, I keep their files in my office as to ensure smoother service. I also make the arrangement with them that as long as they are my patients and attend services with my, their files will be kept in my office. Should they need their file for use in a different section of the clinic, they can get it from my office via our Mental Health Nurse, and bring it back afterwards.	✓			✓
Respondent 9	The most obvious workaround for me is when working with interpreters. Particularly in forensics, one should ensure that the interpreter is at least somewhat prepared and trained for the work ahead. Given the limited resources I have had to make so with student nurses, at times I have even had to use a family member. Having to make do with an inappropriate aid which affects the integrity of the information gathered. Particularly with regards to forensic interviews and psychometric assessment.	✓ ✗	✓ ✗		✓

implied that openness and straightforwardness was a priority and that consent was upheld as the respondent stated that “I had to often get consent to contact nearest family/ guardian...”.

5.3.4.4 Responsibility to society

Although not directly stated, the principle of responsibility to society was upheld by in the stories of respondents 1, 4, 5, 8 and 9. Respondent 1 indicated that there was an attempt to change a system where “required statistics ... are unethical and unattainable for psychologists” and respondent 8 made mention of working towards changing the clinic filing system to improve service delivery. Respondent 4 stated that an “increased the amount of energy (was) devoted to the family system” as a result of their workaround. Respondent 5 had an indirect impact on this

principle as the workaround ensured that offenders received an intervention they would otherwise do without which would hopefully have a positive effect on their future interactions in society. Respondent 9 reacted to the hospital system where there was a shortage of qualified interpreters by arranging informal interpreters in order to “offer services to those who wouldn't normally have access to service”.

5.4 Summary of results

5.4.1 Question 1 – Have clinical psychologists used workarounds during community service?

The results indicate that clinical psychologists have used workarounds in public healthcare and correctional facilities during their community service year.

5.4.2 Question 2 – How do clinical psychologists write about workarounds?

The workaround stories contain the same structure in terms of an obstacle, a workaround and outcomes. The elements of each of these components are also similar to what has been written about in previous research on workarounds (Alter, 2014; Campbell, 2011; Debono et al., 2013; Halbesleben et al., 2010; Halbesleben et al., 2008; Rathert et al., 2012).

5.4.3 Question 3 – Using ethical principles for practice, how can the ethical challenges found in the descriptions of workarounds be understood?

The ethical challenges faced by clinical psychologists to deal with the obstacles they encountered have been negotiated by upholding the ethical principles in order of importance. All accounts prioritised the first and second principles, namely respect for the dignity of persons and peoples, and responsible caring.

Chapter 6: DISCUSSION

This chapter discusses the findings of this study in relation to the three research questions, available literature and the application of the framework of the CPA ethics code. The sample size does not allow for any significant conclusions to be made regarding the quantitative demographic information obtained in this research.

6.1 Question 1 - Have clinical psychologists used workarounds during community service?

In terms of the first research question, “have clinical psychologists used workarounds during community service?”, this study has elicited descriptions of workarounds which clinical psychologists have implemented. The lack of research investigating workarounds used by clinical psychologists does not appear to indicate that workarounds are not used. To the contrary, the public health environment which is notorious for a multitude of policy and resourced related obstacles, as discussed in the literature review chapter, appears to have an impact on not only nurses but psychologists too. Working in challenging environments which are characterised by resource constraints, high patient volumes and procedural conflicts (Marais & Petersen, 2015; Pillay et al., 2012) often demands a creative response. The results captured in the data from this study indicate that the creative responses implemented by clinical psychologists in this sample can lead to workarounds.

The poor response rate received in this study is consistent with reports that eliciting workarounds stories is difficult (Berlinger, 2016; Campbell, 2011; Halbesleben et al., 2008). However, it could also indicate that the term ‘workarounds’ is not a concept that clinical psychologists are familiar with yet. Although research relating to clinical psychologists and workarounds could not be accessed, descriptions of obstacles in the workplace and ways of working were described in some research papers (Elkington & Talbot, 2016; Padfield, 2013;

Pillay & Harvey, 2006; Rohleder et al., 2006). Although these ways of working were not identified as workarounds, they could be understood as such. In the researchers own experience of conducting this research, the term workarounds consistently required explanation when making telephonic or personal contact with potential participants.

