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Examining Tension in the Provision of Palliative Care: Social Workers' Experiences

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EXAMINING TENSION IN THE PROVISION OF PALLIATIVE CARE: SOCIAL WORKERS' EXPERIENCES

by

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ABSTRACT

This dissertation was a qualitative study that explored workplace tension experienced by social workers employed in palliative care settings in Ontario, Canada. Although work in palliative care can be a rewarding, it can also be challenging for a myriad of reasons, including the emotional labour of the work and organizational factors. While many of these challenges are common among most providers, social workers face unique difficulties. Social workers employed in palliative care settings are exposed to existential dilemmas, psychological quandaries, emotional distress, and confront institutional and professional challenges associated with working within the medical model and neoliberal ideologies that dominate many of these institutions.

Although tension frequently appears in the palliative care literature, it has multiple and varying uses and defies a definition that fits every professional and every situation. Few research studies have attempted to understand workplace tension with a specific focus on how structural and relational forces conjoin and contribute to it, and even fewer sample social workers specifically. The purpose of this study was to gain a deep and rich understanding of workplace tension and identify its origins and the factors that perpetuate and sustain it. Using an interlocking theoretical perspective, the works of Foucault and Goffman were intertwined and juxtaposed to gain an understanding of the source of workplace tension in both the formation and structure of discourse and how it is expressed and experienced in face-to-face interactions. The following research questions were used to guide this study: 1) How do social workers employed in palliative care settings define and describe the term tension? 2) What are the individual, relational, and organizational sources of workplace tension? and 3) How do social workers in palliative care settings manage everyday workplace tension?

The experiences of 13 social workers employed in palliative care settings are presented. The work was methodologically grounded in the theoretical paradigm of interpretive description and is informed by Foucault's writings on power and discourse and Goffman's theory of presentation-of-self. Data was collected using unstructured interviews. Participants understanding of tension was explored, and four overarching themes pertaining to sources of workplace tension emerged: (a) social workers' perception of their own reality in palliative care settings; (b) social workers' reflections of how others see them; (c) tension between these two perceptions of reality; and (d) managing and balancing tension.

Participants described concerns regarding the minimization and misunderstanding of social work knowledge and training. Concerns were exacerbated by organizational hierarchies and the devaluing and disempowering of social workers in workplace settings. Participants also discussed role strain and role conflict that resulted from fulfilling several roles. Participants endeavoured to maintain a favourable impression with their colleagues, clients, and organization administration by practices such as using euphemisms, disarming techniques, and role distancing techniques. The findings from this study highlight elements of power and social control and ways in which social contexts produce social practices and daily interactions. Study implications include the need to question, dismantle, and challenge the dominance of the medical model and reposition social workers employed in palliative care settings in order to reduce workplace tension.

DEDICATION

This dissertation is dedicated to everyone I love and everyone who loves me. I have been fortunate to have the right people in my life at the right time, and they've endured me at my best and worst throughout this journey. This dissertation would not be completed without their support, patience, and encouragement. I love you all.

I'd like to specifically mention my daughter, Adley, who was a mere thought in my first year and is now a vibrant, curious, and tender-hearted five-year-old. You were dealt a difficult card at a young age, but you are so courageous and work hard every single day. You helped me truly understand that bravery doesn't mean you aren't scared, it means you're scared but you press on regardless. All of this has been and will always be for you.

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A very special thanks to all the participants who helped me collect my data. Each of you are committed and passionate professionals doing great things in palliative care. Thank you.

Hey Dr. Jamie Henderson – it's done now

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CHAPTER 1

INTRODUCTION

This dissertation was a qualitative study that explored workplace tensions experienced by social workers employed in palliative care settings in Ontario, Canada. There are five chapters, with each chapter section building upon the information provided in the ones preceding. This chapter will include a discussion of the role of social work in palliative care settings, the unique challenges and stressors that may be experienced on the job, and an examination of how tension may be conceptualized. This chapter will also discuss the purpose and aim of the research, the professional significance of this study, and my positionality.

Chapter Two will lay a foundation for examining workplace tension based on the theoretical frameworks of Foucault's (1970, 1973, 1988) writings on power and discourse and Goffman's (1959) theory of presentation-of-self. A detailed consideration of key thoughts from Foucault and Goffman and literature from the field of palliative care is reviewed in order to develop a theoretical foundation and identify gaps in the empirical research for the remainder of the study. Research questions, derived from the literature review, will also be presented. Chapter Three presents the study methodology and ethical considerations of the research. Findings will be presented in Chapter Four, while Chapter Five provides a discussion, recommendations and implications, and a consideration of study limitations.

Background of the Study

Whereas curative care focuses on interventions that aim to save lives, palliative care is a type of comprehensive clinical care that strives to fulfill the physical, psychosocial, emotional, practical, economic, cultural, and spiritual needs of individuals who are facing end of life challenges and necessities (Canadian Hospice Palliative Care Association, 2021; Omilion-

Hodges & Swords, 2017). As such, palliative care is intended to improve people's quality of life by preventing or alleviating the suffering associated with serious illness (Canadian Hospice Palliative Care Association, 2021; World Health Organization, 2016). The provision of high-quality end-of-life care to people depends on the involvement and contributions made by social workers. This is particularly relevant for addressing the diverse and complex needs of both people receiving services and their loved ones (Gwyther et al., 2005).

Although work in palliative care can be rewarding, such as when providers feel as though they are making a difference and are valued for the work they do (O'Donnell et al., 2008; Taylor & Aldridge, 2017; Penz & Duggleby, 2012; Webster & Kristjanson, 2002), it can also be challenging for a myriad of reasons. As an area of practice, it can be taxing due to its fast pace and the emotionally intensive environments where the work is done (O'Mahony et al., 2018; Rose & Glass, 2009). This has been attributed to several factors. Some providers who work in palliative care settings have claimed that palliative care has inherent differences from other areas of practice due to the gravity of the conditions afflicting those who are receiving care and the fact that providers deal with death and dying every day (Georges et al., 2002; Kavalieratos et al., 2017). It has also been suggested that high-impact decision-making pertaining to life and death matters and encountering situations in which providers are unable to alleviate the suffering of people receiving services also contributes to the emotional pressures of the job (Kavaliertos et al., 2017; Pereira et al., 2018; Rattner & Berzoff, 2016). Still others suggest role conflicts and scope of practice uncertainty among the interdisciplinary team, communication gaps between professionals and among people receiving services, and the need to navigate the relationship dynamics of the person receiving care and their care partners - especially as it relates to conflicts pertaining to end-of-life care - are all important and contributing factors to the emotional

pressures as well (Craig & Muskat, 2013; Dunne et al., 2005; Wilkes et al., 1998; Wilkes & Beale, 2001). Lastly, many providers working in palliative care settings regularly face organizational challenges related to limited resources, understaffing, and high caseloads (Sims-Gould et al., 2007). Indeed, the emotional demands associated with providing care are compounded by the nature of the work environment, where people from different backgrounds with different values and beliefs converge for varying personal and professional reasons. While many of these challenges are common among most providers employed in palliative care settings, social workers additionally face difficulties that are unique to their profession. The purpose of this qualitative study was to explore the differing ways social workers employed in palliative care settings experienced and addressed workplace tension.

The Unique Positioning of Social Workers in Palliative Care Settings

People who wish to receive palliative care services can decide between receiving care in hospitals, hospices, long-term care homes, or at home (Closing the Gap Healthcare, 2019). As discussed, palliative care services in each of these settings can be emotionally intensive, and the daily interaction with dying and death makes them inherently different from other areas of practice (Kavalieratos et al., 2017; Rose & Glass, 2009). Social workers employed in palliative care settings are frequently exposed to existential dilemmas, psychological quandaries, and emotional distress (Sanso et al., 2015). Additionally, Sanso and colleagues suggest that social workers also wrestle with institutional and professional challenges associated with neoliberal ideologies that dominate many health, community, and social service institutions where they are employed. Neoliberalism is an approach that supports the belief that the private market and individual skills are sufficient to meet social needs (Baines, 2017). In the health, community, and social service sectors, this approach has led to a reduction in funding for programs and resources

and workplaces that are characterized by surveillance, management control, and high caseload sizes (Baines, 2017).

Social workers have diverse roles in supporting people and their loved ones in palliative care settings (Keefe, Geron, & Enguidanos, 2009; Sheldon, 2000). Complex biopsychosocial and spiritual issues typically arise at end of life, and social workers must be knowledgeable and experienced counsellors, case managers, system navigators, group facilitators, and advocates (Gwyther et al., 2005; Head et al., 2019). Involving social workers in the care of clients has been shown to positively impact their quality of life and temper their healthcare usage and expenditures (Rizzo & Rowe, 2016; Steketee et al., 2017). Studies have also demonstrated that involving social workers in end-of-life care lowers hospice costs, improves team functioning, reduces medical services, results in fewer visits from other team members, and ameliorates many of the additional hardships (e.g., financial strains, psychosocial impacts, role changes, etc.) associated with the diagnosis (Beresford et al., 2007; Reese & Raymer, 2004). Additionally, the ability of social workers to assess client's holistically (encompassing their physical, psychological, emotional, social, spiritual, and practical concerns) appears to improve planning and care in general, given that the entire person and their environment are considered areas worthy of investigation and support (Wilson, 2020). Research has identified clear benefits of early social work assessment and intervention at end-of-life for clients and their families, such as improving family members' ability to cooperate together to share the care for their loved one, improving family members' satisfaction with each other's contributions and the total care provided by the health and allied healthcare team, decreasing the need for crisis management, and reducing the need for contact from other health and social service care providers on the palliative care team (Brown et al., 2021; Rizzo & Rowe, 2016).

However, the importance and breadth of social work in palliative care settings comes with a cost. In addition to the diverse roles social workers play in supporting people and their loved ones with complex biopsychosocial-spiritual issues, it has been suggested that social workers experience challenges due to the emotional costs associated with dealing with death and dying each day (Gwyther et al., 2005; Quinn-Lee et al., 2014). Additionally, some social workers experience tension that stems from holding professional values that conflict with values of other professionals. Indeed, social workers experience tension when practicing within the longstanding and persistent medical model that reduces the focus of health to the physical body and the physiology of disease, leaving the value of social justice unattended (Ashcroft & Van Katwyk, 2016; Brown et al., 2021; O'Donnell et al., 2008; Wilson, 2020). As an approach, the medical model individualizes, decontextualizes, and pathologizes individuals. While opportunity exists for social workers to supplement and enrich this model by employing a critical approach aimed at addressing social injustices, it is more often likely that their practice is limited by the medical model and their knowledge and skillset become subjugated (Brown et al., 2021). This dominant paradigm in health and allied healthcare makes it difficult for social workers to hold onto a social justice perspective which emphasizes a de-individualized understanding of the complex, broader context of clients' lives. Indeed, a social justice perspective considers and attempts to address many important factors that impact a clients' functioning and overall wellness, such as goals, strengths and capacities, demands and resources, roles, resources, and oppression (Baines, 2015; Brown et al., 2021; Craig & Muskat, 2013; Wilson, 2020), and social workers are often restricted in their ability to explore these issues with clients given the limited face-to-face time they have with clients and the outcomes they are expected to achieve (for example, discharge planning, case management, and so forth).

Making decisions in the best interests of people receiving services, without engaging them in the process as collaborators, is a common example of paternalism in the medical model (Brown et al., 2021; Rosenberg, 2011). This conflicts with the ethical principle of self-determination, a concept that means to recognize the rights of clients to make their own choices and decisions and one that is of critical importance to the social work profession (Canadian Association of Social Workers, 2005). Some researchers have described a challenge social workers may experience as being rooted in their collaborative decision-making approach, which contrasts and conflicts with the conventional decision-making line of thinking and doing found in the medical model approach which ties presenting symptoms to clinical assessments and treatment protocols determined by the physician on behalf of the patient (Brown et al., 2021; O'Donnell et al., 2008). This may be especially true in organizations that restrict individuals' self-determination through agency-specific values and policies (Baines 2004, 2006, 2015, 2017; Baines & van den Broek, 2017). In such settings, social workers are pressured to "toe-the-line" in order to maintain their reputation and, in more serious instances, their job. Social workers may struggle when they are faced with having to sacrifice their social justice-based professional education and training in workplaces that require them to subscribe to the knowledge and practices of other professions rather than their own (Craig & Muskat, 2013).

Additionally, the medical model privileges the knowledge of professionals who align themselves with the view that humans are patients whose problems can be understood without considering the social history and overall social context of their lives. In this sense, individuals are rendered passive recipients of knowledge and treatment and are positioned as the object of professionalized medical attention (Ashcroft & Van Katwyk, 2016; Brown et al., 2021). Therefore, professionals like social workers who resist this alignment, despite their position as

members on the medical team, are often relegated to lower hierarchal status and reduced decision-making (Apker et al., 2005; Brown et al., 2021; Craig & Muskat, 2013). The hierarchy typically demonstrates the valuing of certain professionals' knowledge and power over others. For example, traditionally in health and allied healthcare settings, the ordering within the professional hierarchy positions physicians at the top, nurses in the middle, and allied health professionals (such as social workers) below them (Brown et al., 2021; King & Nembhard, 2016). This may result in some social workers employed in health and allied healthcare settings feeling powerless due to their perceived, and oftentimes assigned and acquiesced to, lower rank (Brown et al., 2021; O'Donnell et al., 2008).

Beyond professional knowledge and organizational hierarchy, values that underpin social work often conflict with the neoliberal, pro-market values that dominate health and allied healthcare settings (Brown et al., 2021; Church et al., 2018; Numerato et al., 2020; Ratna, 2020). Baines (2017) suggests that neoliberal values emphasize individualism and cost-efficiency, which results in reduced government spending on social service programs and support and an increase in the privatization of services. They also argue that these values increase the tendency of social services to look and behave like private market services, adopting management models, institutional values, and work cultures that legitimize business approaches rather than care-based approaches. This can create a challenging environment for social workers who are educated and trained to share the non-profit ethos that recognizes the importance of service to others, inclusion and participation in the provision and planning of services, advocacy, providing services without prioritizing profit, and emphasizing social justice (Baines, 2015).

According to Baines (2004), New Public Management (NPM), an approach to running social service organizations, was adopted to make services more "businesslike" and to improve

efficiency by using private sector management models. Within NPM, organizations are considered businesses in which managers are given discretionary power to meet service goals. Accountability and efficiency are constructed as achievement of performance targets, and to meet these targets, management control increases (Baines, 2004; Brown et al., 2021). Although NPM reforms were popularized in the 1980s, they continue to persist today (Brown et al., 2021; Lapuente & Van de Walle, 2020).

Baines (2006) wrote about the impacts of NPM and the globalization of neoliberal, corporate agendas on local social service workplaces. Neoliberalist approaches result in fewer workplace resources and increased surveillance, management control, and caseload size. Social workers engaged in frontline work experience neoliberalism via various forms of suppression of their professional discretion to engage in anti-oppressive practices and other social justice-oriented forms of social work service provision activities (Baines, 2017; Brown, 2021). In fact, some argue that increased workloads and decreased working conditions have subverted the practice wisdom and social justice ethic that strongly influenced social work practice in the past (Baines, 2006). Despite the wide range of important roles social workers play in health and allied healthcare, shrinking resources have resulted in their activities becoming more focused on meeting immediate needs, with less time available for counselling, case planning, and/or advocacy (Brown, 2021; Craig & Muskat, 2013). Limited resources result in smaller social work teams that are expected to fulfill the same diverse roles at a faster pace. This can contribute to role strain when there are differing demands and expectations associated with a single role.

The shift toward managerialism in end-of-life care settings was written about almost three decades ago, when James and Field (1992) argued that traditional biomedical interventions, professional dominance, and the imposition of crude measures of quality and cost-effectiveness

subverted the original hospice ideals that separated it from mainstream model of care. These authors cautioned that the pressures from clinical/medical audits and the re-professionalization of hospice care would encroach upon the practice of holistic care that the pioneers of hospice care originally envisioned. Still to this day, many health and allied healthcare systems operate within a managerial and neoliberal framework where the focus is on task completion, outcome evaluation, and standardized practices as a means of delivering evidence-based care at reduced cost and increased productivity and efficiency (Feo & Kitson, 2016). Many healthcare organizations have embraced the notion that inefficiencies can be removed by routinizing work practices and skills. This standardization involves reducing practice activities down to their smallest features and documenting and promoting them as the most economical and effective way to practice (Baines, 2017). Increased standardization of social workers' day-to-day activities reduces their ability to practice autonomously and use their professional discretion. Ultimately, this results in health and allied healthcare work that is conceptualized solely as technical and physical work (Bridges et al., 2013) and a depersonalized and mechanistic system of care at the expense of relational models focused on engaging meaningfully with people to deliver personalized care. Additionally, although themes of empowerment are central to social work, their involvement in leadership roles rarely extends beyond new ways to streamline services, speed up delivery, and meet workplace performance goals (Baines, 2006).

Neoliberalism has resulted in the restructuring of many workplaces where social workers are employed. The has led to workplaces characterized by reduced government funding, heavy reliance on standardized assessment tools, and requirements to complete time-consuming paperwork and statistical collection forms. This workplace restructuring has constrained social workers' thinking and practice (Baines, 2017). For example, interview data from Canadian

frontline social workers revealed that many social workers felt that the operationalization of neoliberal, pro-market discourses of efficiency and accountability has resulted in their time being dominated by statistic keeping and other forms of documentation. These social workers voiced frustration at the way these tasks dominated their workdays, curtailing interactions with people receiving services (Baines, 2006). Furthermore, the presence of agency level ideologies and discursive practices that privilege management models and professional hierarchies serve the purpose of objectifying and subjectifying social work employees. Foucault (1982) described modes for objectifying human beings with the ultimate goal of making the individual a subject to another by control and dependence. Subjectified social workers are habituated to having power exercised over them, and this results in social workers acquiescing to organizational structures that contravene the values and ethics of the profession. Taken together, these elements of organizational structure and practices force social workers to manage their performance of multiple and seemingly incompatible roles: the employee, professional, and social justice advocate (Baines, 2017).