6.2 Question 2 - How do clinical psychologists write about workarounds?

The three aspects of a workaround that were reported on were:

- i) the obstacle,
- ii) the workaround implemented and
- iii) the outcome or consequences of the workaround.

These features of workarounds are discussed individually below.

6.2.1 Obstacles

The obstacles described in the data fall into four of the five possible categories of obstacles defined in the literature review. Technology and equipment failures were not a feature of the obstacles encountered by the participants which could reflect the difference in the characteristics of the work of clinical psychologists when compared to nurses. Apart from psychometric tests and biofeedback equipment, clinical psychology practice requires little or no technology.

6.2.1.1 Rules, protocols, guidelines and policy

Three participants described obstacles that could fit into the category of rules, protocols, guidelines and policy. Two respondents described obstacles relating to referrals. The need for a written referral before seeing a patient was one of the described obstacles while the other referred to a reported incorrect referral being given. A motivation behind the referral letter policy could be to protect the healthcare professional and patient from potential harm or as an intentional block to

reduce errors. It is possible that the participants understood that waiting for a referral letter or implementing the recommendation on a given referral was not in the best interests of the patient.

Keeping patient files to avoid delays was another obstacle which fitted into this category. The policy to have all the patient files for the clinic in a central place was reported to cause delays in patients arriving for sessions on time. It could be understood that the psychologist perceived the policy to not be in the best interests of their patient and as reported by Debono et al. (2013) and Halbesleben et al. (2008), this could lead to procedure being customised in the form of a workaround.

6.2.1.2 Operational failures, environmental challenges and work process design

One participant described an obstacle that could fit in the area of environmental challenges. This obstacle did not refer to the environment of the hospital; rather it referred to the patient's environment which caused a child patient to arrive without a parent or guardian. The result of this was missing patient information. This situation was described by the participant as 'difficult' due to the urgent nature of acquiring the missing information. Potentially frustrating situations similar to this have been reported to lead to increased use of workarounds (Rathert et al., 2012).

6.2.1.3 Resource constraints

Resource constraints were reported by three participants to be obstacles. Shortages in psychometric test materials, intervention tools and communication devices were recounted. Alter (2014), Berlinger (2016) and Vestal (2008) describe resource constraints as situations that force healthcare professions to make do with what they have and can often result in workarounds. Although this type of obstacle can be temporary, only one participant reported that the resource constraint was a short-term obstacle. Another participant indicated a shortage in communication devices at the clinic they were placed at.

6.2.1.4 Human resource shortages and personnel factors

Personnel shortages were described by three participants. Only one of those referred to a shortage of psychologists which put them under pressure to carry large caseloads. This type of obstacle can result in exhaustion. Rathert et al. (2012) state that exhaustion can increase the chance of a workaround being implemented. The other two participants described personnel shortages of support staff. The shortage of guards in a prison situation was described by Rohleder et al. (2006) who, as experienced by this participant, had to decide whether to adhere to policy or service their patient. The shortage of interpreters in public healthcare settings was also described by Elkington and Talbot (2016) who also chose to use unqualified interpreters in order to get the job done.

6.2.2 Workarounds

The workarounds implemented by the participants fell into four of the eight possible categories described in the literature review. Some workaround descriptions fell into more than one category, suggesting that the categories may need to be revised. None of the participants described workarounds which fitted into the supplement, prevent, pretend or avoid categories. A possible reason for this difference could be the small sample which may not allow for every kind of workaround to have been captured. Another possible explanation, as with the obstacles described in the data, could be that the work of psychologists differs from that of nurses.

6.2.2.1 Substitute

There were three workarounds which were a substitution. Two were due to resource constraints and one was a personnel shortage. Substitution involves using what is on hand when there are shortages. All of the respondents who use substitution described ways in which they used what was available as the substitution. The two respondents who experienced resource

constraints described their substitution as “photocopied test materials and answer sheets” and “bringing own tools and material”. These respondents found a substitution to the shortage of test materials and intervention tools. The respondent who experienced a personnel shortage described their substitution as having “to make do with student nurses, at times I have even had to use a family member” when an interpreter was not available. In this way the respondent substituted the personnel shortage with other personnel, or family members, who were on hand. These substitution examples from the data are consistent with the findings in previous research (Elkington & Talbot, 2016; Padfield, 2013; Rohleder et al., 2006) where healthcare professionals find a substitution to a shortage in order to work around the shortage and continue working.

6.2.2.2 Bypass

Three respondents described workarounds that bypassed policy, guidelines or routines or usual work. In all three cases the policy created an obstacle which the respondent bypassed with a workaround. Guidelines for expected statistics of patients seen by a psychologist created what was described by the respondent as a situation which was “unattainable and unethical for psychologists”. The workaround implemented was to engage in “strategic interpersonal interactions” in order to overcome the obstacle and continue with their work in a more ethical and attainable manner. The other two examples of workarounds which bypassed policy were to see patients without the required referral letter from a doctor and to keep patient files in the respondent’s office to allow for smoother service. Both of these workaround descriptions portrayed a situation where the policy hindered the respondent’s ability to effectively and efficiently continue their work, and the workaround enabled them continue with working.

6.2.2.3 Respond

Three participants described workarounds which responded to the obstacles they experienced. A response is usually a quick fix and frequently involves an unusual situation. The

description by one respondent was of an unusual situation where the referral received for a patient at a forensic hospital did not match the needs of the patient. The respondent worked around the referral and arranged the treatment that the patient needed. This workaround responded to the needs of the patient and to the obstacle of the original referral. The second respondent described the situation in a correctional facility where a personnel shortage of guards often left psychologists in situations where decisions needed to be made in the moment as to whether to see offenders without a guard stationed outside the office (as policy requires) or to continue with a session without a guard. A similar situation was described by Rohleder et al. (2006) in their paper outlining their experiences of conducting community service in a correctional facility. The participant responded to the situation by continuing the session without a guard present. The third description was a response to an environmental obstacle where minor children were sent to hospitals unaccompanied by a parent or legal guardian. Finding ways to obtain necessary and important background information was a workaround that responded to the environmental obstacle. All three of these workarounds responded to the obstacle that was encountered with a quick fix.

6.2.2.4 Design

Two of the workaround descriptions were ways of designing or modifying work routines. Both of these design-related workarounds were also categorised as bypass workarounds. They fall into two categories of workarounds because although the participant described how the policy was bypassed, they also designed a new way of working as part of the workaround. The first description involved bypassing the need for a written referral from a doctor in order to see a patient. The respondent also designed a new way of working as they took verbal instructions in place of written referrals which as is required by the policy. The second description involved the bypassing of the policy to have all patient files in a central place. This is also a design

workaround because the participant designed what was described as a more efficient way of working by keeping patient files. In addition, they also arranged for the files, which were kept in their office, to be collected by other healthcare workers who interacted with the same patients. Both of these new designs were implemented to work around what the participants understood to be shortcomings in institutional policy.

6.2.3 Outcome

The outcomes of the workarounds described in the data covered six of the seven possible outcomes described in the literature review. The only outcome that was not experienced by the participants was the workaround becoming a source of future improvement. A possible reason for this could be the way in which the data was collected. By asking the participants to answer an online questionnaire, the researcher was unable to interact with the participants to further explore possible outcomes of their described workarounds.

6.2.3.1 Work continues despite obstacles

All of the respondents described workarounds which allowed work to continue. The very nature of a workaround is finding a way around an obstacle in order to achieve a work related goal (Alter, 2014; Berlinger, 2016; Debono et al., 2013; Halbesleben et al., 2008). It is therefore not surprising that all of the workarounds in the data allowed work to continue. The wording used by participants when they described the positive outcomes of their workarounds implies that the psychologists involved, the patients and at times other healthcare professionals, all benefitted from the implementation of the workaround. Phrases such as “work could get done and clients could be assisted ethically”, “I was able to deliver the services that were needed by many of my needy clients”, “was able to do the interventions”, “offenders had access to psychological services”, “doctors and nurses appreciate me taking the initiative to see a patient before they

realise the need to write a referral”, “the hospital I referred to implemented the recommendation”, “there is smoother flow in my service delivery as a whole”, “allowed me to get work done, and offer services to those who wouldn't normally have access to service” are all positive and all imply a continuation of work and attaining work-related goals.

6.2.3.2 Potential errors and inefficiencies are created

Only one participant described an outcome which had the potential to create errors and inefficiencies. The participant wrote “having to make do with an inappropriate aid which affects the integrity of the information gathered”. The obstacle experienced by this participant was a personnel shortage of available interpreters and the workaround was to use student nurses and sometimes family members to interpret for them. Although the participant reported that this workaround had not created errors for them personally and, furthermore, their experience of using the workaround had so far been positive where work could get done. However, the potential for errors is also likely.