Ultimately, the principles of neoliberalism are a perfect fit with the dominant medical model which reinforces social injustice through a decontextualized and individualized emphasis on disorders. The combination of neoliberal principles and managerialism, framed by the medical model, results in services that are depoliticized, pathologizing, standardized, and primarily evidence-based and short-term. These approaches fail to address important sociopolitical concepts that impact clients such as inequity and oppression; thus, it can be challenging for social workers to hold onto a social justice commitment when confronted with the limitations of neoliberalism `and the medical model (Ashcroft & Van Katwyk, 2016; Brown et al., 2021; Carey, 2019; Esposito & Perez, 2014; Joseph, 2017; Morrow & Malcoe, 2017).

Moreover, social workers are held to a standard that is reflective of these ideologies that dominant the settings where they work. This has a delimiting effect on social workers' practice autonomy and can diminish their theoretical perspectives and skillsets.

However, like any workplace, tensions that are experienced by social workers in the palliative care work environment present both limits and possibilities; they can impact one's emotional well-being, social interactions, and overall workplace experience, but they can also contribute to professional growth and practice innovation. To explore workplace tension requires an exploration of the visible (such as managerial practices, hierarchal order, and interpersonal relations) and underlying (such as power-knowledge relations) arrangements in the workplace and the ways by which social workers manage workplace tension in order to fulfill their roles as employees and service providers.

Tension

In general, tension can be understood as an encompassing term for stress and strain; however, it is difficult to distinguish between these three similar concepts. According to Lazarus and Folkman (1984), stress is a particular experience between a person and their environment that is appraised by the person as taxing or exceeding their personal and social resources. Scott and Charteris (2003) defined strain as the individual's internal response to stress. However, one must recognize that an individual's response to stressful encounters does not always result in strain (Thatcher & Miller, 2003). It is possible that certain stressors could lead to increased performance levels, not just strains. Regardless, strain is often referred to as a negative response to stress. When excessive demands are made on any type of system, it can lead to strain. For individuals, these excessive demands can be likened to physical, mental, and emotional overload. Together, strain and its accompanying stress can create tension; a balanced relationship between

strong opposing elements. The discomfort and uneasiness of tension pressures a person to seek relief through action.

Tension frequently appears in the palliative care literature and has multiple and varying uses. For example, researchers have used the term to describe analogous physiological and emotional responses providers have to different situations. In some studies, tension was used interchangeably with feeling uncertain, uneasy, and uncomfortable (Benoot et al., 2018; Rashotte et al., 2011; Stephenson et al., 2019). Meanwhile, other studies used the term to describe feeling frustrated, stressed, and burnt-out (Claxton-Oldfield & Bhatt, 2017; Kavalieratos et al., 2017; van der Riet et al., 2009). It has also been used to describe the sensation of feeling physically tense (Rose & Glass, 2009). To add to this ambiguity, the word tension has also been extended beyond personal experiences to refer to a range of interpersonal and relational experiences. For example, it has been used to refer to disagreements between staff (McInerney et al., 2009), conflicts among people receiving services and their family/friends (Stephenson et al., 2019), and the misalignment of priorities between providers and people receiving services (Beresford et al., 2008). Though it has predominantly been used as a descriptive word for personal and/or interpersonal experiences, more consideration of the institutions where these experiences occur is needed. The way organizations come into existence, persist, and are transformed through interconnected activities (i.e., the workplace activities that create, generate, sustain, and constitute the organization), and the arrangement of and relations between these elements (i.e., the structure of the workplace) are implicated in tension, and it is necessary to examine these phenomena in order to better understand the experience of workplace tension.

Krawczyk et al. (2019) offered a definition of “practice tension” in the context of health and allied healthcare providers’ experiences and perspectives of using outcome measures in

hospital-based palliative care. They defined practice tension as the strain when a provider concurrently holds and/or values differing perspectives, beliefs, and/or behaviours about a specific practice and as an effect of the provider's ongoing requirement to negotiate interpersonal, organizational, and larger health care system goals and priorities expressed by stakeholders. These authors suggested practice tension was not a contradiction, but rather ambivalence situated in lived experiences of providers engaged in palliative care as they routinely attempted to appease competing interests in the delivery of care, interests of people receiving services and their families, and workplace organizations that endorse neoliberal philosophies. This definition of practice tension moves beyond the (inter)personal levels of tensions to suggest workplace tensions may be occurring across many levels. Not only do organizational characteristics and structure create sources of tension, but providers experience tension as they navigate through these structures and negotiate the various roles they must play in their daily work lives. This study sought to understand the experience of workplace tension from the perspectives of social workers employed in palliative care settings. To this end, the term "tension" will refer to thoughts, feelings, and behaviours that arise from experiences in the workplace.

Problem Statement

As demonstrated by its diverse use, the term "tension" defies a neat, to the point definition that fits everyone and every situation. Thus, providing a standardized definition or understanding of tension would be arbitrary as it would not account for the variability of persons, personalities, positions, and conditions that exist among those who experience it. Indeed, tension is not given and immutable; individuals have different thresholds for what causes them tension and can use and understand the term differently. This creates freedom on the part of the user of

the word to frame it differently based on their own understanding of it and their unique experiences with it. Moreover, few research studies attempt to understand tension with specific focus on how structural and relational forces conjoin and contribute to it. Ultimately, tension has the potential to catalyze positive change and growth, and/or damage relationships and sully work environments (Artemov et al., 2016), which made it a worthy topic for applied social science investigation.

Regarding social workers and palliative care: the elder boom, coupled with advanced medical science that supports those living with chronic and serious illnesses to live longer, has led to increased need for comprehensive, end-of-life care (Berkman & Stein, 2018). Social workers are an integral part of palliative care services, yet there is a shortage of trained social work professionals to meet the needs of individuals receiving these services (Kamal et al., 2019). Furthermore, despite their valuable skills and insights, the role of social workers has been devalued and their voices have been diminished in many secondary settings where social work is not viewed as the core business (Brown, 2021; Rossiter & Heron, 2011; Spolander et al., 2014).

Given their importance to the client's experience, social workers should be encouraged to enter this area of practice, and those already employed in these settings should be retained. Therefore, in order to capitalize on its benefits and mitigate its negative effects for this group of professionals, the experience of tension must be better understood. The problem addressed by this study was the lack of understanding of how tension is experienced by social workers employed in palliative care settings.

Professional Significance of the Study

Understanding workplace tension has intrinsic importance, affecting both palliative care organizations and social workers who are employed there. This understanding has the potential

to support employee well-being and job retention and promote system change. Illuminating structural and relational causes of tension also has the potential to drive changes in organizational constitution and the human interactions and relationships that occur there (Holladay, 2017). Indeed, Maxwell (2005) argued that tension between the current state and the desired state is what creates stress necessary for change. However, while workplace tension has the potential to inspire positive change, chronic, unresolved tension can contribute to employee stress and attrition (Howatt et al., 2017) and have costly and disruptive consequences due to workplace turnover and discontinuity of care (Fakunmoju et al., 2010). Fakunmoju and colleagues (2010) go on to suggest that the costs of recruitment and training can be astronomical and, ultimately, disrupt the quality of service to clients.

Tension can affect the entire workplace environment, and this study is such that the findings are valuable for professionals at all levels of practice. Given the amount of time that people spend at the workplace, positive workplace relationships are important for satisfaction at work (Mann, 2018). Therefore, the topic of this study is meaningful for those interested in mitigating conflicts and improving collaboration between colleagues. The findings of this study may also be meaningful for organizational decision-makers who are interested in building and sustaining workplace relationships that are based on principles of mutuality and collaboration rather than hierarchy (Reisch & Garvin, 2016). Furthermore, the meaningful findings of this study contribute to the field of social work research that supports creating and maintaining genuinely democratic decision-making processes in organizations, strategic planning that involves staff and clients, and consideration for alternative organizational models rather than the traditional hierarchal model (Reisch & Garvin, 2016). This study also aligns with other research that raises critical consciousness of power inequities within the workplace structure and

operations and promotes employee empowerment (Reisch & Garvin, 2016). Furthermore, it supports other research that urges us to reconsider the medical model in favour of biopsychosocialspiritual models (Fennig & Denov, 2019; Sajid et al., 2021; Wehbi, 2017).

With the emphasis on readiness for practice and teaching practice skills in social work curricula (Council of Social Work Education, n.d.), it is important to prepare future social workers for working in the area of palliative care. The findings of this study may be useful for informing students about the social work experience in multidisciplinary settings (especially healthcare settings), as they prepare for work in their chosen field of concentration. Lastly, from a researcher standpoint, the interlocking theoretical perspectives I employed in this study have not been widely used as a synthesis of thought to understand a social phenomenon; therefore, this study adds to the body of social work literature by expanding the frameworks of Goffman and Foucault to mediate actions that take place in palliative care settings. The interlocking of Foucault's structural and Goffman's interpersonal ideas likely yielded some useful methodological findings about how social workers experience and make sense out of workplace life at the personal, interpersonal, and structural levels.

Taken together, examining the visible and underlying arrangements that constitute the workplace, acknowledging and supporting professionals' well-being, and guiding system change all support the study of workplace tension. Acknowledging and claiming tension can provide the psychological basis for the motivational commitments necessary for sustained participation in such efforts of interrogation and change (Holladay, 2017; Marx & Holzner, 1977). Perhaps above all else, by addressing tensions that exist in the provision of palliative care, the care offered in these settings can improve. This creates the potential to shape the end-of-life context and impact how death and dying are experienced by people receiving services and their families.

I believe the findings presented in Chapter Five are of value to social workers in the field and organizational leaders who aim to improve workplace culture and, perhaps by extension, the service user experience.

Positionality Statement

In reflection upon my personal experiences as a frontline social worker working in a hospice palliative care community-based setting, I have written the following statement regarding my perspective: palliative care should be comprehensive, with the entire interdisciplinary team equally contributing to the care plan that is created and guided by the person receiving services. To relieve suffering and improve quality of life, allied healthcare providers working in these care settings must be able to identify and respond to all the complex issues individuals and their loved ones may face. These issues can be categorized into eight equally important domains: disease management, physical well-being, psychological well-being, social well-being, spiritual well-being, practical needs, end-of-life care/death management, and loss and grief (Canadian Hospice Palliative Care Association, 2013). Additionally, not only should the experience of being a social worker employed in a palliative care setting enhance one's practice skills, the sense of professional competency that can be derived from being an important part of an interdisciplinary team can lead to emotional and social development, and increased self-worth. The ability to address complex issues in the face of impending death are advantageous for the skill-development of frontline social workers. These experiences that are unique to palliative care work, along with the experiences that are "standard" parts of practice, enrich a social worker's development.

Beyond frontline work, social workers are also well-positioned to hold management positions. Despite the predominance of managerialism, social justice-oriented social workers

provide an important perspective. These social workers are positioned to examine management practices and promote alternative models that share workplace power and draw on the expert knowledge of practitioners and people receiving services while also providing leadership, protection, and support to the staff, people receiving services, and to the wider community (Baines, 2017).

Given my employment experience and the research topic of this study, I am not only interested, but also had some pre-conceived ideas of what the structural power/political sources of tension were and how they manifested themselves in the day-to-day experience of the participants. I anticipate that my experiences may have influenced the data in some ways; however, the information shared by participants supported some of my presumptions about social work in palliative care settings and illuminated new issues as well. Below, I will reflect on how I believe my voice may have influenced the data for this study.

I was a social worker working in a frontline hospice palliative care setting for nine years; therefore, I asked certain questions to probe specific topics and used certain language and terminology that was common to me and the participants. Specifically, my insider knowledge enabled me to shape the interview protocol so that each question's answer lead into another and touched on topics that were relevant to my research questions. These informed questions elicited substantial amounts of data that resonated with my research questions.

It was also imperative that I remained aware of my potential biases, as they may have led me to question certain aspects of the job that I believed created tension. As a frontline social worker, there were times when I felt powerless on the interdisciplinary team. Things such as exclusion from meetings about practice-related matters that included hospice physicians and nurses, and theoretical and philosophical disagreements with senior management who did not

have a background in social work and did not understand or appreciate social work theory (such as anti-oppressive practice) were common occurrences. There was also frequent confusion regarding the role of social workers by other professionals on the team. This was evident by late (e.g., when a person was already close to death and their care providers were in crisis) and questionable (e.g., when a person receiving services and/or their loved ones were referred because they stated they were sad or worried) referrals. Many times, I felt pressured to ensure people receiving services behaved a certain way; one that aligned with the dominant ideology of how death ought to be experienced while receiving public-funded end-of-life care. To manage these situations, I would often suspend my personal and professional values and "fall in line" in order to be seen in a positive light with my managers and remain secure in my job.

I often felt over-worked on an understaffed team and underpaid, considering the vast scope of my role. In hospice palliative care, the person and their loved ones are typically the focus of the plan of care (Unit of care, n.d.). I was responsible for providing counselling to the individual and their loved ones of all ages (often individually); a role that encompassed responsibilities that could include resourcing on a crisis-basis (including housing, income, legal, and practical supports), substance use and addiction counselling, suicide assessments/interventions, managing serious mental illness, and bereavement support. Furthermore, unlike other professionals on the interdisciplinary team, I was required to provide support to the individual regardless of their care setting. I followed individuals who were admitted to hospitals or long-term care institutions, and who moved in with family residing in other municipalities. This was unique to social work, as the physicians and nurses would defer to care providers in those institutional settings or refer to other palliative care doctors/nurses responsible for different municipal jurisdictions. Likewise, while other providers would close the

person's file once the person had died, I was responsible for providing bereavement support for their family and loved ones. Beyond these responsibilities, the social work team I was on was responsible for providing almost all support groups and psychoeducation sessions for the community-based Wellness Centre.

As a former manager for my team, I felt that my time was dominated by statistic keeping and other forms of documentation and meetings. This was compounded by the feeling that I had little say in determining which events would fill up my days. I also felt as though I was under constant pressure to use supervision time as an opportunity to micro-manage the social workers' time and "outcomes" in order to minimize risk to the agency and control practice. This was accomplished by reducing each social worker's professional discretion and continuously moving toward standardization. More often than not, I felt more like a task manager than a leader. This created tension for me as I juggled the role of management with the role of being an anti-oppressive social worker. This became apparent when the social workers looked to me to advocate on their behalf with senior management that seemed to resist the values of the social work profession. This led me to wonder if the participants in this study would articulate the same experiences. Given my experience working in multiple levels of social work practice at the organization where I was employed, I am more aware of and concerned for the interests of social workers, and I was curious as to how aware the participants were of structural/constitutive elements and control mechanisms embedded within their own organizations. While these biases posed a risk to my research, I believe that participants felt comfortable with me and believed that I was willing to listen and was positioned to better understand their perspectives.

The next chapter will present the theoretical and empirical contributions that outline the knowledge base upon which this study was built.

CHAPTER 2

REVIEW OF LITERATURE

Introduction

Throughout Chapter One, assertions have been made that connect workplace tension experienced by social workers employed in palliative care settings with personal, interpersonal, organizational, and social factors. Idiosyncrasies of day-to-day interaction occur within and are shaped by the framework of discourse, and further analysis of this connection provides additional insight into this supposed relationship. This chapter presents an overview of the theoretical assumptions of Goffman and Foucault and a summary of existing information derived from studies conducted in palliative care settings. Specific examples of causes of workplace tension are cited that parallel the ideas that underpin the presentation-of-self and the material elements of discourse; therefore, the intent of this study is to determine if they are similarly in social workers' experiences. The literature review in this chapter provides insight into answering this question and a better understanding of what factors contribute to tension.

The Search Process

To complete the literature review, the following published research databases were searched: *Social Work Abstracts, Social Service Abstracts, PubMed, ProQuest (all databases*), *PsychINFO, PsycARTICLES, PsyCRITIQUES*, *Cumulative Index of Nursing and Allied Health Literature,* and *Medline.* Additionally, the following unpublished research databases were searched to control for publication bias: *ProQuest Dissertations and Thesis Global, Google,* and *Google Scholar*. To ensure the largest number of results, there was no restriction on the date of publication and the keyword search was kept broad. The following keyword searches were used: (tension OR stress OR strain AND hospice OR "palliative care" OR "end-of-life care" OR "end

of life care" OR "terminal care"). An additional general Google search was also conducted with the phrase: "tension in social work." These searches were expanded with bibliographic reviews of retrieved manuscripts.

Theoretical Contributions

Francis Turner (2017) emphasized the importance of a broad-based theoretical approach that reduces the potential of becoming overly identified with a narrow focus that limits understanding of people and their contexts. According to Turner, providing an interlocking framework that allows for choice in selecting theoretical perspectives opens the door to comprehensive explanation and understanding. Thus, this research explored workplace tension from an interlocking theoretical perspective which intertwined and juxtaposed Foucault's (1970, 1973, 1988) thoughts on power and discourse with Goffman's (1959) concept of presentation-of-self. Foucault proposed his ideas of structural processes that determine discourse and action from the top down, whereas Goffman proposed ideas about the ways in which human roles are constituted in face-to-face interactions; an examination of local incidents and idiosyncrasies from the bottom up (Hacking, 2004; Nunkoosing & Haydon-Laurelut, 2012). Together, Goffman and Foucault both contribute to an understanding of how society functions from seemingly divergent lenses, which, when considered together, actually converge in the creation of an interlocking theoretical narrative for understanding how people make sense out of life at the personal, social relational/interactional, and structural levels.

Foucault's Perspective

Foucault's writings on knowledge, power, and discourse (1970, 1977) offer a way of understanding tension, especially tension that is experienced in medical settings. Foucault (1972) explored how meanings are temporarily stabilized, or fixed, into a discourse, and how this

ordering of meaning is achieved through the use of power in social relations. Discourses produce and mediate shared phenomena and play a role in the formation and function of social structures and how they deliver services and provide care (Leclercq-Vandelannoitte, 2011). Chambon (1999) describes discourse in terms of being systems of thought that are used to construct and order reality. Considering discourse as structures of knowledge, it is reasonable to conclude that they also influence systems of practice. Foucault questioned how some discourses that have shaped and created meaning have become stabilized and accepted as "truth". He was interested in how these discourses dominate how we define and organize both ourselves and our social world, while alternative discourses are marginalized and subjugated. Indeed, while a dominant discourse promotes a preferred version of the world, one that disqualifies competing versions (Miller, 2008), alternative discourses have the potential of offering opportunities for contesting, challenging, and resisting hegemonic practices (Foucault, 1970).