6.2.3.3 Affects subsequent work

Two participants described outcomes which affected subsequent work. Alter (2014) explains that some workarounds do not create errors or harm while they are being implemented. However, the impact of the workaround may be felt further down the line. The participants described instances where the workaround they implemented affected the quality of information they received when they implemented the workaround. One participant wrote that their attempts to source information “sometimes resulted in patchy information which didn't help the patient” while the other participant reported that they “know of colleagues who have received incorrect information. Furthermore, they have had issues in a court setting when acting as an expert witness and their testimony has been questioned due to the use of an informal interpreter”. Both

of these workarounds used to obtain information have the outcome of potentially affecting subsequent work.

6.2.3.4 Obstacles are not addressed

Six participants reported that the implemented workaround did not address the obstacle even though all six disclosed the obstacle and their workaround to seniors, managers and peers. Disclosing the workarounds does not seem to have brought any negative consequences to the participant which is contrary to what has been found in previous research. Berlinger (2016) found that obstacles are not always reported to management as this would create awareness of the workaround and the violations of policy which could result in punitive consequences. Even though both Berlinger (2016) and Stutzer and Hylton Rushton (2015) found that failing to report the obstacles and workarounds could conceal potentially dangerous conditions in the workplace, five of these six participants described the obstacle as long-term which also indicates that it remained unresolved even after reporting it to management.

6.2.3.5 Development of interpretive flexibility and autonomy of practice

Alter (2014) describes healthcare professionals who use common sense and resourcefulness as flexible and Debono et al. (2013) refers to autonomy of practice when describing a healthcare professional who uses workarounds that are viewed as acceptable and not harmful. Five of the participants described workarounds that had the outcome of developing autonomy of practice or interpretive flexibility. All of the accounts describe instances where the participant had to think creatively to overcome the obstacle. Two of the participants dealt with resource constraints with interpretive flexibility, the one reporting that “I used photocopied test materials and answer sheets in order to perform psychological assessments such as intellectual and personality assessments” while the other reported “bringing own tools and material” in response to a shortage of tools to perform interventions. These participants used common sense

and resourcefulness to overcome the obstacles they encountered. The other three participants responded to obstacles relating to policy. Their workarounds all demonstrated a sense of autonomy of practice where the participants became self-sufficient in the way they overcame the obstacles they faced.

6.2.3.6 Ethical consequences

All of the stories submitted by the participants had ethical implications. Many of the stories indicated that the participant attempted to uphold their ethical principles while some indicated potential harm. One of the stories acknowledged that the workaround was a violation of copyright laws when they photocopied test material and answer sheets. The ethical implications of the workarounds will be investigated in depth in the next section.

6.3 Question 3 - Using ethical principles for practice, how can the ethical challenges found in the descriptions of workarounds be understood?

As discussed in the literature review, the Canadian code of ethics for psychologists (Canadian Psychological Association, 2017) has been used to understand the ethical challenges faced by the participants because of its ease of use and focus on ethical decision making when compared with local and other codes. This section does not only highlight potential harm or ethical violations, it also indicates where the participants have acted in a way that upholds the ethical principles of practice. The four principles found in the CPA code are applied individually to the workaround stories to identify the ethical implications.

6.3.1 Respect for the dignity of persons and peoples

Respect for the dignity of persons and peoples holds the highest weight of the four principles (Canadian Psychological Association, 2017). This principle highlights the need to respect individuals for their innate worth and includes the principle of confidentiality. One of the

participants wrote about a situation that could impact negatively on the confidentiality of their patient. The participant wrote that “at times I have even had to use a family member” when there was a personnel shortage of interpreters. Using a family member as an interpreter could compromise the confidentiality of the intervention. There is no indication in the story on how the participant obtained consent for this type of interpreter and it is therefore not possible to comment on this. The ethical dilemma faced by the participant to afford the patient the available psychological intervention with an inappropriate interpreter or to withhold the intervention is evident. In this case providing fair treatment and non-discrimination aspects of this principle are in conflict with the confidentiality aspect of the principle.

All the other workaround stories, and arguably the story mentioned above, upheld the principle by choosing to implement a workaround to ensure that clinical service delivery could continue. The participants were respected for their innate worth as human beings irrespective of their personal attributes or circumstances.

6.3.2 Responsible caring

Maximising benefit and minimising harm are the central aspects to this principle. Seven of the participants’ workarounds implied that benefit was maximised. The participants wrote that “clients could be assisted ethically”, “was able to deliver the services that were needed by many of my needy clients”, “Was able to do the interventions”, “increased the amount of energy devoted to the family system”, “I decided to conduct individual and group therapy sessions in spite of no security”, “I will see a patient (i.e. a mother who has given birth to a still born) even before a referral is made” and “it was clear that he'd really benefit in psychotherapy since he never received it, so I organized it”. These seven participants all worked to maximise the benefit to the patient.

The story told by respondent 8 does not clearly indicate that the workaround implemented maximised benefit to the patient. This story also does not indicate any harm that the patients experienced by their files being kept in the participant's office.

The workaround story in response 9 both maximised benefit and had an indication of possible harm. The participant reported "making use of informal interpreters has allowed me to get work done, and offer services to those who wouldn't normally have access to service". This indicates benefit to the patients. However, there is mention of foreseeable harm when the participant acknowledged that some colleagues "received incorrect information" and "have had issues in a court setting when acting as an expert witness and their testimony has been questioned due to the use of an informal interpreter". The ethical dilemma faced by this participant seems to have been resolved by their previous personal experience. This participant stated that they "have managed thus far without negative incident".

6.3.3 Integrity in relationships

The workaround stories described by participants did not specifically cover a narrative which related to the principle of integrity in relationships. The participant whose story is marked response 4 implied that openness and straightforwardness was a priority. In order to obtain required information the respondent stated that "I had to often get consent to contact nearest family/ guardian...". This participant relayed that they upheld the principle of obtaining consent before contacting family for further information. This, arguably, indicated a relationship with the patient that was characterised by honesty, openness and straightforwardness.

6.3.4 Responsibility to society

Responsibility to society is rated fourth most important when conflicts arise, however the interests of the individual should not be sacrificed for the interests of society (Canadian Psychological Association, 2017). The principle acknowledges and respects existing social

structures. However, if these same structures deny persons or peoples respect and dignity, the psychologist could advocate for changes to these structures (Canadian Psychological Association, 2017). The workaround stories did not clearly state any reference to this principle. However, there was an indication in five of the stories that participants acted in a way that upheld the principle. Response 1 indicated that the participant advocated changing the practice of unethically large caseloads for psychologists in order to maintain the respect and dignity of the patients. The participant's story in response 9 describes the situation of not having appropriate interpreters. The existing structure significantly prejudiced patients who were language discordant with the participant. Even though the use of informal interpreters has potential negative consequences, the participant worked against the existing structures to afford access to patients who otherwise would be denied services.

The workaround story in response 4 stated that an "increased ... amount of energy (was) devoted to the family system". This workaround implied that the participant acknowledged the existing social structure of the patient as important.

The workaround described in response 5 could potentially have a long term benefit to society. The participant made the decision to continue with their psychological interventions with offenders at a correctional facility which could potentially have a positive effect on their future interactions with society. The immediate benefit of these interventions could be to the social structure of the correctional facility as offenders' access in beneficial services.

Response 8 worked against the system of the clinic to keep patient files in a central location in order to improve service delivery. This change could also impact the patient who was coming for psychological services by allowing them to come for sessions less frustrated by the time delay in obtaining their files.

The workaround implemented in response 2 was acknowledged as a violation of copyright laws. Implementing this workaround fails to respect the existing laws and is therefore a violation of this ethical principle, but is somewhat offset by the principle of respect for the dignity of persons and people.

The limited amount of information supplied in the workaround stories makes a more comprehensive ethical evaluation difficult. The information that is available indicates that the participants acted in ways that responded to the obstacles in the most ethical way they could.

Chapter 7: CONCLUSION

7.1 Conclusions regarding the research questions

This study aimed to explore the use of workaround by clinical psychologists in community service settings. Furthermore this study aimed to understand these workarounds in terms of the ethical responsibility that clinical psychologists have to their patients, society and their profession.