Foucault developed the concept of the *discursive field* as a way to understand the relationship between language, social institutions, subjectivity, and power. Discursive fields are a series of discrete but over-lapping discourses and practices, shaped by institutions and disciplines. They are broader than individual discourses and make sense of some aspect of the social world and are viewed as "truth." Each discursive field frames meaning and understanding in a specific way and allows the possibility of only certain things to be experienced in the social world, thereby structuring an individual's way of being. Discursive fields that have been adopted by a person, in workplace contexts and by way of professional socialization for example, allow the possibility of only certain things to be thought, felt, and acted on, structuring an individuals' way of being in the world. They contain a number of standalone, interconnecting, and interlocking discourses that can provide meaning to and organize social institutions and

processes. For example, a social worker employed in palliative care might espouse two interrelated discourses: with one adopted discourse (framed by their workplace), they might view clients as passive recipients of care, and a second discourse might be the professional code of ethics and specifically the principle of fostering autonomy and respecting self-determination in clients. This illustrates the potential for a discursive field to create tension for this particular social worker.

Foucault regarded knowledge as providing order to social realities and asserted that power relations define which types of knowledge were elevated to the position of truths and consequently used to construct contemporary realities (Foucault, 1973; Porter 1998). In the biomedical paradigm, for example, medical discourse is dominant and stabilized. As discussed in Chapter One, physicians, in the traditional medical model, are positioned as experts whose knowledge is considered most legitimate (Ashcroft & Van Katwyk, 2016; Brown et al., 2021; Mitchinson, 2013). Thus, physicians' position at the top of the structural hierarchy is unquestioned and adopted in most health and allied healthcare settings. This establishes the order of knowledge and hierarchal rank in these settings. Power is exerted through professionals' interaction and discourse through the structural hierarchies of the workplace. Those professionals who are positioned in high-ranking positions on the hierarchy are able to construct a system of norms via a general acceptance of their normalizing judgements. In organizations, discourse legitimates specific positions and reaffirms status relations (Leclercq-Vandelannoitte, 2011).

Foucault's (1973) writings reveal how individuals have become objects of observation and discourses. The dominant culture constructs a system of norms, or regimes of truth, that guide behaviour and decisions through discursive practices (Foote & Frank, 1999). According to Foucault (1977), every society has its regimes of truth:

> its ‘general polities’ of truth: that is, the types of discourse which it accepts and makes functions as true; the mechanisms and instances which enable one to distinguish true and false statements, the means by which each is sanctioned; the techniques and procedures accorded value in the acquisition of truth; the status of those who are charged with saying what counts as true. (p. 131).

Foucault (1977) thought of objects as things that are constituted by relevant bodies of knowledge, thus discourses enable us to talk about objects by attributing particular meanings to them. In this sense, discourse gives sense to the material world through the way it differentiates, labels, categorizes, and produces objects. To Foucault, discourses aim to reveal a truth, but instead create and govern objects they claim to know insofar that discourse can both constrain and enable the production of knowledge.

As stated, Foucault was interested in the affirmation of discursive practices, independent of their social setting and accepted as being objective or touted as being true. He questioned how some discourses maintain their authority; how some voices get heard whilst others are silenced. For Foucault (1972), power produces dominant discourses, and in organizational settings, discourse subjectifies staff and influences how they should think, feel, act, and talk (Leclercq-Vandelannoitte, 2011). In this sense, dominant discourses bring people into being, ascribe to them certain interests (e.g., professional matters), and position them in specific relationships according to their assumed, assigned and/or perceived place within or when intersecting with the systems and structures of power. Applying the perspective of Foucault (1981) to palliative care organizations, through means such as policies and procedures, discourses produce and transmit cultural norms, beliefs, and practices around death and dying (Fox, 2006; Zimmermann, 2012). Both organizations and the providers themselves can use their professional lens to craft

communication to describe anything outside of the "palliative care norm" as inconsequential, thereby objectifying and Othering people receiving services who hold alternative beliefs or preferences. Consider the "good death" concept: the idea of a good death creates a local discourse in palliative care settings that greatly contributes to how providers conceptualize important factors associated with dying; becoming an ideal or goal to strive for. Over the years, the good death has become a desirable outcome of the delivery of palliative care; one that providers believe the achievement of is paramount to demonstrating high-quality end-of-life care (Cipolletta & Oprandi, 2014; Cottrell & Duggleby, 2016; Hart et al., 1998; Kehl, 2006; Masson, 2010). Viewed from a Foucauldian perspective, discursive practices such as surveillance, evaluation, and discipline, pressure health and allied healthcare providers into adopting the philosophy of the good death and may consciously or unintentionally supress or delete alternative explanations and practices which in turn might better suit how to understand, explain, and engage with others around the dying processes (Zimmermann, 2012).

Furthermore, the discursive practices that constitute workplaces have implications in terms of interpersonal relationships impacted by the exercise of power and control (Cooren, 2004). For example, relations that occur through mainstream Western medical exchanges position providers as experts over those receiving care (Ashcroft & Van Katwky, 2016; Brown et al., 2021; Lee & Garvin, 2003). Through power, normalization, surveillance, and disciplining of subjects, providers become able to govern people receiving services by the production of truth (Foucault, 1977). When people receiving services do not fulfill the required participatory and compliant role, that resistance can create tension for the provider. Likewise, health and allied healthcare service providers working in palliative care settings may experience tension in situations that challenge their professional knowledge and skills and/or personal values. For

example, past findings illustrate that social workers experience tension when their professional skills and knowledge are discredited and devalued in favour of the skills and knowledge of healthcare providers (Brown et al., 2021). Other findings have suggested that tension can arise when there is an incongruence between people receiving services' wishes and the providers' own beliefs (Stephensen et al., 2019). When there is a misunderstanding or incompatibility of beliefs, providers may experience tension between doing what they believe is appropriate and honouring the people receiving services' self-determination. In instances like this, social workers, whose values are often greatly shaped by professional socialization, may unwittingly subjugate the beliefs of people receiving services despite the ethical call of duty to respect human diversity. This is especially important because of their scope of practice. Many social workers regularly deal with ethical, value-laden situations and are often required to make high-risk, high-impact decisions (Bisman, 2004; Dolgoff et al., 2012; Regehr, 2018). As they encounter matters of value judgement, social workers strive (and struggle, at times) to separate personal background from the strong influence of professional factors (Dolgoff et al., 2012; Lorenc et al., 2014).

Discourse offers a tool to achieve specific organizational purposes, such as legitimating specific positions and reaffirming status relations (Leclercq-Vandelannoitte, 2011). Alternatively, discourse can be used to erode or remove authority and position. Applied to the organizational context, one who adopts a Foucauldian perspective would seek to understand how discourses become stabilized, constitute workers' subjectivities, establish and naturalize managerial control and practices, and discipline the productive body. According to Foucault (1980), systems of power enforce docility on human beings to the effect of maintaining order. Foucault's concept of "docile bodies" refers to passive and subjugated individuals upon which disciplinary force is enacted to render them productive. Through disciplining, surveillance, and

punishment, workplaces create bodies that are habituated to external regulation. This works to discipline the body and increase its usefulness and docility. Foucault (1977) described bodies that are disciplined and rendered docile as texts in which to inscribe dominant ways of doing things. This made the body become receptive to and accept powers to work on it and resulted in the body being extorted for its forces and integrated into systems of efficient and economic controls (Pylypa, 1998). Social workers employed in secondary settings are rendered docile through practices like supervision and discipline whereby they become coopted by the philosophies and practices of the dominant medical model that frames the ideologies where they work. This can result in social workers distancing themselves from the role of social justice advocates and adopting de-contextualizing and pathologizing frameworks when dealing with clients (Brown et al., 2021). Indeed, individual identities and subjectivities are constructed and reconstructed in the workplace through policies, procedures, practices, and the interpretation thereof and assignment of meaning thereto by way of discourses, which creates an analyzable subject (Leclercq-Vandelannoitte, 2011). According to Leclercq-Vandelannoitte (2011), Foucault's work is useful for examining the effects of dominant discourse in relation to concepts of authority, power, and control. These issues are central concepts to organizations because they are components of all social and organizational interactions.

By their very nature, power relationships create a space where tensions can develop (Foote & Frank, 1999). To Foucault, power was a relationship, and when power was exercised, response in some way, shape, or form was to be expected. People act and react in relation to discourses, whether with acceptance, resistance, or compromise (Doolin, 2002). Resistance to power is not linear and is rarely uncontested. For example, it may appear as arising from people

resisting their subjugation to dominant discourses and also as people suppressing the resistance of those who are dominated.

Through the lens of Foucault, relationships among discourse, power, knowledge, discipline, and subjects are brought into focus (Leclercq-Vandelannoitte, 2011). However, in order to achieve a complete picture of how the forms of discourse influence the daily lives of individuals and how discourse become institutionalized and made part of the structure of organizations, I will turn to Goffman, whose focus on interactions and exchanges, will be interlocked with Foucault's perspective to articulate dynamic political and social processes of organizational constitution.

Goffman's Presentation-of-Self

Goffman's perspective focuses on the everyday interactions between individuals and institutions with respect to the subjective meanings that influence their contemplations, decision-making, and actions (Rawls, 1987). Like Foucault, Goffman recognized how social structures influence people's thinking, emotions, and actions in private and in public ways; however, he placed more emphasis on the creative role an individual plays in producing and sustaining the norms and values that underpin their social world (Swingewood, 2000). Goffman (1959) suggested that individuals' thoughts, feelings, and behaviours have a propensity to change when the structure or place of the situation changes, due to the different rules which govern how the person interacts with others and they with them.

Goffman (1959) is credited for his dramaturgical model of social interaction, which likens ordinary social interaction to theatrical performance. Conceptualized in dramaturgical terms, Goffman (1959) argued that human interactions incorporate a series of masks, or presentations-of-selves which, given the context, are displayed to and perceived by others. While

Foucault provided a framework for understanding how discourse produces contexts; Goffman was interested in how people behave and interact within those contexts. He believed that social interactions involve enacting roles and staging how they appear. These role performances are tempered by the setting and those with power in said setting, and are moderated by past experience and future expectations of how the individual was and will be received. Foucault's work reveals that the medical model is the dominant discourse that determines what knowledge is true and who the ultimate informants are, and organizational discourses constitute the status hierarchies, organizational structure, and preferred practices, while Goffman's thinking helps to explain how social workers navigate these formative structures while providing care from a practice framework that has been subjugated and while maintaining a favourable impression among management, colleagues, and clients.

Goffman believed people are habitually concerned with how they are perceived and are constantly working to be acknowledged and accepted by others and to have their performances validated by the given audience. For example, when an individual encounters another person, they attempt to control or guide the impression that the other person will form of them by reworking the surroundings, which serves as a backdrop for their presentation-of-self, and by altering or enhancing their appearance and manner to gain recognition and favour. Simultaneously, the person that the individual is interacting with forms an impression of the individual. In workplaces, employees traditionally aim to convince their employer that they meet or exceed the requirements of employment by presenting an image harmonious with the organization's expectations. At the same time, they choose a role to perform that will be congruent with the specific audience's expectations. For example, if an individual values collegial relationships, they may strive to fit in with workmates and gain their approval.

Employees are able to maintain their employment and good standing among their employers and colleagues by leveraging a perceived desired image. Likewise, service providers perform their duties in ways that convey to service users that they are competent, capable, suitable, and desirable providers of support and services. This becomes more complicated as the number of individuals involved grows. For example, in situations where there is conflict or disagreement between individuals receiving care and their loved ones, health and allied healthcare providers are faced with the choice between getting involved or allowing the individuals to resolve their disagreements while simultaneously attempting to manage their impression with everyone involved.

According to Goffman (1959), people play a range of different roles determined by the situations they find themselves in and how they think they are coming across to others. Goffman describes social interactions as performances that are influenced by both the setting and audience; people play different roles throughout their daily lives and engage in certain performances dependent on the role they are playing. For example, most people, consciously or subconsciously, behave to a greater or lesser degree differently in their public roles as a professional as compared to the roles they play in private. Importantly, Goffman qualified the relationship between the role performer and the role performed. Coined as role distance, Goffman posited that performers would have differing levels of commitment to the various roles they played related to their expectations of the interaction (Coser, 1966; Stebbins, 2013). Role distance is a critically important aspect of engagement or avoidance with others as it relates to perceived and experienced tension. Whether the role distance is considered to be major or minor depends on the level of presumed or perceived threat and whether it is believed to be true or contrived (Stebbins, 2013).

Like Foucault, Goffman also acknowledged the possibility of resistance. People, as social actors, have the ability to modify the details of their performance before a specific audience (Fitzpatrick et al., 2016). For Goffman, people can utilize role distancing techniques and/or display different appearances and kinds of behaviour. This affords them the opportunity to manipulate their behaviour to put on a show of acquiescence or sham authority. Furthermore, this allows people to maintain order without subscribing to the norm. When in the process of managing the impression that others (the audience) forms of them, individuals determine which qualities are preferred and hopefully appropriate to exhibit. They then display those qualities and engage in an ongoing process of reflection that assesses the audience reception and reactions to their presentation and performance as it conforms to the desired impression, and then attempt to correct any incongruency between their ideal and real performance (Swingewood, 2000).

In the context of organizations, an individual's presentation-of-self can result in tension when they experience role conflict where one or more roles are contradictory. For example, although those who are ranked lower on status hierarchies have options available to them to resist prevailing power relations (Collinson, 1994), we learn from Goffman's (1968) writings that these individuals are expected to visibly engage at appropriate times in the activity of the organization, such as playing their part on the care team. Those who choose to resist their assigned position may be met with further scrutiny and limits, such as being overlooked or excluded from discussions or having their opinions unacknowledged or discounted. Indeed, Goffman (1959) proposed that most social interactions are the person's attempt to fulfill expectations associated with a particular social role. He believed people experience tension when there is an incongruence between their underlying attitudes and public behaviour, and when they find themselves trying to play multiple roles and juggle masks.

Goffman (1959) also described backstage and front stage performances. According to Goffman (1959), people engage in front stage behaviour when they know they are visible to and being embraced by an audience. Similar to Foucault's (1972) thoughts on how discourse subjectifies individuals and influences how they should think, feel, and act, front stage behaviour reflects internalized norms and expectations for behaviour shaped partly by the setting and the particular role one plays in it (Cole, 2019). For social workers in palliative care settings, the front stage performances must be consistent with the dominant ideologies and expected practices of the organization. This encompasses how they behave among colleagues and clients. In these situations, their behaviour is highly routinized and scripted; it is shaped and regulated by surveillance, the threat of discipline, and typically follows an adopted social script shaped through socialization and in accordance with sociocultural norms. The performances people engage in with others typically follow ascribed social rules and they convey thoughts, emotions, and behaviours expected for the given setting and audience. For example, social work employees may feel compelled to accommodate a difficult supervisor or engage in idealized and/or normative narratives of practice among colleagues or in front of people who are receiving services. In these instances where performers are playing a role they are not fully engaged in, they can employ role distancing techniques such as downplaying their attachment and commitment to the role to colleagues (e.g., undermining employers or workplace practices) or using the backstage as the place where all the support activities necessary for maintaining the performance on the front stage occur.

Goffman (1959) conceptualized backstage behaviour as how people behave when no one is watching. When people engage in backstage behaviour, they are free from the expectations and norms that dictate front stage behaviour, even though they remain aware of norms and

expectations that influence what they think and how they behave. According to Cole (2019), when individuals are backstage, they are able to let their guard down and behave in ways that reflect their uninhibited selves. If front stage behaviour is shaped by particular technologies of power (e.g., mechanisms to control how one thinks and behaves), the backstage can be likened to Foucault's (1982) notion of resistance, a form of opposition to the effects of these technologies. Informal conversations with colleagues offer an example of the backstage at the workplace. For example, social workers may debrief or speak informally with social work colleagues behind closed doors or after hours to ventilate feelings or frustrations with broader workplace policies and procedures that misalign with social work principles. Backstage conversations have the potential to reveal feelings about what and how employees think about their work and how they may prefer alternative ways of being and doing. The backstage also affords individuals the opportunity to rehearse certain behaviours in preparation for their upcoming front stage performances (Cole, 2019). For example, in the backstage, social workers might practice social behaviours, rehearse a particular conversation or service intervention, or prepare themselves to look a certain way once they are in front of an audience again. When one ignores the expectations for front and backstage behaviours, it can lead to confusion, embarrassment, and shame. Thus, most people strive to keep these two realms separate and distinct (Cole, 2019). To Goffman (1959), both the front stage and the backstage are essential for social interactions; backstage behaviour allows people to express feelings safely and out of sight of the audience so that they do not interfere with or invalidate front stage performances.

Goffman (1959) believed people have the tendency to define themselves in terms of the social roles they perform at a particular time. Each new role consists of behavioural expectations (e.g., employees are expected follow the policies and procedures of the workplace) and

assumptions about personal characteristics (e.g., social workers are expected to be compassionate advocates). Throughout the course of performing roles, individuals often internalize role-relevant personal characteristics. They perceive themselves to possess the qualities suggested by the roles they play, internalizing the role. Furthermore, some may internalize and adopt the behaviours and opinions of the dominant group (Freire, 1997). Sometimes, an individual's self-conception is incongruent with the roles they adopt or the expectations that others, the audience, have of and for them. However, they often come to adopt the attitudes and beliefs that accompany their social role. This is especially true when the attitudes and beliefs are incongruent with the different roles they play. For example, a social worker who views themselves as a social justice advocate might find that they are at odds with the requirement to carry out unjust workplace policies. Over time, the social worker may come to adopt the attitudes and beliefs of their workplace as it is their source of income and livelihood. This occurs for several reasons: the social worker may come to think of themselves as a model employee because that is how they think their superiors at the organization perceive them, because that is how they are behaving, or because to do otherwise would lead to incongruency between their actions and beliefs. In these situations, people may modify their performance to present themselves in a certain way or refrain from saying what they really think or feel. For Goffman (1959), these behaviours were primarily driven by a desire to reduce tension.

Empirical Investigations

Given the small number of studies that examined tension explicitly, and the variability of how the term tension is used in the literature, the following literature review extended to more general research on strain with the hopes of gleaning a better understanding of the experience of tension in palliative care settings. The conclusions of these studies suggest that there are three

levels which appear to interact in a complex manner, affecting each other, and in turn creating tension among health and allied healthcare providers working in palliative care settings.