7.1.1 Question 1 - Have clinical psychologists used workarounds during community service?

The results of this study indicate that psychologists do implement workarounds as a response to the obstacles they encounter in public healthcare settings.

7.1.2 Question 2 - How do clinical psychologists write about workarounds?

The nature of the obstacles, the workarounds and the outcomes are consistent with existing research into workarounds in public healthcare settings (Debono et al., 2013; Halbesleben et al., 2010; Halbesleben et al., 2008; Rathert et al., 2012; Seaman & Erlen, 2015), even though existing research is largely focussed on the nursing profession (Debono et al., 2013; Halbesleben et al., 2010). The differences in the accounts could be due to the individual characteristics of the work of psychologists compared to nurses.

7.1.3 Question 3 - Using ethical principles for practice, how can the ethical challenges found in the descriptions of workarounds be understood?

The ethical evaluation concluded that the clinical psychologists who participated in this research conducted themselves in an ethical manner and tackled ethical decision making by prioritising the respect and dignity of the patients. The difficult circumstances that the participants found themselves in and the various obstacles they had to overcome led to very few potentially harmful situations.

7.2 Limitations of the study

This research made use of an online questionnaire to collect the data. This type of data collection does not allow the researcher to interact with the participants. Some of the data collected was ambiguous while other parts felt incomplete. A face-to-face interview could have allowed the researcher to explore the questions in more depth with the participants which could have resulted in a richer data set. The researcher would have been able to gain a deeper understanding of the way the participants approached the obstacles, the ways in which they devised the workarounds and how they approached any ethical conflicts they may have experienced.

The poor response rate and small sample obtained in this research probably affected the results. A larger data set could have revealed a different and more complex and varied picture of the way obstacles are dealt with and the type of workarounds implemented.

7.3 Recommendations

The data presented above suggest that further research into workarounds and clinical psychologists is needed. There is a lack of research on this topic and more focus in this area could lead psychologists to becoming more aware of their use of workarounds as ways of working in public healthcare systems, especially in a resource-constrained setting like South Africa. Future research should be in the form of individual interviews or more in-depth questionnaires. An attempt to gain a deeper and fuller understanding of the obstacles, workarounds and outcomes is needed. An in-depth knowledge of the ethical decision making of psychologists faced with workflow obstacles would significantly add to the knowledge base and understanding of the ethical implications of workarounds.

The obstacles mentioned in this research are not limited to the experiences of the participants. Other research (Padfield, 2013; Pillay & Harvey, 2006; Pillay et al., 2012; Rohleder et al., 2006) has highlighted similar obstacles in public healthcare settings, many of which are resource constraints or personnel shortages. These types of obstacles affect service delivery and ultimately patient care. The obstacles mentioned in this paper require attention if the implementation of workarounds is to be reduced.

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Appendix A - Questionnaire

* 1. BY COMPLETING AND RETURNING THIS QUESTIONNAIRE I AM CONSENTING TO PARTICIPATE IN THIS RESEARCH, SUCH CONSENT BEING COMPLETELY VOLUNTARY AND FULLY INFORMED. I AM ALSO DECLARING THAT I HAVE READ AND UNDERSTOOD THE COVERING LETTER WHICH EXPLAINS THE PURPOSE OF THE RESEARCH AS WELL AS THE POSSIBLE RISKS AND BENEFITS.

I hereby confirm that I understand the contents of the document and the nature of the research project, and I consent to participating in the research project. I understand that I am at liberty to withdraw from the project at any time, should I so desire.

I AGREE

I DO NOT AGREE AND EXIT

PLEASE DO NOT ENTER YOUR NAME ANYWHERE IN THIS FORM

* 2. Race

* 3. Age

* 4. Gender

* 5. University where Masters Degree was obtained.

* 6. Year of community service

* 7. Province where community service was conducted

* 8. Geographical classification

* 9. Type of Community Service Centre (eg, hospital, correctional facility, clinic etc).

The topic of interest is workarounds.

What is a workaround? A workaround is implemented as a work procedure to bypass perceived or real barriers in work flow.

What a workaround is not Errors or mistakes, deviance and shortcuts are not the same as workarounds.