Individual/Personal Level

Evidence points towards a relationship between certain situational experiences that create a personal reaction from the health and/or allied healthcare provider and tension. For example, in a provocative study, McNamara and colleagues (1995) suggested that tension may occur when providers working in palliative care settings are forced by some circumstances to personally re-evaluate their own response to death and, in doing so, re-examine their own beliefs and propensities. Following semi-structured interviews with 16 nurses engaged in hospice services, the researchers found that some nurses who dealt with the realities of death and dying within the context of their daily activities experienced a personal response that was confounding, and which might bring unquestioned beliefs into question.

Beyond reflections about one's own life and death, certain situations can also provoke negative emotions. Stephensen and colleagues (2019) completed a secondary data analysis of qualitative data collected from 28 hospice providers that included nurses, physicians, social workers, and an expressive therapist. The researchers used focus groups, reflective journaling, and one-on-one interviews to examine spiritual uncertainty and found that care situations that provoked powerlessness, self-reflection, and feelings of deficiency caused tension among providers. For example, some participants shared that they experience tension when people receiving services have expectations that cannot be met, such as opting to wait for a miracle in lieu of treatment or expecting a medical cure when such a thing is not possible. Likewise, participants reported experiencing tension when they were unable to help certain people receive services. Some participants also stated they experience tension when they are expected to change

or relieve suffering that cannot be changed or relieved, despite being positioned as experts with the abilities to do so. Similar results were found in a qualitative study that explored nurses' decision-making related to the administration of anti-seizure medications to children with long-term seizure disorders in palliative care settings. Rashotte et al. (2011) completed unstructured interviews with six paediatric hospice nurses and registered practical nurses and found that tension arose in times when these nurses had to bear witness to suffering that they could not fix. In this study, much of the reported tension arose from a desire to make the decision that the child's parents would make while ensuring that the child would not suffer. Indeed, nurses in this study described experiencing decision-making tension when they struggled to find the right thing to do in each child's seizure event. These findings, that situations requiring decision-making can provoke personal reactions from providers, echoed those from previous studies. Findings from a qualitative study that included two focus groups with 15 nurses and individual interviews with four physicians working in two Australian palliative care units found that providers experienced tension in relation to decision-making and medical nutrition and hydration during end-of-life care, specifically as it pertained to maintaining quality of life versus the prolongation of life (van der Riet et al., 2009).

These studies suggest that certain contextual factors specific to hospice and/or palliative care settings may play a role in the experience of tension; for example, in situations that create an incongruence between the providers' underlying attitudes and beliefs (about life and death, for example) and their public behaviour as a health and allied healthcare provider of mainstream hospice and/or palliative care services. For example, given that the primary aim of palliative care is to prevent and relieve suffering, health and allied healthcare staff employed in these settings are expected to reduce and relieve suffering (Rattner & Berzoff, 2016), and may experience

tension when these (sometimes unrealistic) expectations are not met or when they feel as though they have failed their performance.

Social Relational/Interactional Level

Past research also suggests certain social and relational exchanges at the workplace can be a source of tension. This occurs as a result of interactions providers have directly or vicariously with clients and their care partners, or coworkers.

Tensions in Client and Health and Allied Healthcare Provider Relations

Evidence suggests that certain situations that occur between the health and allied healthcare provider and the people that they provide care to can be sources of tension. Additional findings from a previously described study by Stephensen and colleagues (2019) suggest that witnessing strain between others may create tension when it causes providers to consider the need to intervene, mediate, or engage. For example, some providers experience tension when they witness situations in which family members have goals of care that are unrealistic or incongruent with those of their loved one who is receiving care (e.g., wanting aggressive therapies to be initiated or not accepting that death is imminent). In these situations, providers were drawn into family conflicts and had to consider when they should intervene, mediate, or advocate for the person receiving services. Situations that require a decision to be made with the quality of relationships and the provider's own presentation-of-self at stake can create tension given the importance of relationships in the delivery of palliative care (Borimnejad et al., 2014) and the need for individuals to receive validation for their role performances. Indeed, some nurses in the previously discussed study by Rashotte and colleagues (2010) described experiencing distress if they felt that their decisions might negatively impact their relationship with both the child and their parent.

Implicit pressures that are inherent in the philosophies and policies and procedures that constitute mainstream, Western hospice and/or palliative care may play a role in this relational tension. Indeed, many providers feel pressured by their workplaces to ensure family conflicts are resolved. For example, findings from a study that utilized semi-structured interviews with 29 nurses employed in a hospice setting about determinants of a "good death" suggested that some hospice staff valued deaths that were minimally disruptive to the tranquility of the hospice ward; deaths that were accepted by people receiving services and families and that were met with a large degree of peace (Costello, 2006). Likewise, in the previously described study that used interviews with nurses in an in-patient hospice (McNamara et al., 1995), data analysis found that tensions can arise when providers are faced with people receiving services who do not internalize mainstream hospice philosophies that establish the norm for dying while receiving end-of-life-care. This includes things like accepting death, achieving closure, and resolving conflicts (Cagle et al., 2015; Goldsteen et al., 2006; Hirai et al., 2006; Kastbom et al., 2017; Masson, 2010; Patrick et al., 2001; Payne et al., 1996; Singer et al., 1999; Steinhauser et al., 2000). Similar findings were uncovered in a study that used eight focus groups with nursing aides and the residents in a nursing-home, where nursing aides discussed the tension they felt when residents did not follow direction and/or trust the providers' expertise (Levy-Storms et al., 2011). More recently, these findings were supported in a literature review that explored the underlying discourse in the literature on the "good death" in Western societies (Cottrell & Duggleby, 2016). In that literature review, the authors found that people receiving services who held alternative views of dying and death than those of their health and allied healthcare providers were sometimes labelled as angry, non-accepting, non-compliant, and even deviants who violated the established norms of health and allied healthcare.

These studies demonstrate the tension health and allied healthcare providers experience when having to choose whether or not to involve themselves in disagreements between individuals receiving care and their loved ones, especially at the risk of damaging their professional relationship. Situations like these, where one's personal preferences or propensities may misalign with the expectations of what one's roles and responsibility are when delivering hospice and/or palliative care services, can lead to role conflict and create tension. The aforementioned studies demonstrate how the "good death" imperative, which has become adopted in Western palliative care settings, can contribute to tension for health and allied healthcare providers who feel pressured to mold their practice and tightly control client's experiences to fit best practice guidelines and other program benchmarks.

Tensions in Relations with Colleagues

Research findings also suggest that certain interactions with colleagues in the workplace can lead to tension. One's position on the hierarchy of the organization and statuses that are attributed to different professional disciplines both influence workplace interactions between colleagues and create power differentials that have been shown to be sources of tension. Past research has suggested tension that health and allied healthcare providers working in hospice and/or palliative care settings experience can be associated with hierarchies in their workplaces. These hierarchies can be attributed to things like educational differences, traditional superior-subordinate positions, and professional designation. For example, in a study exploring tensions in work team relationships, Apker et al. (2005) interviewed 54 health and allied healthcare providers employed at a hospital (nurses, clinical nurse specialists, physicians, personal care assistants, unit clerks, and unit coordinators), and found that some providers report experiencing tension created by their lower hierarchal status in the health and allied healthcare teams'

structure. Participants in this study described being faced with traditional structures that position physicians as superiors due to their expertise and higher education levels, despite being expected to be assertive and collaborative on their interdisciplinary teams. These results resembled findings from a quantitative study that surveyed 187 social workers employed in health centres and community hospitals which found that respondents perceived themselves as less powerful members on the medical hierarchy and who were treated as such by physicians (Gellis, 2001). Similar sentiments were shared by social workers employed in mental health care settings in the Canadian Province of Nova Scotia (Brown et al., 2021). Findings from a large, mixed-methods study that utilized online surveys, interviews, and focus groups revealed that social workers often feel devalued when working in healthcare settings where they are situated low on the status hierarchy, a system and structure of power within the health and allied healthcare system that renders them with little power or autonomy to determine or shape their practices (Brown et al., 2021). Social workers in that study stated that the bottom ranking contributes to their skills being questioned, services devalued, and their limited influence in decision-making processes.

Indeed, cultural patterns in the workplace, perceived absences of equity and fairness in expectations, and a lack of understanding between team members all contribute to power differentials among the team and the experience of tension. For example, in a qualitative study exploring contradictions on an interdisciplinary health team, the analysis of semi-structured interview data collected from five doctors and eight nurse practitioners revealed that participants held the belief that some physicians have a lack of understanding of the roles of members on their interdisciplinary teams and believe that they have the right to change or modify care plans developed by the team (Martin et al., 2008). This finding was supported in another study of teamwork on geriatric and palliative care teams (Goldsmith et al., 2010). Following semi-

structured interviews with a psychologist, a social worker, a chaplain, a nurse, and two medical fellows (n = 6), findings showed that participants felt frustrated with not being understood or utilized by physicians. This lack of understanding of professional roles may begin as early as post-secondary education, where future professionals are being socialized into their chosen fields. In a study that used seminar discussions and focus groups, responses from 55 social work and nursing undergraduates suggest that students from the different programs have limited knowledge about the other students' discipline, and that the knowledge they did have was often incorrect, resulting in tension between the two different professions while working on a shared task (Chan & Lam, 2013). These misunderstandings can continue on into employment settings and were echoed in focus group responses from 65 Canadian social workers employed in urban hospitals who discussed the lack of understanding of social work that other workplace colleagues had (Craig & Muskat, 2013).

The studies outlined in this section suggest that sources for tension can include the arrangement of the work environment (e.g., hierarchies in the organization), lack of communication among team members, disagreements among the team, and a lack of understanding of jobs, roles, and scopes of practice. In these situations, tension may be created when health and allied healthcare providers compare the ideal democratic team structure that implies egalitarianism with the reality of a medical hierarchy. The conclusions of the Apker et al. (2005) study support past findings that even though all hospice personnel are expected to respect one another and work together, they are governed by hierarchies of position associated with knowledge and power (McNamara et al., 1995). Indeed, these hierarchal structures perpetuate a lack of understanding regarding the value of various professions within health and allied healthcare settings, creating tension between colleagues (Baum et al., 2009).

Structural Sources of Tension - Organizations

Beyond the interpersonal sources of tension as a result of the arrangement of hierarchies and status differences in the workplace, researching findings also suggest that tension can result from organizational factors such as institutional decision-making structures, service provision philosophies, workload demands, and the influence of neoliberalism. Baines and van den Broek (2017) completed a secondary data analysis of 105 interviews with social workers and nurses employed in both community and nursing home-based settings to gain an understanding of workplace experiences. They noted that tension is created as a result of program planning and development being shifted from frontline workers to managers who have largely been removed from frontline work and who are distant from the experiences, issues, and concerns of frontline providers and people receiving services. Further, they suggested that many frontline workers providing health and allied healthcare services resent the loss of professional autonomy due to the increased caseloads and pace of work accompanying standardized metrics and performance management. In fact, other studies of health and allied healthcare providers in settings that provide palliative care reveal similar conclusions regarding the relationship between increased workloads, time constraints, and tension. For example, the lack of time, inadequate support on shifts, and the intensity of care that individuals require have all been associated with role strain due to increased demands on time, according to semi-structured interviews with 44 personal support workers and four non-clinical staff employed in long-term care homes (Sims-Gould et al., 2007). Likewise, other findings from qualitative studies with health and allied healthcare service providers have suggested that time constraints create tension for workers who feel as though the focus on efficiency impedes their ability to provide compassionate, comprehensive care (Levy-Storms et al., 2011; Miller & Apker, 2002).

The organizational factors discussed in these studies have the potential to limit health and allied healthcare workers' ability to make decisions based on their professional discretion and restrict the time they are able to provide to people that are receiving care. Further, the localised discourses that constitute the organizations where social workers are employed promote efficiency often at the expense of comprehensive care. This is a source of tension given the fact that social workers are constrained by the realities of the workplace, resulting in an incongruence between the ideal level of care they aim to provide and the reality of what they are able to do.

Structural Sources of Tension – Social

Finally, research has shown that broader societal messages about death and dying can also be as source of tension for health and allied healthcare providers working in palliative care settings. Findings from a previously-discussed study have shown tension is created when the personal views of the provider seem to be at odds with those whose views more closely resemble general societal attitudes towards death and dying. These attitudes are marked by apprehension, fear, and avoidance, and involve secrecy and embarrassment (McNamara et al., 1995). Nurses working in hospice settings, for example, have indicated that they felt people outside of the hospice system lack the understanding of what was involved in providing care to individuals who are dying and perceive stress to be related to the general society's death-denying tendencies and disregard for hospice values of death acceptance (McNamara et al., 1995). These broader societal messages can contribute to individuals and families misunderstanding the aim of palliative care, being resistant to end-of-life care conversations or requesting invasive treatments that are unlikely to improve or ameliorate the individual's condition (Banjar, 2017). Furthermore, they can also contribute to late referrals to palliative care services from other specialists on the person's care team (e.g., oncologists; Saraswathi Devi, 2011). These situations can create tension

for providers who work in hospice and/or palliative care settings because the field of hospice care has constructed its own shared values of death and providers experience tension when they perceive threats to those values, especially when the impede the delivery of care (McNamara et al., 1995; Rosenberg, 2011).

Summary and Critique of the Theoretical and Empirical Contributions

Theoretical Literature

A consideration of the way by which workplaces are organized through the work of Foucault (1977) and Goffman (1968) provides an eloquent explanation of how tension is created. Foucault (1977) speaks of a knowledge of the body that he calls the political technology of the body. This knowledge is not of how the body works, but of how it can be mastered through forces. This is the kind of knowledge that institutions and organizations employ in various ways to bring about the subjection of the body of the employee. Foucault (1977) defines discipline as a modality of the exercise of power, a technique of application which subjects individuals by minute analysis and regimentation of space and time (Leib, 2017). Dominant discourses in workplace settings subjectivize employees through discursive practices and control systems like supervision and surveillance. In organizational settings, the exercise of disciplinary power renders a subject regular and culpable through making them visible (Leib, 2017). It leads to a docile body, which may be trained by the disciplinary institution to become productive. According to Foucault (1977), various technologies (i.e., hierarchal observation, normalizing judgement, and dressage) appear to govern, discipline, and correct abnormal behaviours. He uses the metaphor of the panopticon to represent the development of disciplinary power, characterized by invisible surveillance, depersonalization of power, and subtle coercive mechanisms. Discursive practices that constitute organizations may be considered regimes of truth and

discipline that constrain an employee. Indeed, discourse constitutes workers' subjectivities, establishes and naturalizes managerial control, and disciplines the productive body (Jian et al., 2008).

The discursive field specific to palliative care creates norms and expectations that order realities in those settings. This includes the ways in which organizational hierarchies are structured and the way health and allied healthcare providers should think, feel, act, and talk. Discourses become stabilized through mechanisms such as surveillance and supervision, which are achieved through means like performance appraisals and statistic keeping. Throughout the studies referenced in this literature review, tension was related to this discursive field insofar that it regulated, exalted, and subjugated behaviours and thoughts that deviated from the "palliative care norm." Studies described scenarios in which participants felt tension when they believed they failed to live up to the norm by successfully addressing all of the pain and symptoms that clients experience and/or achieving a good death, felt their own or their clients' dying and death preferences were outside of the norm of Western palliative care values, their knowledge and practice autonomy was subjugated and they were positioned low on the status hierarchy, and when workplace practices centred on efficiency and surveillance impacted the time they have for client-care.

Goffman's (1968) work fits specifically within this space. It offers descriptions of the ways in which individuals are made and unmade by the social and material forces, produced by discourse, of their everyday lives. His insights allow us to look at interactions between the people who are the subjects-objects of organizational control and discipline and the organization itself. For Goffman, power is a matter of taken-for-granted, "normal" everyday rules and expectations of interaction, which enables and constrains efficiency and capacity (Nunkoosing &

Haydon-Laurelut, 2012). The employee whose views differ from the dominant discourse of the organization is not only labelled but subjected via the discursive practices of the organization. Goffman would suggest that the panoptic gaze of the disciplinary institution does not spontaneously evoke docility, as Foucault claims, but does so only through systematically depriving the individual access to the various kinds of spaces (i.e., the backstage) required for one to manage oneself. Without access to the backstage, the individual finds it very difficult to understand the self as anything other than a function of the institution, thereby decreasing their level of resistance.

With Foucault, it is possible to focus on the historical, social, and cultural contexts that created the interactions that Goffman was interested in (Nunkoosing & Haydon-Laurelut, 2012). Foucault's concern with power directs us to consider how dominant discourse and subject positions are produced. Power and its relationship with knowledge generate the discourses that limit and define what is knowable. However, while Goffman did not refer specifically to power, he alluded to it in terms of the creation of social practices, the rules and roles of interactions, and the demeanour of discourse. Health and allied healthcare providers navigate through the discursive field of palliative care settings that encompasses social interactions that occur within those contexts. Indeed, each context parallels the settings where role performances take place that Goffman referred to in his dramaturgical analysis. The empirical studies reviewed in this chapter indicate that tensions are inherent in these interactions. In palliative care settings, health and allied healthcare providers must perform several roles that have different role expectations associated with them while seeking validation from their given audiences. Study findings suggest that tension may exist in relation to role expectations, performances, and desired feedback from

the audience. This appears to include managing competing interests of the organization, clients, colleagues, and the provider themselves.

Interlocking Foucault and Goffman's work provides a beneficial link between the individual/relational and the structural aspects of society. Goffman's work augments Foucault's by providing an understanding of how the forms of discourse become part of the everyday lives of people and how they become institutionalized and made part of the structure of institutions at work. Likewise, while Goffman's work allows us to understand how people interact day-by-day within an existing institutional and cultural structure, Foucault's work helps us question how institutions come into being and what their formative structures are (Hacking, 2004). Indeed, Foucault's and Goffman's perspectives interlock to contribute a comprehensive understanding of human behaviours. Together, the works of Foucault and Goffman provide insight for understanding the source of workplace tension in both the formation and structure of discourse and how it is expressed and experienced in face-to-face interactions.

Empirical Literature

There is a relative paucity of studies on tension in palliative care, specifically as it relates to social workers. Indeed, few studies were located that explicitly engaged with tension from the outset; none of which took the responses of social workers into consideration. One of these studies engaged with tension in the discourse during end-of-life care (van der Riet et al., 2009), and two explored tension as opposing values in relationships among interdisciplinary healthcare teams (Apker et al., 2005; Martin et al., 2008).

Although very few studies engaged with tension directly, and none attempted to explicitly define the term, the examples from the literature offer entry points for understanding how tension is experienced and understood by providers working in palliative care settings in general, and

possibly by some extension, social workers more specifically. Indeed, while the findings from the studies presented in this chapter can speak to the experiences of some health and allied healthcare professionals working in palliative care settings, only four included social workers in their sample. This raises questions about whether the sampling used can provide a generalizable reflection of views and experiences, especially considering the fact that social workers adhere to different professional values than other health and allied healthcare professionals.

Many of these studies omit a consideration of relationships among identity, discourse, discipline, control, and subject in an organization. These elements, coupled with institutional practices, generate multiple social identities that individuals must represent in different interactions with different people. Health and allied healthcare providers employed in palliative care settings must not only navigate power-knowledge-discourse relations every day, but also decide how to manage the always-optional resistance while maintaining a good impression with their organization's administration, their colleagues, and the people they provide care to.

A review of the literature highlighted a preponderance of qualitative designs and findings; therefore, the studies reviewed here are methodologically limited. The studies are predominantly qualitative with small sample sizes that ranged from 6 to 115 participants. While qualitative research methods are useful when approaching a rich and nuanced subject such as a question of human experience, qualitative studies' traditionally small sample sizes make it difficult to ascertain whether the same findings would appear in different areas and among different providers. Indeed, palliative care differs regionally, nationally, and internationally, and by the settings of care where it occurs (e.g., hospitals, hospices, community, etc.). However, while the results of qualitative studies are not generalizable in the probabilistic sense, they may be transferrable. Given the aim of this study and the research questions that guided it, a

qualitative approach was appropriate. Qualitative approaches are selected to understand, explore, and discover, in depth and in context, phenomena from the participant's perspectives. It was my intention to capture and understand participants' unique experiences in their professional contexts.

After reviewing the key findings from relevant literature, two key gaps were determined. First, there are multiple and varying uses of the word tension and relatively little research that asks health and allied healthcare providers engaged in palliative care services to discuss their understanding of the term and how they use it to explain their experiences. When referring specifically to social workers, the dearth of research is much more apparent. Rather, participants have been asked to describe their experiences that have caused them tension. When health and allied healthcare providers have responded to research questions about tension, most have developed their responses based on a pre-defined conceptualization by the researcher which has often conflated the term with stress. Multiple and varying states of tension have been studied; however, it is difficult to ascertain if respondents were describing different experiences or if respondents were using different words to explain similar experiences. Second, there is a lack of consideration of structural power/political sources of tension, and how it is reinforced, enacted, and managed in "normal" everyday interactions.

This study examined workplace tension with a field-of-practice specific lens in order to better understand how it is understood and experienced, including its constraints and possibilities. With limited research undertaken to explore tension experienced by social workers employed in palliative care settings, it is important to bridge the gap in order to advance knowledge in this field.

Focus of the Study

Given the variation of how tension may be experienced in the day-to-day lives of social workers, the focus of this study was to glean an understanding of workplace tension from their perspectives. This study explored workplace tension (how it is understood and experienced), particularly as it related to produced truths that constitute the workplace and the interactions that occur there. Once a clear understanding of how tension is experienced in daily interactions in the workplace was established, ways to interrogate constitutive truths were illuminated.

The purpose of this study was to gain a deep and rich understanding of tension as it was experienced and understood by social workers employed in palliative care settings and identify its origins and the factors that perpetuated and sustained it. This knowledge will aid in better understanding tension and contribute to the ever-growing body of literature focused on supporting the continuing advancement of palliative care services. Further, the illumination of hegemonic discursive formations uncovered processes of "othering" and the subjugation of alternative knowledges.

Research Questions

The key research questions for this study were: 1) How do social workers employed in palliative care settings define and describe the term tension? 2) What are the individual, relational, and organizational sources of workplace tension? and 3) How do social workers in palliative care settings manage everyday workplace tension?

CHAPTER 3

METHODOLOGY

The specific gaps identified in the literature review include an exploration of the experience of workplace tension in palliative care settings from the perspective of social workers. This study endeavoured to address this gap. Since there is no simple or complex event common to all instances of tension to which the term tension ultimately refers, qualitative research was required to uncover a thick understanding of the experience of workplace tension from the perspective of social workers. The essence of people's viewpoints is subjective and informed by their personal experiences about what tension is and its origins. In keeping with this, qualitative research methods accept people's subjective views and offer appropriate ways to explore these unique perspectives. This study applied a qualitative approach in order to better understand people's perspectives relative to the theories of Foucault (1970, 1973, 1988) and Goffman (1959). This chapter explains the study's methodology.

Interpretive Description

Interpretive description was applied as the analytic framework for the study. According to Thorne (2018), although traditional qualitative studies in health derive methodologically from the social sciences, interpretive description offers an analytic framework for applied health science researchers that seek to generate knowledge that is useful in practical situations. It was a particularly useful analytic framework for the current study given its utility in small-scale qualitative studies where the aim is to understand individuals' experiences and ground them within contexts of practice. Although social scientists can and do research phenomena oriented to practical situations, the knowledge these studies produce is often directed toward understanding problems of a more theoretical nature rather than a practical one (Thorne, 2016). Frequently,

when social science research methods are applied to health research, the objective is to understand the behaviour of certain social groups and what constitutes human nature rather than attempt to address issues of daily life (Teodoro et al., 2018). Specifically, interpretive description methodology arose in response to the need for an accessible and theoretically flexible approach to qualitative analysis that can develop better understanding of situations where health practice occurs (Burdine et al., 2020; Thorne, 2016). This approach is responsive to the needs of applied sciences insofar that it generates practical knowledge that can support the work being done in these settings (Thorne et al., 2004). It was an appropriate methodology for the current study as it facilitated my ability to address questions pertaining to human experience while producing practical outcomes that could be applied in the field. Ultimately, interpretive description allows for the advancement of practical knowledge without sacrificing methodological integrity that long-established qualitative approaches provide, which aligns well with the pragmatic requirements of applied disciplines (Burdine et al., 2020).

Interpretive description emanates from phenomenology, ethnography, and data-based theory (Thorne, 2016). Hence, it uses research methodologies that are familiar to those methods. However, even though traditional qualitative methodologies were employed, the ultimate goal was not to overly theorize results, but rather to generate knowledge and offer promising practical solutions to the problems pertaining to tension experienced in palliative care settings. More specifically, by delving deeply into the narratives of the participants, I captured themes and patterns within their subjective perceptions and generated an interpretive description capable of informing practical understanding. Interpretive description provided direction in the creation of an interpretive account that could ultimately guide and inform thought and practice in some manner.

Study Design

Qualitative methods are useful for researchers who seek to delve deep into the topic at hand to gain an understanding of the world as another experiences it (Denzin & Lincoln, 2005). These methods are useful for exploring details that are more challenging to ascertain through quantitative approaches (Strauss & Corbin, 1998). Interviews were used for data collection, as they provide valuable information about the social milieu in which people exist, and insight into the participants' attitudes, experiences, and perspectives (Ryan et al., 2009). Unstructured interviews were used to elicit rich description using the participants' own words and to provide them more freedom to describe their individual experiences and perceptions. The study conformed to the ethical policies and standards established by the Research Ethics Board at the University of Windsor and aligned with the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS-2018).

Instrumentation

Data collection consisted of unstructured interviews that began with an open-ended prompt to encourage conversation. The unstructured interview does not have predetermined question or answer categories, but instead relies predominantly on the interaction between the researcher and the participants (Minichiello et al., 1990; Zhang & Wildemuth, 2009). This allows the researcher to have a conversation with participants and to generate questions in response to what they share. These types of interviews are most useful when the research aims to gain an in-depth understanding of a particular phenomenon within a particular context (Zhang & Wildemuth, 2009). Since my research goal was to understand workplace tension from the personal perspectives of those who experience it, allowing the conversation to be flow naturally and be mutually shaped by myself and the participants was the most logical approach.

According to Zhang and Wildemuth (2009), in order to attempt to understand participants' perceptions, researchers must invite participants to describe their experiences in their own terms. Given the freedom of individuals to frame workplace tension differently based on their own understanding of it and their unique experiences with it, and considering the purpose of this study, unstructured interviews were chosen because of their potential to generate data with different structures and patterns from each participant (Zhang & Wildemuth, 2009). Ultimately, this interview style uncovers unanticipated themes and helps researchers develop a better understanding of the participants' social realities from the participants' own perspectives.

The interviews in this study began with this prompt and broad, open-ended question: "as you are aware, I'm interested in discussing your understanding of tension and your experiences with it in the workplace. I don't have a starting definition of tension; I'd just like to discuss your experiences as a social worker working in palliative care settings. As I think back to my own story as a social worker working in palliative care, I realize that tension isn't something that's easy to define or describe. When you think of tension, what do you think of, and what have your experiences of it been like in the workplace?" Following this prompt, I allowed the interview to flow like a natural conversation with each participant. I followed each participant's description and generated questions spontaneously based on my reflection of their story. The conversation was loosely guided by a list of questions (an *aide memoire*; Minichiello et al., 1990). This served as a broad guide to topic issues that might be covered in the interviews, rather than actual questions to be asked. Unlike an interview guide, an *aide memoire* does not determine the order of the conversation and is subject to revisions based on the responses of the participants (Burgess, 1984). The main topic areas on my *aide memoire* included: understanding tension, sources of tension, managing tension, addressing tension, consequences of tension, and using

tension (see Appendix 5). Using this *aide memoire* afforded me a certain degree of consistency across the interviews, enabling me to balance flexibility and consistency.

Following suggestions made by Fife (2005), throughout the interviews I remained mindful of the study's purpose and aim. This assisted in framing the scope of the issue that I intended to discuss. My control over the conversation was minimal, but nevertheless I attempted to encourage the participants to describe experiences and perspectives that were relevant to the problem of interest.

Research Participants

Given this study's intent to learn about social workers' experience of workplace tension in palliative care settings, homogenous purposive sampling was utilized to recruit social workers in this field. Unlike probability sampling methods, purposive sampling is judgmental, selective, and subjective because it relies on the judgement of the researcher when it comes to selecting the units. Purposive sampling was used because of the specific population of interest and recruiting social workers enabled me to answer my research questions. Although the sample size of this study is modest, generalizability is not a concern nor is it a weakness when utilizing qualitative methods. My intent was to examine the experience of workplace tension among social workers employed in palliative care settings in detail, thus my rationale for using homogenous sampling. Participants were recruited based on the criteria that they were direct practice social workers working in palliative care settings in Ontario, Canada. Social workers who were not involved in direct practice and who did not speak English were excluded from the study. Each participant was provided a $20 Visa gift card and a written thank you card for their participation.

While the sample size in the majority of qualitative studies should generally follow the concept of saturation, it can be difficult to prove when it has been reached (Mason, 2010). The

appropriate sample size for interpretive description typically ranges from samples of six to 32 participants (Teodoro et al., 2018). This aligns with Charmaz's (2006) suggestion that a small study with modest claims might achieve saturation more quickly than a study that is aiming to describe a process that spans disciplines. Given the homogeneity of the study, the target sample was 20 participants. The initial call for participants for this study yielded 10 interested participants. Using snowball sampling with those who contacted me, I augmented the sample to include an additional three participants. Snowball sampling is another non-probability sampling technique that assists researchers with gaining access to a desired population. Three interested participants contacted me and were excluded from the study (one did not work in direct practice and two did not work in palliative care settings). Ultimately, thirteen social workers participated in interviews, and 10 participated across two peer-validation sessions. All study participants identified as female. Their work experience in palliative care ranged from 1.5 to 10 years. Four worked in palliative care units in urban hospitals and eight worked in community-based hospice palliative care organizations that served both urban and rural areas.

Having practiced as a clinical social worker and educator in a hospice palliative care setting for several years meant that I would know some social workers who obtained the initial recruitment email. This highlighted the importance of remaining mindful of my personal, professional, and academic identities. As a practitioner-researcher, I have been intimately connected with social work practice in palliative care settings, which is the practice setting I am interested in studying. In agreement with Kuhn (1962), I believe that complete researcher objectivity is not possible. Thus, I acknowledge my positionality in order to mitigate bias in the collection and analysis of data. As a dual role researcher, I remained aware of the potential effect of undue influence and cognizant of situations where undue influence may have undermined

voluntariness of participants' consent to participate in research. The relationship of trust and collegiality between myself and participants could have imposed undue influence on the individual to participate in my research. To mitigate this, I used full disclosure of all the information necessary for individuals to make an informed decision about participating. I also put myself at arm's length from the research by time; I was no longer a frontline practitioner in a palliative care setting by the time I collected my data. As such, the dual-role nature of the relationship between colleague-researcher had ended.

Procedures Used

A recruitment email was distributed by the Ontario Association of Social Workers (OASW) to 5,325 social workers who are registered with the OASW and employed throughout the province (see Appendix 1). Interested participants emailed me directly to indicate their interest in the study; I contacted those who did not specify their occupation status in their initial email in order to receive clarification and confirm that they met the inclusion criteria of the study. Those that met the inclusion criteria were sent a detailed information letter in response (see Appendix 2). Those who wanted to participate after reading the information letter emailed me once again to confirm their interest, receive their unique participant identification and register into the study, indicate their preference for means for the interview (i.e., phone call or online video-conferencing software, Zoom), and schedule the interview itself. These options for completing the interviews were chosen due to the public heath restrictions that were instated by the Federal and Provincial governments as part of their response to COVID-19 during the time of data collection. The Zoom platform was chosen due to its wide-spread use during the time of stay-in-place orders and consequential familiarity to participants. Each participant received a confirmation email that included the date and time of their scheduled interview and a reminder

email three days prior to their interview in order to ensure participation. All but one participant chose to complete their interview via Zoom. The remaining participant opted for a phone interview.

Each interview began following confirming verbal consent to participate and to audio-recording (sees Appendices 3 and 4). The average interview lasted one and a half hours, with the shortest interview lasting 48 minutes and the longest lasting two hours and fifteen minutes. Each interview was audio recorded to ensure accuracy and authenticity in data collection for the purposes of analysis. Brief notes were kept throughout the interviews to remind me of topics I wanted to revisit and discuss more or help me remember topics the conversation prompted me explore. I also took brief notes during the interviews and wrote up more detailed notes immediately after each interview (Fontana & Frey, 2005; Lofland et al., 2006). These notes consisted of observations made during the interviews and the contexts in which they occurred, such as reactions and non-verbal language, and annotations of emerging themes (Thorne, 2016). Following each interview, the audio file was labelled with the participant ID and transferred within one business day onto my password-protected laptop for transcription by me. Interviews were also retained on a password-protected external hard-drive.

Once all interviews and data analysis were completed, each participant was invited to attend a peer validation session which occurred via Zoom. This allowed participants to attend the session from the convenience of their personal computer. In order to protect anonymity and confidentiality as much as possible, participants were given the ability to use a unique username and refrain from sharing their camera during the session. Prior to the session commencing, participants once again provided verbal consent to participate and consent to audio-recording. De-identified, preliminary findings were shared with the group to ensure rigour and

trustworthiness. The audio from the video conference was recorded on an audio recorder to ensure accuracy. The audio recording was handled and retained in the same manner as the audio files from the interviews.

In addition to the interview and peer validation of the data collected by audio-recorder, I maintained field notes in a journal that was used to construct an audit trail for the study. The notes created context and added to what I gathered and gleaned from the interviews. This was consistent with interpretive description methodology and allowed me to note emerging patterns that I wished to follow and encouraged my critical reflection (Thorne, 2016).

Data Analysis

All interviews were transcribed verbatim by me using the Descript software as soon after the interview as possible to ensure that participants' points were documented accurately (Denscombe, 2003). Each transcript was carefully reviewed for errors and corrected manually. Data management and analysis was completed with Microsoft Word. Only I analyzed the transcripts of each session.

Once the interview data was transcribed, I reviewed my field notes to help contextualize the data during analysis (Thorne, 2016). This helped to maintain the integrity of the participants' stories and consistency throughout the comparative process. I then engaged in thematic analysis of the data by focusing on capturing broad issues of the overall picture. While reading the transcripts, I focused on questions such as "what is going on here?" and "what am I learning about it?" (Teodoro et al., 2018), and tracked these broad themes in a separate Microsoft Word document. According to Thorne (2016), this process allows relevant themes to emerge and contributes to a holistic understanding about the topic.

In order to increase the validity of the analysis, I read each transcription several times to develop a sense of the whole beyond the immediate impression of what the transcripts contained. After identifying initial themes, I generated preliminary coding notes from the data rather than using pre-existing theory to identify codes that might be applied to the data. Through the process of opening coding, the transcripts were transformed into meaning units (words, statements, and/or phrases) for analysis (Graneheim & Lundman, 2004). Each segment of the text was then coded to classify and organize the information in a manageable way. Data was coded and categorized so that significant issues and new/other emergent themes were revealed. These initial themes were provisional and were modified and/or deleted as the process developed (Thorne, 2016). As the codes became saturated, I began coding patterns. Codes were constantly compared with each other and across interview transcripts, and connections between codes were identified. At this point, the codes were refined and specific dimensions of the experiences of workplace tension were grouped into recurring themes. This enabled me to create a rich description and detailed understanding of the workplace tension social workers experienced in a way that illuminated deeper and more complete aspects of the experience.

Rigour

In order to ensure rigour, methodological soundness, and trustworthiness, measures were used to ensure credibility, confirmability, dependability, and transferability (Drisko, 1997; Lincoln & Guba, 1985; Padgett, 1998). The first measure was prolonged engagement, which typically entails spending extensive time with participants in their everyday world in order to gain a better understanding of their experiences (Marshall & Rossman, 2016). I interpreted this to mean spending sufficient time in the field to learn or understand the culture, social setting, or phenomenon of interest. To this end, I have considerable experience working in the area of social

work in palliative care settings and was able to use that shared experience to build trust and rapport with participants. Second, I used supervision meetings with my committee chair and other committee members as appropriate to present ideas and themes in order to receive feedback for coding and analysis. The third measure was thick description. Here, quotes from the interview data were presented with each generated theme. Finally, the peer validation session offered participants a summary of data analysis and obtained their reactions, corrections, and further insights (Marshall & Rossman, 2016).