Working definition of a workaround: "Work patterns an individual or a group of individuals create to accomplish a crucial work goal within a system of dysfunctional work processes that prohibits the accomplishment of that goal or makes it difficult." (Morath and Turnbull in Halbesleben et al., 2008, p. 4)

Reasons for workarounds occurring: In health care work there is often an urgency in the work with a need to just get things done. Frequently there are obstacles and policies that slow or inhibit the goal of the health care worker. In order to get the job done and to bypass the obstacles, shortcuts and counter-policy methods are employed.

* 10. Did you ever engage in a workaround?

- No
 Yes

* 11. If you have engaged in a workaround, please describe the obstacle or barrier you encountered that required a workaround.



Please rate the level of difficulty you experienced and the duration the difficulty was experienced.

* 12. Level of difficulty

- Mild difficulty
- Moderate difficulty
- Severe difficulty

* 13. Duration

- Short-term
- Long-term

* 14. Please describe the nature of the workaround used to bypass the difficulty or barrier.

* 15. Please describe any consequences of the workaround (positive or negative).

* 16. Did you disclose the workaround to anyone?

Yes

No

* 17. Please indicate to whom the disclosure was made.

Seniors / Managers

Peers

Subordinates

Other (please specify)

* 18. What were the consequences or repercussions (if any) of the disclosure?

* 19. Your participation and contribution is much appreciated.

Please indicate if you would like to receive the results of this research.

No

Yes. If yes, please send your email address to workarounds@research@gmail.com

Appendix B - Ethical clearance certificate



23 September 2016

Mrs Della Anne Miranda (212542109)
School of Applied Human Sciences – Psychology
Pietermaritzburg Campus

Dear Mrs Miranda,

Protocol reference number: HSS/1246/016M

Project title: Workarounds practiced by South African clinical psychologists – an ethical evaluation focussing on the community service year

Full Approval – Expedited Application

In response to your application received on 17 August 2016, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted FULL APPROVAL.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

Dr Shenuka Singh (Chair)

/ms

Cc Supervisor: Professor Doug Wassenaar
Cc Academic Leader Research: Dr Joan Steyn
Cc School Administrator: Ms Ayanda Khanyile

Humanities & Social Sciences Research Ethics Committee

Dr Shenuka Singh (Chair)

Westville Campus, Govan Mbeki Building

Postal Address: Private Bag X54001 Durban 4000

Telephone: +27 (0) 31 960 3567/3560/4357 Facsimile: +27 (0) 31 960 4009 Email: dms@ukzn.ac.za / steyn@ukzn.ac.za / mbh@ukzn.ac.za

Website: www.ukzn.ac.za



Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville



22 March 2017

Mrs Delia Anne Miranda (212542109)
School of Applied Human Sciences – Psychology
Pietermaritzburg Campus

Dear Mrs Miranda,

Protocol reference number: HSS/1246/016M

Project title: Workarounds practiced by South African clinical psychologists – an ethical evaluation focussing on the community service year

Approval Notification – Amendment Application

This letter serves to notify you that your application and request for an amendment received on 19 March 2017 has now been approved as follows:

- Change in Research Methodology

Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form; Title of the Project, Location of the Study must be reviewed and approved through an amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for period of 3 years from the date of original issue. Thereafter Recertification must be applied for on an annual basis.

Best wishes for the successful completion of your research protocol.

Yours faithfully

Dr Shamila Naidoo (Deputy Chair)

/ms

Cc Supervisor: Professor Doug Wassenaar
Cc Academic Leader Research: Dr Joan Steyn
Cc School Administrator: Ms Ayanda Khanyile

Humanities & Social Sciences Research Ethics Committee

Dr Shenuka Singh (Chair)

Westville Campus, Govan Mbeki Building

Postal Address: Private Bag X54001, Durban 4000

Telephone: +27 (0) 31 200 5687/8960/4557 Facsimile: +27 (0) 31 200 4689 Email: ethics@ukzn.ac.za / sh-mann@ukzn.ac.za / ms.aidoo@ukzn.ac.za

Website: www.ukzn.ac.za



Founding Campuses: ■ Edgewood ■ Howard College ■ Medical School ■ Pietermaritzburg ■ Westville



22 November 2018

Mrs Della Anne Miranda (212542109)
School of Applied Human Sciences – Psychology
Pietermaritzburg Campus

Dear Mrs Miranda,

Protocol reference number: HSS/1246/016M
New Project title: Workarounds practiced by South African clinical psychologists during their community service year: Ethical Implications.