In addition, an audit trail was maintained throughout the data collection, coding, and analysis to describe the research process and document any decisions that were made. Notes of discussions with the members of the dissertation committee were also kept. The audit trail included the reflective diary that documented the research progress and developing codes, categories, and themes (Marshall & Rossman, 2016). Finally, I utilized reflexivity and bracketing to examine and mitigate my bias as a former social worker in palliative care. Bracketing is a key component of qualitative research and was used to minimize the potentially harmful effects of preconceptions that could impact the research process. van Manen (1997) described bracketing as the process of setting aside personal experiences, biases, and preconceived notions about the research topic. To bracket, I recorded my opinions, based upon experiences and readings, in order to determine what my biases are and how they have and do impact the decisions I make (see Positionality Statement in Chapter One).

Summary of Methodology

The day-to-day professional life of each social worker is impacted by their own beliefs and experiences, the structure of the workplace, and the interactions that occur there. Examining their experiences through their eyes, with a focus on workplace tension, provided a rich

description of their experiences. The unstructured interviews were a useful method for developing an understanding of an as-of-yet not fully understood experience in a particular setting. They were flexible and comfortable, which allowed participants to relax and open-up more in the interview. The data collected from these participants, analyzed in conjunction with the interlocking theoretical perspectives of power and discourse and presentation-of-self, provided a better understanding of how tension is experienced within the context of palliative care.

This chapter has explained the methods used in this qualitative study of workplace tension experienced by social workers in palliative care settings. The next chapter presents the findings obtained with those methods.

CHAPTER 4

FINDINGS

As stated in Chapter One, this study examined workplace tension experienced by social workers employed in palliative care settings. This chapter will present the findings of this study from the interviews with participants and the post data collection peer validation sessions. The findings represent the views of these 13 social workers who participated in the study and work in either hospital or community-based palliative care settings throughout Ontario, Canada. Although the participants' centres of employment were based in urban settings, the majority serviced both urban and rural areas. While their length of employment varied, this and the location of their work settings were not found to be significant factors when considering the findings. Indeed, taken together with the literature reviewed in Chapter Two, a picture of the experiences of workplace tension among social workers engaged in the delivery of palliative care emerged. The following sections of this chapter describe and discuss three main themes that emerged from the data analysis: a) understanding the experience of tension itself, b) sources of workplace tension, and c) managing and balancing workplace tension. To distinguish the source of the direct quotes provided by participants in this chapter, they will be identified by a unique number.

Understanding the Experience of Tension Itself

The term "tension" is ambiguous; it defies a neat, to the point definition that fits every person in every situation. This was apparent in the diverse ways participants described their understanding of the term and how they experienced it. The exploration of what tension means to social workers employed in palliative care settings yielded three subthemes, which are framed as the good, the bad, and the nebulous.

The Good

Tension is not always a negative experience. Many participants described positive characteristics of tension. These participants described tension as being a force for good; something that can lead to new perspectives on life and the workplace and create meaningful value at the personal, interpersonal, and professional level. The positive characteristics these participants discussed included the healthy and natural experience of tension, tension as an information provider, and tension as an antecedent for change.

Several participants stated that they perceive tension as a normal, and even healthy, experience; one that should not be pathologized. This differentiates tension from a negative experience, which was a common theme highlighted in the literature summarized in Chapter Two. These participants described tension as something that is to be expected in work environments where people have differing priorities, professional practice philosophies, and styles of engagement. As one participant stated:

> It seems like a normal non-pathological experience. I think healthy working relationships will include tension because we actually have to be able to disagree with each other and create tension between each other in order to do good work (Participant 8).

This was echoed by several other participants, who emphasized the importance of normalizing the experience of tension. According to the following participant, tension should be a common experience while practicing as a social worker, something that should be accepted and used as an indication that additional reflection is needed:

> I would say it's necessary for you to develop frameworks of reference for your experiences of tension that doesn't pathologize tension but allows you to observe it and ask yourself questions about it...If you're not experiencing any tension, that's noteworthy (laugh) and you might want to check yourself on that (laugh) (Participant 5).

When things are normalized, it helps to create a culture of acceptance and a space where the experience can be harnessed and used rather than admonished and repressed. In fact, one

participant shared their thoughts about tension being normal and warned of a potential negative consequence of trying to negate it. According to this participant tension is “always going to be there...you'll have a lot more emotional suffering if you are trying to always be perfect at the balance" (Participant 7).

Indeed, tension was described as a source of information, something that provides insight to the social worker about their own emotions, cognitions, and/or behaviours. This can be most closely compared to previous findings that suggested tension is an opportunity for self-reflection (McNamara et al., 1995); however, it differs in the scope of the information it can provide. For example, it may provide queues to consider other possibilities. As one participant shared, tension can help signal the need to reflect on other options prior to making decision:

> I use tension to help listen to that not listened-to part...I sometimes describe it as dials. If you've got...one decision you're very comfortable with. Sometimes you have to turn down that decision, like on a dial and imagine not doing that one, to allow space, to turn up another one (Participant 10).

Other participants described how tension provides insight into one’s performance and presence at work. According to one participant, “if I'm not a little bit tired and there hasn't been a little bit of tension in me about ethics and about physical fatigue, then it's possible that I didn't show up to work that day fully” (Participant 11). Similarly, another participant stated, “I think feeling tension probably tells me that I'm doing an okay job, that I'm not sitting back and just kind of letting work hit me. Like I'm being proactive” (Participant 9).

Tension may also provide information about a social worker’s use of self and boundaries between their own experiences and those of a client. For example, when discussing their work with a client living with ovarian cancer, one social worker described the physical sensation of tension in their own body, which queued them that they may be overidentifying with the client. According to this participant:

> It provides you with such good information about how your own lived experiences are colliding with your professional experiences. Tension does not feel good, but it's good information...because even though I sympathize or empathize with [the client], it is not happening to me. So that's really good information that I needed to check my boundaries...I'm grateful that that tension exists, because it's a queue for me, right? That I need to pay attention to something (Participant 8).

Finally, tension was described as an antecedent for growth and/or change. Many participants shared that tension was needed in order for them to evaluate their current situation and determine whether or not things can remain the same or if they require a change. According to one participant, "sometimes you need to wrestle with [tension] and say 'is this a situation I can live with?'...I do think tension has to exist in order for movement to happen" (Participant 12). This was echoed by another participant who believed tension was an important motivator needed for one to "take stock" and consider new possibilities:

> I think that in many ways if there wasn't [tension], we [couldn't] identify that there's something that doesn't feel right. Then we wouldn't ever be challenged or look deeper into it and say, "is there a possibility for something new to come out of this?" (Participant 11).

Lastly, the following quote exemplifies a notion shared by many participants: enough tension between the status quo and new possibilities means that change could occur. To this portion of participants, there is no change without tension, and once a certain threshold of discomfort with a given situation is met, one can be pushed to consider alternate options. They acknowledged that tension could reveal new opportunities and possibilities for changing the status quo:

> If we don't have some differences or we don't have tensions, we can get stagnate. So, I don't think that tension on its own [is] a bad thing, because it can give you a chance to pause and reflect and look at something, and maybe see that there's a different way to do something and a different approach that can move us out of a way of doing things into expanding a whole new way that's going to improve services and interactions for people (Participant 4).

The Bad

While some participants discussed the positive characteristics of tension, others' descriptions more closely resembled findings from studies cited in Chapter Two: tension characterized by conflict, hostility, disagreement, and incongruence. These participants described tension as a predominantly negative experience that can harm relationships and/or contribute to emotional exhaustion. For example, a large portion of participants discussed how tension can be a result of a discrepancy between their real and ideal personal and professional self, leading to incongruence. According to the dramaturgical perspective (Goffman, 1959), individuals experience tension as a result of role conflict; when there is an incongruence or contradiction between some aspect of the role they are performing, like their underlying attitudes and public behaviours, for example. This notion is captured in the following descriptive quote:

> It affects your own personal values and beliefs and professional identity. The core value of who you believe [yourself] to be is affected. When you're not allowing yourself to be authentic, [or] working in a way that makes you feel disingenuous or unauthentic...it's a lot more soul draining (Participant 3).

Other participants discussed a relational component of tension and described how tension is characterized by conflict or opposition between two or more parties. Interestingly, almost every participant described tension in relationships between themselves and their colleagues, with very few describing it between themselves and clients. This is consistent with previous research that has characterized tension as disagreements between colleagues (McInerney et al., 2009), yet different from the research that characterized tension as conflicts among people receiving care and their loved ones and/or between clients and their health and allied healthcare providers (Stephenson et al., 2019). The following quote describes situations where the approach and/or beliefs of the social worker conflict with the approaches or beliefs of colleagues:

> I would see [tension] as a conflict of intent...an opposing approach/opposing beliefs that are conflicting with each other and causing distress and anxiety. [It's] not necessarily a different belief system. Sometimes it's within the same belief system, but a different approach that just causes conflict (Participant 11).

For some participants, conflicts between themselves and colleagues can be especially turbulent. Words such as "anger" and "hostility" were used to describe the negative emotions that undergird tension between workmates. The following quote describes how situations where colleagues disagree over workplace decisions and/or practices can become particularly unfriendly:

> When I think about tension, I think about the many, often-negative connotations and the imbalance...[or] lack of agreement between different team members...I personally think [of] tension more when there is a certain type of conflict in relationships...I do think of hostility or opposition between diverse groups or individuals [in the workplace] (Participant 5).

The Nebulous

While some participants described tension as a positive experience and others described it more negatively, other participants describe tension as falling somewhere along the continuum between these two extremes, revealing an imprecise and imperfect third option. These participants struggled to describe tension and had difficulty distinguishing it from stress. The quote from the following participant captures the difficulty many participants experienced when trying to explain tension:

> It's really hard to put this in words. I guess things not sitting right in the workplace, like a conflict of maybe your interests [and] somebody else's interests.... a clash of, maybe, my values and somebody else's values or, um, yeah, I began [thinking of tension] like that kind of conflict, but maybe it's more of an opposing side kind of [thing]. I really can't explain it (Participant 2).

Another participant discussed how tension is more complex than just being torn between the two extremes of good and bad or positive and negative, and can involve thousands of possibilities, something that they struggled to describe clearly and succinctly:

> Tension is recognizing that something is not always one way or not always another way. It's the gray zone... Sometimes it's because they're two positive values or five positive values, and we're trying to figure out well, which one is most important? And sometimes it is about a negative value and a positive value, but yet you can't totally just do the positive value. To be honest, I'm confusing myself the more I'm trying to think about this, to explain this. Tension is very difficult to describe (Participant 10).

Likewise, other participants struggled to distinguish tension from stress. These participants acknowledged the similarities between stress and tension yet found it challenging to explain the differences between the two experiences. For example:

> When I think of tension it really evokes the word balance for me and when you're being pulled in so many different directions, it can create tension. Tension really seems like being pulled. Whereas stress is something that...you feel [or] something that is put on you, whereas tension might be something inside you...Honestly, if I think about it, [it's] semantics; I'm cutting hairs. To me, I guess, tension and stress are very similar (Participant 9).

Finally, the ambiguity of tension was evidenced by another participant who offered a description that went beyond an emotional or psychological experience - which predominated the findings - to include physiological elements. This participant described the physical sensation of tension and how it is stored in the body:

> My relationship with tension is mostly an embodied one. So, what comes to mind initially is how the body keeps the score, right? Like how the cost of doing this difficult work is stored in our bodies and feeling like not only storing the interpersonal dynamics in your body, but the vicarious trauma and that kind of stuff...for me right now, it's like muscle tension and even fascia and organ tension in my body...like a tightness (Participant 8).

Sources of Workplace Tension

This section will present findings regarding the second main theme which considers the sources of workplace tension for social workers employed in palliative care settings. Three overarching subthemes emerged: (a) social workers' perception of their own reality in palliative care settings; (b) social workers' reflections of how others see them; and (c) tension between these two perceptions of reality. Within each of the overarching subthemes, additional subthemes

were also identified to capture the variability of and to better describe the experiences of the participants.

Social Workers' Perception of Their Own Reality in Palliative Care Settings

The first overarching subtheme that emerged from the data was related to factors that influence social workers' subjective experience of reality in their workplace settings. Three additional subthemes emerged from participants' responses: the fulfilling and trying aspects of the job, devaluation, and disempowering and underpowering social work and the need for a stronger voice.

The Fulfilling and Trying Aspects of the Job

This subtheme pertained to tension participants experienced while balancing the psychological rewards they receive from their work with the arduous aspects of the job. Many participants shared a strong passion for palliative care and discussed internal rewards they receive from doing their work ("I have a passion for it. It gives me a great sense of value and purpose" [Participant 3]). This was typified in the special role they felt they played in providing care to individuals who are at the end of their lives and how they feel privileged to be employed in palliative care settings. For example, one participant stated:

> It's rewarding...it's very special to be part of helping people through that stage in life...you can see the gratitude and how much of a difference you're having in that moment...it can be very rewarding (Participant 2).

Similarly, another participant shared that the rewarding aspects of the work are powerful enough to make them remain at their job, despite the challenges:

> I've never been so close to grace...it's the stuff of life...and that's why I stay, because the gifts of this work are immeasurable. I will never be able to describe it to you. There's just no words that I could give you that would do it justice for how meaningful this work is to me (Participant 8).

While every participant indicated that they feel a sense of fulfilment from the rewarding aspects of the job, they each also discussed the need to balance that with the diametrically opposite, trying characteristics and demands of working as a social worker in palliative care settings. Interestingly, every participant attributed these difficulties to work-related factors rather than the emotional toll of working with clients who are at the end of life. For example, a large portion of participants shared that they commonly experience role strain when too much is required from a single role. These participants described experiencing tension when they are expected to fulfill one work responsibility at the expense of another that they believe ought to take priority. This is commonly a result of expansive responsibilities, and the diverse roles social workers fulfil that may seem incongruent (e.g., counsellor, case manager, discharge planner). The following quote exemplifies the role conflict some participants experience:

> In hospital social work, one of the tensions I regularly have is discharge planning and the flow hat, while also being the social worker to the patient, and the expectations that families might have around what social work does. So, trying to balance those things (Participant 7).

In general, participants lamented how busy they were and the role strain they were experiencing. They shared a common struggle of trying to fulfill high expectations with few resources and described having large volumes of work that included high caseloads comprised of clients with complex needs and time-consuming administrative responsibilities. Participants also described how they are expected to not only fulfill their frontline responsibilities, but provide education sessions, facilitate support groups and wellness programs, and mentor students as well. These participants stated that they struggled with the unrealistic expectations of what can be accomplished given their considerable amount of work. For these social workers, the sheer volume of work and unrealistic expectations about what can be accomplished contributed to burnout and starkly juxtaposed the fulfilling elements of their jobs. One participant described

their experience of having to sacrifice dedicated personal time for recuperation and self-care in order to maintain their work responsibilities, something that has not only made a job they love challenging, but has also driven them to contemplate leaving:

> I also have other things that people asked me to be a part of not just patient care, like teaching and being a mentor to some of the palliative care fellows, committee work, presentations...but I get so inundated with patient and family care...there's all these expectations of me to do these things, but without any time to do it. So, I have to take it up on my own time...then I compromise my personal obligations because [the] bottom line always becomes priority. I'm like, "okay, you guys have me doing all these other things and I'm happy to do them. I love doing them, but I don't have enough time to do them...I can't keep doing it" (Participant 3).

Further exasperating the role strain social workers are experiencing, a large portion of participants described an unspoken and implied expectation to also provide emotional support to their colleagues, above and beyond the support they provide to their clients. For these participants, this expectation often comes from management and contributes to their burnout, reduces the time they are able to spend with clients, creates ethical tensions, and is far-removed from the aspects of their job that they derive satisfaction from. Participants described situations where their colleagues reached out to them for support, and in some instances, stated that colleagues were directed to seek out and speak to the social worker by management. From a Foucauldian perspective, the dominant culture in workplaces constructs regimes of truths that guide behaviour and decisions through discursive practices (Foote & Franke, 1999). Through these discursive practices and threat of discipline, social workers are subjectivized and may be positioned to carry out responsibilities that they do not agree with, such as blurring boundaries and providing emotional support to colleagues, for example. The quote from the following participant illustrates how this expectation to support staff compounds their other job-related stress and leaves them feeling exhausted:

> We're expected to be the listening ear for everybody (laughs). So it's not just my patients that I support, but [I also] support my whole staff, and that's sometimes a lot. Like, my [colleague] that I told you about, she'll joke and say, "[participant name], you're my social worker!" (laugh) She'll call me with all of her problems...so you get drained (laugh) in multiple ways (Participant 2).

Devaluation

One of the most common concerns discussed by participants related to the worth of social work being reduced or underestimated in their organizations. In general, participants reiterated the longstanding feeling among social workers that they are devalued and perceive themselves at the bottom of the service hierarchy, especially in healthcare settings (Brown, 2021; Rossiter & Heron, 2011; Spolander et al., 2014). Indeed, most research participants described how social work is not valued or respected in their organizations, despite social workers feeling that they have demonstrated their abilities to enhance the quality and/or comprehensiveness of palliative care services. In general, participants discussed feeling demoralized and disillusioned, and shared stories of how being devalued created tension within themselves and among colleagues. Many participants shared that, at a minimum, they believe there is a continual need to justify their value and role in the palliative care system, despite the important work that they do. The quote below exemplifies a belief shared by many participants that they must justify their worth despite being an integral factor in positive client outcomes:

> We have to...justify our value within the system at times; like what it is we do. I am 100% convinced that [a] patient's physical health is better, because their psychosocial health is better...I'm 100% convinced that the hospital gets way less patient relations complaints because we're there (Participant 11).

Participants attributed these experiences to the dominance of the medical model. The medical model is the fixed, stabilized dominant discourse in healthcare settings, exalting those who align closely with its philosophies and leaving less space for colleagues from other disciplines like social work who do not ascribe to that approach. Many participants discussed

ways in which their perceptions of being devalued created tension between themselves and their healthcare colleagues. For a large portion of participants, this tension was a result of feeling as though their job is easy and can be performed by non-social work colleagues:

> We had one of our nurses go on leave...and when she came back, she couldn't go back into the role she was in before... so (laugh) my manager goes, “you can train her, to do the mat leave girl's job”. And I'm like, “whoa, that's a social work job.” “Well, it doesn't have to be, a nurse can do it” (Participant 6).

Most participants attributed devaluation to the ideological differences between social work and the medical model. However, a large portion of participants also suggested that social work is misunderstood by organizational leaders and non-social work colleagues, and this lack of understanding contributes to being devalued. This supports the findings from Chan and Lan (2013) and Craig and Muskat (2013) discussed in Chapter Two. As captured in the following quote, some participants believed that social work can be esoteric and, therefore, devalued by many organizational leaders and medical professionals:

> They don't understand it...I think for a lot of people, it...scares them a little bit. It's intimidating, it's awkward. They don't know how to capitulate, it. So rather than try to understand it, I think they just kind of, shove it off to the side a little bit. Cause it's too complex. It's too confusing. It's not black or white...it's grey (Participant 3).

Compounding the tension created by working in settings where they feel devalued is the notion that social workers must advocate for themselves in order to prove their worth to the team. In addition to the need for social workers to have a stronger voice, a theme which will be discussed later, participants felt that the onus was on them to demonstrate their value. The necessity to validate their role in palliative care settings contributes to tension for social workers who have a passion for their work and understand their importance on the care team. This is described in the following quote:

> One of the things that I think is behind it is many professionals think they do what we do...So, they don't actually think we’re that useful...[I’ve] had to elbow my way in with

> the nurses...to help them see how there was something in it for them, to have me on the team. In the first six months, they went to the boss and said, “she should have no access to our records. She should not have permission to see our clinical files. Those are ours; who is she to see it?” I'm like, “I'm on your team”. But they did not respect my credentials. They didn't respect the role and they didn't see how there was anything in it for them. And it took me several years before they actually would bring things to me (Participant 10).

Many participants echoed the sentiment that there is an implicit pressure to justify their roles and prove their value. In healthcare settings, social workers have made a sustained effort to develop their role on the interprofessional healthcare team (Blacker & Deveau, 2010; Radbruch & Payne, 2009). To this end, participants commonly described going over and beyond when discussing the work that they do; feeling the need to provide excessive detail in order to receive validation and affirmation from the interdisciplinary team and management. The following quote illustrates how some participants overcompensate and overexplain the work that they do:

> We're always fighting to prove ourselves...when I come to a staff meeting, let's say, fundraising, would say like, “oh, we've got this and this fundraiser we're doing this year”, and then they're done, their checked in, like in two seconds. I'm like, “alright...I'm supporting 35 people in this program, 25 in this program, 35 in this program. And I'm doing a public talk for provost club...and I'm doing a training and I'm doing this [and this and this]”...usually by the end (laugh) of the social work check in, the rest of the team is like (shocked face) (Participant 6).

The tension that is created by feeling devalued was substantiated and exacerbated by several factors including funding concerns, organizational hierarchy, and managerialism. The dominant medical model discourse not only exalts medical professionals as the ultimate authority but is also reified by government funding that allocates money to support their functions. Given that social workers are not aligned with the medical model as closely as traditional medical professionals, they are not afforded the same security when funding decisions are made. Many participants felt devalued to the point of being dispensable and easily replaced and most attributed this feeling to funding decisions. The following quote illustrates this worry:

> I also think there's this fear, this tension, (laugh) [that] if for some reason we lost funding, we'd be the first to go because the focus is on medical care and that's where we get our donations...we are more disposable [because] we don't bring in the big bucks...That's tension in and of itself, every day wondering if we lose a big donor, am I going to lose my job? (Participant 2).

Another participant echoed the sentiments about how their perceived value is correlated to funding. Consistent with previous research in other community-based and hospital settings (Brown, 2021; Brown et al., 2021), participants described working conditions characterized by few resources and limited staff. Many participants shared that social work is underfunded in their workplace settings, resulting in the social work department providing only skeletal services due to receiving the bare minimum in terms of human resources. This contrasts with other departments who they perceive to be generously supported: As one participant shared, "we're understaffed...but they're hiring more PSW's and nurses...[and] a new marketing manager...all these other departments get new staff...it's been six years...[and] there's no new person on the horizon...[if] I need a translator, well, there's no budget for that" (Participant 13).

The second factor that substantiates and exacerbates social workers' feelings of being devalued is related to their low rank on the status hierarchy in their workplace settings. According to Foucault (1973) knowledge orders social realities and power relations determine which types of knowledge are elevated to the position of truths and are used to construct contemporary realities. In the biomedical paradigm, the knowledge of professionals who align themselves with the medical model is privileged. The status hierarchy in medical settings typically positions physicians at the top, nurses in the middle, and allied health professionals (such as social workers) below them (Brown et al., 2021; King & Nembhard, 2016). In organizations, discourse legitimates these specific positions and reaffirms status relations among the interdisciplinary team. Accordingly, participants lamented their skills being questioned, their

expertise being minimized, and their services being devalued. They also believed themselves to have limited influence in system-level decision-making. According to one participant, social work has:

> A less valuable role. I'm on a palliative team, right? And there are nurses, nurse practitioners, doctors, an occupational therapist, and [makes hand motion to signify being at the bottom] a social worker. And I have the least status, the least pay, the least airtime, the least [everything] (Participant 13).

The hierarchal arrangement of individuals within the workplace according to power, status, and job function resulted in many social work participants feeling as though their profession is less valuable, and created tension between them and their colleagues. For many, this arrangement contributed to stifled collaboration and communication between colleagues and a sense of inferiority. When asked about challenging the hierarchy or addressing situations that made them feel inferior, a large portion of participants acknowledged that they acquiesced in the interest of saving face and avoiding conflict. Goffman's (1959) main point was that individuals are all performers in the interest of order and that the aim of performances is to produce a reaction or confirmation. In general, participants in this study opted to accept their role in the hierarchy and continue their front stage performance so as to maintain a favourable impression among their peers. As one participant shared, "I realized how important it was to me to be liked [and] respected at work. And I know I'm 100% respected, that I had no problems with, but I worried about being liked" (Participant 9). This was echoed by other participants who emphasized how critical it is for them to be liked in their workplace, even if there are workplace procedures they do not agree with. For example, one participant disagreed with the move toward standardizing social work assessments but refrained from speaking out in order to maintain a favourable impression. This social worker stated, "my other fear is that I want to fit in with my

group. But [in this situation], for me to fit in...I had to be...silent at times...otherwise I will hate coming in. I will not feel like I belong" (Participant 1).

Some participants described scenarios where their social work colleagues distanced themselves from their social work role in order to increase their value or professional legitimacy. For example, one participant commented on the role performance of a social work colleague who entered a management role. They described how this colleague seemed to lose touch with the "soft skills" of the profession by following the social scripts of how managers are expected to think and act, thereby internalizing the ideology of managerialism. According to this participant:

> They've [social work colleague] very much gone the policy, leadership way. And I think they've been doing that so long, [that] I don't always know if the other pieces are remembered...their decisions don't feel like...the patient's side has been thought of, it often can feel more like it was a numbers decision (Participant 7).

Similarly, other participants discussed how feeling devalued and low on the service hierarchy contributed to social workers internalizing the medical discourse in an effort to improve their status in the workplace. Goffman (1959) explained how individuals ("performers") employ impression management strategies in order to control the conduct and responses of others ("the audience"). Indeed, some participants described the need to adopt the language and discourse of the medical model in order to be heard and valued. One participant shared that by adopting the language and terminology of the medical model, they were able to play the role that is necessary to gain the favour of the rest of the medical team. Role distancing can be normative when it occurs in situations where the performer faces contradictory expectations as it enables them to not fully engage, attach, or commit to the role. According to Goffman (1959), individuals may use role distancing when they are experiencing role conflict where one or more roles are contradictory. The following quote demonstrates how they performed the role with a degree of cynicism, or role distance, which allowed them to remain detached from the role:

> It took me 10 years to learn what some of the terminology is that they [nurses and physicians] have. So, they can throw around diagnoses, they can throw around terminology, they can play the game. And part of the game is understanding some of the language...that in order to play the game, you [have to] speak [their language], so that people can listen (Participant 12).

Many participants discussed tension due to role conflict. When reflecting on the reason why internalizing the medical model may create tension, one participant attributed this to the role of power. Indeed, social workers have the ethical responsibility to empower clients by respecting their autonomy and self-determination (National Association of Social Workers, 2008), and as such, power is seen as something to share and encourage. This contradicts how power is traditionally perceived and used in the medical model, where the relationship between the provider and the "patient" is paternalistic; the provider is seen as the powerful expert who directs the patient on a treatment path that should mitigate a health concern. According to one participant, when social workers adopt the medical model approach, tension is created between their power as a healthcare figure and their notion of empowering their clients. This participant believed that social workers are, "really focused on deconstructing power...we're not comfortable with that idea of having power ourselves...that's the tension inherent with social work...our whole point is to empower people, but we're not comfortable with [having power]" (Participant 12).

The final factor substantiating and exacerbating social workers' feelings of being devalued pertains to managerialism. Many participants discussed tension as a result of the management approach at the organizations that they work at and how management decisions often reflected a lack of value for social workers. Participants explained that decisions about the role and scope of social work practice were top-down and that they had minimal, if any, input on these decisions. Being informed on how to do their work without being included or invited to collaborate on those decisions seems to have resulted in both distrust and a sensed lack of value.

For example, one participant discussed how their professional judgement was constrained by a new process to prioritize clients to be seen and discharged. This process was introduced by their management team and "took [away] our professional judgment...it totally took all professional ability and judgment away. And it [the assessment tool] did not relate to how distressed a family was, it related to discharges" (Participant 4).

Participants also described the impact neoliberal managerial models, such as New Public Management, has had on the perspectives and practices of individuals working in management. With a primary focus on standardization, routinization, and the elimination of inefficiencies, some managers' compassion and understanding for their employees has diminished. These participants described being devalued and reduced to mere people-processors whose primary function is to serve the needs of the organization. One participant shared a poignant anecdote about how the management team at their workplace overemphasized the importance of policy and procedures at the expense of showing compassion to them when their mother died and father was ill:

> At the time it was 20, 21 years [that] I've been there [employed at the organization]. And I had to take some time off...I never took time off...I got called up [by management] a year later, because of the time I took off...that discipline really makes your job challenging, because working in the area that we do is professionally exhausting and emotionally exhausting, fatiguing...somebody needs to come and say "[name], you need to take some time." Nobody really did that. I took it upon myself and then I got reprimanded for it (Participant 3).

Almost every participant discussed how the management model of their organization reflected the hierarchal structure of the medical model, one in which the value of social work is diminished. Many participants discussed how senior management at their organizations are nurses or from a medical background, something that not only reified the embeddedness of medical discourse, but also contributed to the marginalization of social work as a profession. As

one participant explained, “the managers are nurses, the director is a nurse. So, the nursing role is always valued and strong. And then the allied health role is kind of like this afterthought a lot of the time” (Participant 2). Likewise, another participant explained how the ideology that supports the management model not only emphasizes the importance of nurses and assigns social work a secondary role, but obliges social workers to support the nurses to do their job well:

> Their [nurses] priority comes from our management...management comes from a nursing background. And that, I think perpetuates that nursing is a very highly valued skill. And social work is not...there is an emphasis placed [on nurses]; we have to support our nurses to do their job (Participant 8).

In fact, many participants shared the belief that social workers should be better represented in management positions. Participants suggested that social workers possess the skill set to make excellent leaders and believed that they would be considered for management roles more often if they were valued more and if their knowledge and skill set was not subjugated. Indeed, from championing causes to understanding organizations and ensuring compassionate communication, many believed that social workers have the ability to create a healthy and supportive work environment for their employees. For example, when comparing a past social worker-led workplace with the more traditional nurse-led workplace, one participant shared that, “it’s definitely a different culture. When you have a social worker as a manager versus a nurse that's the manager...like, top down...[it] definitely sets a more contextualized and compassionate tone for the team and how people interact together” (Participant 2).

It is difficult to overstate how serious this sense of being devalued seemed to be to social worker participants. Beyond feeling less important than colleagues on a regular basis, many participants also discussed the implication this has for attrition. In fact, these participants stated that the ways in which workplace structure and management practice contribute to their sense of

being devalued is one of the most prominent factors that lead to social workers resigning. As one social worker shared:

> You're trying to do too much with too little time, and you're overextending yourself, not doing good self-care during that time. On top of that, you feel like no one knows the value of what you do or appreciates how much you do. That would make you leave...People I know that have left our field have left to go to other teams because it's more management that hasn't [appreciated them]. It's not the patients that made them leave, it was the culture (Participant 2).

This was echoed by another participant who stated that social workers "experience oppression" (Participant 4) when they must deal with being constrained by management in addition to the emotionally challenging nature of the job. According to this participant, "not all work environments are healthy, some of them are quite toxic and abusive," which results in social workers resigning.

These experiences with managerialism depict scenarios where social workers feel devalued and paint a grim picture of some palliative care settings where they are employed. It is interesting to juxtapose the experiences of these social workers with those who work with supportive management; administrations that communicate well, encourage professional autonomy, and value the role social workers play on the team. Participants shared that these management styles serve as a buffer for tension. For example, one participant who works with supportive management shared that they feel valued and secure in their social work, and able to practice in a way that is congruent with their personal and professional values:

> My [manager is] amazing [and] super supportive. She doesn't micromanage me. I have a lot of freedom in the work that I do. There's really nobody overlooking my work...I feel like I'm able to operate within my principles...I feel very grateful for that (Participant 8).

As outlined above, many social workers felt tension between their practice and professional discretion and management that devalues, misunderstands, and subverts their profession. Alternatively, management that values, understands, and trusts the social worker

seems to serve as a protective factor. While the majority of organizational arrangements that were explained by participants in this study represented managerialism with traditional healthcare workers situated at the top, many social workers discussed how their profession is well-positioned for management roles. However, role conflict is once again implicated in tension. Participants shared that the roles of being a frontline social worker and a manager clash and described a tension between practicing in a way that is consistent with social work values or distancing themselves from those values in order to advance one's career and enter into management positions. When discussing this tension, one participant shared questions they often ask themselves: "do you value individualism? Do you value Western medicine? Do you value playing along with the game? Do you want career advancement and to move into management? Or do you value in the ethics you prescribed to?" (Participant 12).

Disempowering and Underpowering Social Work and the Need for a Stronger Voice

The final subtheme related to participants' perception of being disempowered, constrained, and/or rendered ineffectual at work. Participants described the tension they experience when their professional activities are limited and the importance of their role is diminished in their work settings, despite the strengths and capacities they bring to the organization. The most prevalent concerns that were discussed regarding being disempowered and underpowered included lack of autonomy, voicelessness, and exclusion.

Lack of Autonomy. A large portion of participants discussed how they have had their professional power, control, and autonomy reduced by management and organization policy. For example, the following quote describes how management has restricted one social worker's ability to prioritize which clients they are supporting, thereby suppressing their ability to accommodate differing levels of need:

> The whole priority list [that is established by management] is based on discharge 100%...families' distress didn't become part of the equation. So that pissed me off. That was my final straw...you're constantly juggling priority in your own professional brain and to have that minimized and reduced...[is] not okay with me (Participant 12).

Several participants described working in settings with top-down management that included hyper-policing of their work which impeded their ability to practice in a manner consistent with their education and skills. For example, some participants stated they were limited in their ability to engage in advocacy ("the frustration comes from the people at the top blocking [social workers advocating for change]" [Participant 10]), and another described how their creativity is suppressed by management, impacting the satisfaction they derived from their work and limiting the support they were able to provide clients:

> It's a lot of stifling of creativity...the beating it gives me, [it] squashes my spirit...social workers don't get paid a hell of a lot. So really, we want to do what is meaningful to us, and even what is meaningful to us we don't get to make a lot of headway with... I feel a little stifled, and I think we're also stifling a lot of really amazing possibilities for people at the end of their lives (Participant 12).

In general, participants discussed feeling disempowered and underpowered when their managers consistently dictated details of how they are to do their job and used metrics to check these details. According to Foucault (1977), various technologies including hierarchal observation, discipline, and discursive practices such as surveillance produce docile bodies that can be trained by the organization to become productive. Organization priorities can be fulfilled through the use of management tactics to monitor and control social workers' activities; discursive practices that constrain their autonomy and discretion. Participants described how certain administrative tools are created to scrutinize the work social workers do and keep them under surveillance. These social workers feel as though the data they are required to collect poorly reflect the work that they do, reducing it to a fraction of the scope of social work activities

and directing them to perform tasks that are prioritized by the organization. As one participant shared:

> They want us to track the time we spend with a stable patient, an unstable patient (laugh), and a new patient. Then we're supposed to write down the activities we do into pre-made categories that don't capture everything. So it feels like they are really scrutinizing what we're doing and it's hard for us to, [report] black and white what social workers do (Participant 2).

Participants also discussed the use of discipline and the threat of punishment as a driving force behind tension. These are often used as means to constrain and restrict professional autonomy. For example, one social worker stated, "I think job security is the biggest thing. I think everyone thinks that if we speak up and if we speak against the norm, then we are going to be fired" (Participant 1). Likewise, when speaking about having to choose between prioritizing time spent directly with clients and completing administrative charting and data collection, another participant shared that, "there's been leadership where if things aren't done in a certain period of time, then you get into trouble. So I always made sure I did it, even at the expense of spending more time with the family" (Participant 4). This exemplifies how docile bodies are produced: individuals experience constraints, obligations, and prohibitions that are forced upon them via mechanisms of power with the purpose of rendering them docile for the sake of productivity (Foucault, 1980).

Voicelessness. The second major concern regarding being disempowered and underpowered related to being rendered voiceless in the workplace. Many participants described situations at their workplace when they felt as though they were not being listened to. For example, one participant described that "there's always that tension, that feeling within the organization...of you're not listening to us. There's a feeling of, 'this isn't registering' right?" (Participant 13). This was echoed by many social workers and is reflected in statements such as,

"I put my hand up, they don't call on me. They never call on me," and, "I feel [frustrated]. I have no power, right? Cause I'm the little peon" (Participant 10). The experience of not having their voices heard and having their struggle for access to power and equality in an unequal workplace ignored leaves many social workers feeling hopeless, something that was shared by participants (e.g., "the knowing that maybe nothing will change, even if you do bring it up [because] you're not gonna really be heard anyways" [Participant 2]). As one participant stated passionately:

> My voice doesn't seem to matter. And it doesn't matter how much education I have, it doesn't matter how many times people say "[participant name] you're so smart blah blah blah." I'm like, that's bullshit. And it doesn't matter because [even though] I might have the research to back me, I might have the stories to back me and the experience to back me, you don't care (Participant 12).