Approval notification – Amendment Application

This letter serves to notify you that your application for an amendment dated 14 November 2018 has now been granted Full Approval as follows:

- Change in Title

Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study must be reviewed and approved through an amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number. PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

Best wishes for the successful completion of your research protocol.

Yours faithfully

Dr Shamila Naidoo (Deputy Chair)
Humanities & Social Sciences Research Ethics Committee

/pm

Cc Supervisor: Professor Doug Wassenaar
Cc Academic Leader Research: Dr Maod Mthembu
Cc School Administrator: Ms Priya Konan

Humanities & Social Sciences Research Ethics Committee

Professor Shenika Singh (Chair)

Westville Campus, Govan Mbeki Building

Postal Address: Private Bag 254001, Durban 4003

Telephone: +27 (0) 31 260 3597/8353/4557 Facsimile: +27 (0) 31 260 4898 Email: ethics@ukzn.ac.za / shenika@ukzn.ac.za / mthembu@ukzn.ac.za

Website: www.ukzn.ac.za



Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

INFORMED CONSENT

Dear Psychologist

My name is Delia Miranda. I am a Masters student in the School of Applied Human Sciences in the discipline of psychology at the University of KwaZulu-Natal, Pietermaritzburg.

You are being invited to consider participating in a study that involves research on workarounds. The aim and purpose of this research is to get an idea of the workarounds that clinical psychologists use in public health care facilities and to conduct an ethical evaluation of the workarounds.

What is a workaround? A workaround is implemented as a work procedure to bypass perceived or real barriers in work flow.

What a workaround is not: Errors or mistakes, deviance and shortcuts are not the same as workarounds.

Working definition of a workaround: "Work patterns an individual or a group of individuals create to accomplish a crucial work goal within a system of dysfunctional work processes that prohibits the accomplishment of that goal or makes it difficult." (Morath and Turnbull in Halbesleben et al., 2008, p. 4)

Reasons for workarounds occurring: In health care work there is often an urgency in the work with a need to just get things done. Frequently there are obstacles and policies that slow or inhibit the goal of the health care worker. In order to get the job done and to bypass the obstacles, shortcuts and counter-policy methods are employed.

I hope to enrol approximately 380 Clinical Psychologists from all over South Africa. It will involve the writing of a short description of your experience of a workaround during your community service. The questionnaire will provide prompts to guide the writing of your experience. This will be a once-off activity and will not require you to post or email your response. The questionnaire can be accessed by clicking on the link in this email. The link will redirect you to the questionnaire which can be completed and submitted directly and anonymously.

The study may involve some risks and/or discomforts. It is possible that a degree of regret and possible distress will be experienced when a workaround is written about. We hope that the study will also create some benefits. The results of the study, which will be made available to you if you request them, will hopefully provide a greater insight into the risks involved with the practice of workarounds and how to ethically work within the demanding environment of public health settings.

In the event that any regret or distress is experienced by you, it is advised that you seek help in the form of supervision or counselling to work through this.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number HSS/1246/016M).

In the event of any problems or concerns/questions you may contact

- The UKZN Humanities & Social Sciences Research Ethics Committee, contact details as follows:
HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban, 4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557- Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

Participation in this study is entirely voluntary and withdrawal at any time will not affect your access to the results of the study. Should you not wish to participate in this study, you should simply click on the "Do not agree and exit" button on the first page of the questionnaire. The results of the research will be made available to you if you request them once they are finalized, even if you choose not to participate.

There should be no direct cost to you as the questionnaire is in an online format. The cost of your time will be greatly appreciated although the researcher will not be in a position to compensate you for this.

The content of your description will be anonymized and reported on without any embellishment or adjustment. The personal information you provide will be treated confidentially and will be included in the study for demographic purposes only and will be reported, together with other participants' information, in the form of descriptive statistics. No identifying information will be included in the write-up of this research. The completed questionnaires will be stored under lock and key with my supervisor and destroyed after 5 years.

By completing the questionnaire you are consenting to participate in this research, such consent being voluntary and fully informed.

Please access the questionnaire using the following link:

<https://www.surveymonkey.com/r/workarounds101>

Please take note that the questionnaire will be available at this link until 20:00 on 31 March 2017.

Yours Sincerely



Delia Miranda
Clinical Psychology Masters student

Supervised by



Prof Douglas Wassenaar
Clinical Psychologist