Exclusion. Another concern about being disempowered and underpowered pertained to exclusion. Participants described occurrences where they were barred or excluded from certain activities or had certain privileges withheld from them in the workplace. In general, participants described being largely excluded from decision-making conversations and management positions. In many cases, participants described how social workers were given minimal time to speak with management, especially as it pertained to their role and responsibilities. As one participant shared, "I don't get to deal with upper management very often, and because of that, I know any decisions they make are not necessarily going to represent the work that's being done by the social work team" (Participant 4). Another participant described how they have had a "manager for a year who...I could count on one hand how many times they actually came to visit us at our location" (Participant 12). This illustrates how social workers can be neglected by management even as it relates to check-ins and informal conversations. Furthermore, a large portion of participants voiced frustration about their absence in policy conversations and explained how their exclusion often resulted in the creation of ineffective policy developed by

those with a poor understanding about what social workers do. Not only did many participants share the perception of being left out of decision-making and policy decisions, but they also discussed instances of being excluded from interdisciplinary meetings pertaining to client care:

> I don't think we're really heard...in terms of decision-making in terms of running the organization; definitely not. In fact, I had to advocate for myself to be at tables where they're doing case conferences...I'm like, "there needs to be more psychosocial folks at this table because this is so heavy with pharmacists, nurse practitioners, physicians, RPNs, and RNs." It's sick because these things are getting missed (Participant 6).

The exclusion that social workers experienced extended beyond decision-making tables and meetings with their managers. Other participants described situations where they were excluded from meetings ("the freeze out is a typical one...not being invited to meetings" [Participant 12]) and other work functions in general. As one participant shared, some social work teams are "in a totally different building (laughs) than our residential hospice," and "very aware that [they are] siloed and don't have the lunches that other team members have. [They] don't have the benefits that the other team [has]" (Participant 11). That illustrates how social work teams are sometimes completely separated from their colleagues and excluded from team-building activities.

Many participants lamented being disregarded for management positions. Despite the general consensus among participants that social workers are well-suited for positions in leadership, many described the perception that applying for management roles was a fruitless endeavour. For example, one participant shared:

> It's rarely a social worker that goes into management. And yet probably of all the frontline professions, we're akin to management. We may have some of the most insight into some of the management functions because we do things like discharge. We do have to watch things like patient flow. But we rarely get there (Participant 11).

To some participants, even when social workers *were* present at leadership-level meetings, it seemed as though they were not chosen for their merits and instead merely as an act

of tokenism. They described situations where they had been able to attend and participate in meetings but were unable to make meaningful contributions and did not benefit from any follow-through on their input. According to a participant, “at least someone from social work is here, but is that someone making decisions for social work? No. We’re still not making decisions, so we need more presence at those levels” (Participant 1).

Despite being excluded from policy discussions and the procedures that result from them, there may be opportunities social workers can take advantage of in order to have a presence and voice. One participant, a social worker employed in a hospital, echoed others’ experiences of exclusion; however, they discussed ways that social workers can amplify their voice and attempt to shape future policies, provided that they are willing to take on additional work:

> What we’re trying to do to continue [to] have our voices heard is to be active at an organizational level in terms of participation in policy development [by joining] hospital interdisciplinary committees. We’ve actually been quite active...So there is an opportunity but there is a lot of work that needs to be done and effort on our part to explain our role and the benefits (Participant 5).

Finally, many participants explained that social workers need to do much more to empower themselves and strengthen their position in their organizations. These participants shared the belief that social workers should actively support and promote their role in palliative care settings and attributed their devalued and disempowered profession to the lack of a unified, collective voice. Participants described feeling frustrated with their social work colleagues who seemed to adopt their assigned low rank in the service hierarchy and their relative absence from decision-making positions. Even those who shared that they were assertive and resisted the status quo in the workplace believed that their single voice was not enough to create change in the hierarchy and opined the need to have more support from their social work colleagues. For example, one participant shared:

> We are not fighting enough. We're not making our voices heard. We're just basically [saying] "let me do my job and get out."...we shouldn't be here to...do [the] job and get out. Otherwise, just get out and don't do the job! (laugh)...The decision is going to be made for me...that's just the reality. So, we need to step up. I feel like we need more of a voice...we need to be more present at the higher levels of the hierarchy, but the only way to be present is when...we have a unified voice. [We can't] just keep complaining and sitting where we are...there's so much potential in us (Participant 1).

Many participants theorized as to why social workers acquiesce to the status quo and refrain from advocating for change as a unified front. One of the most common responses discussed feeling defeated and helpless about creating change, as exemplified by the following quote:

> I feel like there's not a lot of fight in people. Like the advocacy piece is going down...people are just feeling defeated at this point in the game...those that may [have been] more vocal in the past...don't seem to have the fight in them to take it on right now (Participant 2).

It seems as though this lack of a unified voice is not new nor is it uncommon. One participant who was researching the history and role of social work in palliative care settings explained that social workers have done a poor job historically of promoting their full abilities and demonstrating their expertise:

> There's almost no books by social workers in all of Canada...[which] tells me is that we as a profession don't have a strong voice. We don't have an expertise that people come to us for. So, we need to grow that. (laugh) (Participant 10).

Social Workers' Reflections of How Others See Them

The second overarching subtheme pertaining to sources of tension was related to factors that influence how social workers believe they are seen by others. Two additional subthemes that emerged from participants' responses were tension with team members and the subjugation of anti-oppressive practice (AOP) approaches.

Tension with Team Members

According to Goffman (1959), every social interaction is a performance in which individuals attempt to gain support from the intended audience. In situations at work, an individual determines how they will perform and then evaluates their performance based on audience feedback. Goffman believed that it is distressing for an individual when they do not receive the validation they seek from the audience, and this may be a source of tension for participants. Indeed, participants described several different scenarios that can create tension between themselves and colleagues. A large portion of participants, particularly those who have not been in the field long, described issues stemming from aggressive colleagues who prefer to work at a different pace. Many participants shared stories of having their efficient time-management skills, creativity, originality, and persistent advocacy for clients, admonished by teammates who prefer to maintain the status quo. For these participants, these situations compelled them to choose between practicing in a way that is meaningful for them and practicing in a way that is consistent with the performance of others. For example, as one participant shared:

> Tension really arose whenever I wanted to go above and beyond my role. And that was perceived as, "you're setting an expectation for the [rest of the] social work team"...[the] tension between me and my colleagues was "do less, do less, do less because you're going to make us be expected to do more" (Participant 1).

Other tension-inducing situations with colleagues from other professional backgrounds included situations where the boundary of the role of the social worker was encroached upon. The medical model exalts the power and prestige of traditional medical professionals, positioning them as the ultimate knowers of truth and solver of problems. This often results in the marginalization of social workers in medical settings as their knowledge and skills become subjugated in favour of the dominant discourse, even if it is at the expense of holistic care for the

client. One participant in particular described a situation where they were not called in to support a client who was experiencing difficulties in areas that fall under the purview of social work services, leading them to believe that they were perceived to be unimportant by colleagues:

> They won't call us...we physically are in another building. And often times, when there's a really complex situation...they're too proud to call social work. It's like, "nope, we can fix this problem. I can sit and hold this person's hand." That sometimes creates tension (Participant 12).

Tensions between colleagues also stems from misconceptions and biases about who is doing more working more and whose work is more impactful for the organization. This extends beyond the interdisciplinary team and includes staff in multiple areas of the organization. As one participant described:

> There is almost always tension. (laughs) It's like, [a competition of] who actually does the most work. Admin people feel like, "we're doing the most, we pay the bills, we keep the lights on. We make sure that the funding's here." And the nurses feel like, you know, they're keeping people medicated. And social workers are like, "hey, we're following up with the family drama. We're keeping everybody in check. We're doing bereavement work, mental health stuff" (Participant 6).

It is in the interest of the performer to control the conduct and responses of their audience through impression management, and Goffman (1959) argued that individuals are continually obliged to manage the impression they are making on others. However, participants in the study shared a tension between the necessity to use impression management techniques and being too emotionally exhausted to maintain the effort it requires. Many participants shared the sentiment that they are simply too overworked and burnt-out to speak with their colleagues and address the tension, which results in the tension perpetuating and/or worsening instead of becoming resolved. For example, as one participant shared:

> We're already so past the burnout zone (laugh)...We're so tired and we're spread so thin that we don't have the emotional resources to be like, "oh, I noticed some tension. We should work that out," or, "we should talk through it or explore what this means to us." We just kind of bury it, or get mad at each other for it, as though we're not allowed to

> have disagreements. I wish I had more opportunity to explore tension in a healthy way with my colleagues (Participant 8).

The Subjugation of Anti-Oppressive Approaches to Service Delivery

The second subtheme that related to how social workers believed they were seen by others was the subjugation of anti-oppressive approaches to service delivery. Anti-oppressive practice approaches argue that individuals must always be seen in their social context and, in palliative care settings, social workers practicing with AOP frameworks are compelled to interrogate the taken-for-granted dominance of the medical model and its exclusion and devaluation of other practice approaches. Many participants stated they received their education from social work programs that were framed by anti-oppressive theory, and they shared that their education is frequently at odds with the expectations of the efficiency-based, neoliberal healthcare settings where they work. Many participants reported that they are dissuaded from using AOP frameworks and are often given a negative label such as "difficult" or "shit-disturber" when they attempt to challenge taken-for-granted assumptions or raise critical consciousness about oppressive structures in the workplace. As one social work shared, "I've [seen social workers] from my team pulled aside to [be told] that they are being negative and they need to get their act together" (Participant 12).

Goffman (1963) used the term *stigma* to describe situations of the individual who is disqualified from full social acceptance. For Goffman (1963), stigma complicates everyday interactions whereby stigmatized individuals may be cautious about engaging with those who do not share their stigma, and those without a certain stigma may disparage, ignore, or avoid stigmatized individuals. Furthermore, Goffman (1963) believed that stigma reproduces social inequality through the maintenance of group hierarchies, something that participants in this study experienced according to their reports that they were pressured to conform to the medical model

expectations of the dominant groups in the workplace. Those guided by AOP frameworks were subjected to stigmatization practices, as described below.

Several participants discussed how differences in practice philosophies among social workers on their teams was a source of tension. While skilled social work practitioners ought to use respectful and consultative approaches with clients, and often include advocacy and policy critique in their practice, there is an apparent divide between those who align with anti-oppressive practice and/or critical frameworks and those who see problems in a depoliticized way. These "mainstream" social workers (Baines, 2017) sometimes ignore inequities and the way injustices are embedded in the way institutions are structured. According to one participant, "there's a spectrum even within our profession. There's people who have gone through anti-oppressive schools or programs...and there's other people who have gone to some schools that are very...clinically based, that don't really ascribe...being anti-oppressive; not at all" (Participant 12). Some participants described instances where they were asked to think and behave more like their social work colleagues who did not frame their work with AOP principles. According to one particular participant, this felt like being asked, "'why can't you be more like so-and-so who went to [name of university] and who actually reinforces some of these paternalistic culture [characteristics]...rather than being who you are?'" (Participant 8).

For these participants, the philosophical divide between themselves and other social workers created tension as it related to the perceived cause and purpose of the work that they do. As another participant shared, colleagues with a "mainstream" approach to practice emphasize professionalism, career advancement, and expert authority, leaving little or no space for the struggles of clients and/or a consideration of system-level issues. The following quote, taken

from a participant who was describing a social work colleague who had moved into an administrative role, demonstrates this divide:

> [They are] about policy, but not challenging government policy or systems. [They are] about accreditation, doing things according to the man, and making sure that [the organization] shines...I get the point, but I think it's bullshit. I think that if we were really into quality improvement, we would...listen to people's stories and see how we could do it better. And I think right now we're just ticking boxes, and we're doing it for the wrong people (Participant 7).

These participants shared that several factors compounded the tension they experienced when comparing themselves to and interacting with other members on their team. Given the scarcity of funding for and relatively small number of positions in psychosocial services in palliative care settings, and the aforementioned beliefs of being devalued and underappreciated, many social workers feel insecure in their employment status and threatened by their colleagues. According to one participant, social work teams are understaffed as it is, and the lack of funding and/or intent to expand the team can contribute to feelings of job insecurity and fear:

> When we have conflict, it really comes from people feeling like somebody else was stepping on their toes or doing something. And I think that comes more from the environment we're in... there's only so much pie to go around...I feel fear all the time, like, I could get kicked off the island (Participant 12).

This participant explained that colleagues whose job performance most closely resembles the expectations and philosophies of the organization are more likely to be retained, while those who practice with AOP and/or critical frameworks are under heavy scrutiny and feel insecure in their job. They described that situation as such:

> If we were in an environment where we were acknowledged and celebrated for the work that we do, or just felt valued, there wouldn't be that sense of being threatened... if I step out of line, if I don't do my job, I don't perform those outcomes that [management wants], then I really can't provide for myself. There can be some stepping on toes by [social workers] just to prove themselves...it comes from a place of fear (Participant 12).

For many of these participants, tension existed when they were faced with the choice of practicing according to AOP values or aligning with the values of the healthcare system they were working in. Many participants likened this to “selling out”, sacrificing AOP values in the name of self-preservation and job retainment. According to one participant:

> I feel this tension about where I want to be practicing and what my practice actually looks like...I look at the bigger picture and think, “yes, I'm aware that this is how I want to be practicing and I'm just not there right now” ...I'm actually not living my [AOP] values at all times (Participant 8).

Indeed, the silencing and subjugation of AOP approaches to service delivery may also contribute to the lack of social workers being considered for management positions in healthcare settings. As participants noted, social workers seldomly held leadership and management positions. These participants shared a belief that this exclusion from these positions may be a consequence of stigmatization and the perception that they are disruptive, non-team players for bringing a critical lens to organizational processes.

Anti-oppressive approaches require social workers to assess the person and consider the context of their lives, which calls for an understanding of the complex intersection of biopsychosocialspiritual factors. These social workers also examine sociopolitical issues within a client’s environment that are contributing to their struggles. In reality however, they are expected to practice in a significantly different way, especially in palliative care settings that ascribe to a short-term, standardized, one-size-fits all, pathologized, and decontextualized model (Brown et al., 2021). This was difficult for many of the participants in this study. In general, participants shared the belief that the medical model uses a simplistic approach that does not recognize the complexities of client’s lives and experiences; the larger context within which clients live and operate. One social worker described how they are positioned to “see the system...the whole

picture...[that other medical professionals] don't see...the nurses are excellent...but they don't see it. They don't see all the other stuff going on" (Participant 13).

Indeed, many participants also described how the systemic issues that impact clients are ignored by the medical model that pathologizes their experiences and implies their concerns are a result of individual failures or deficits. This partners well with neoliberal ideologies that undergird the palliative care settings where participants work as this ideology promotes individual responsibility of their own circumstances and there is no attempt to understand the impact of problematic systems that perpetuate oppression. Participants reported that their efforts to raise consciousness about oppressive and marginalizing structures did not seem welcomed in the existing system. One participant described situations where they "had a critical perspective that [they] wanted to bring to the table about how things might be different [and] there was a whole bunch of defensiveness" (Participant 12). Another participant described how they are dismissed by colleagues when they offer critical suggestions for change. According to them, "social workers are trained in being critical, that's what we do, but every time that we name something that might be the potential to be changed, or it might be a problem, [we're told] that we're too negative" (Participant 1).

Tension Between These Two Perceptions of Reality

The third overarching subtheme that emerged from the data was related to factors that compounded the tension between how social workers perceive their own reality and their reflections on how they are seen by others. Here, two additional subthemes emerged: ideological tension and conflicting paradigms, and the organizational context of practice.

Ideological Tension and Conflicting Paradigms

One's beliefs about what motivates actions and explains outcomes in the social world informs their values, what they believe is possible to achieve, and their beliefs about the overall nature of social relationships. When individuals hold differing ideologies and practice from different paradigms, it can create tension and can contribute to strong reactions from either side. Many participants discussed tension that is created by the imposition of hospice and palliative care values onto themselves and clients and their families. One such dominant ideology is that end-of-life care is uniquely special work. End-of-life care has been described as being intimate, important, and sacred work, and those professionals who deliver palliative care services are described with epithets such as heroes, angels, and otherwise special individuals (Middleton et al., 2018; Tempero, 2017). This discourse has the potential to influence the expectations placed upon those who work in palliative care settings. For example, when discussing the temptation to cross boundaries while providing care, one participant described this phenomenon as such:

> A lot my colleagues work very long hours, or take calls, or give their personal cell...it's less common in other sectors of social work or in nursing even...there is this temptation to feel special for the work that you do. And I think this feeds into the desire to work harder, longer hours and to keep up this idea that you are special for doing this work (Participant 8).

For many participants, this temptation to transgress one's own boundaries has become almost-expected behaviour in palliative care settings. Social workers are routinely taught about boundaries and self-care as cornerstones of ethical practice, which inevitably puts them at odds with these expectations in the field. Furthermore, those who opt to maintain more rigid boundaries risk being stigmatized. For example, one participant shared that "colleagues do not respond well" (Participant 7) when they establish boundaries. Although this participant has colleagues who work long hours, they stated that it was important for them to "remain

unwavering in [their] own boundaries," and not work more than they are paid for, give out their personal number, or keep their work phone on them at all times. While these are reasonable boundaries for this particular participant, they shared that the boundaries are unpopular with their colleagues and that when they suggest colleagues partake in similar practices, they are looked at "like [they are] an alien."

As one participant explained, the normalization of boundary transgression has become stabilized as a local discourse in palliative care settings; reinforced with rewards and recognition and serving as an indicator of passion and high-quality job performance. However, this normalized and adopted expectation affects the workers whose boundaries become transgressed. For example, the following quote describes the idea that health and allied healthcare providers in palliative care settings must be ever-present and accessible in order to meet all of the needs of the client and ensure they "die well":

> The idea behind the savior complex is that you transgress a lot of your own boundaries in order to provide what you believe is high quality care for vulnerable people...in palliative care you're actually rewarded for that behaviour. It's seen as going above and beyond...and that creates a lot of tension for me (Participant 8).

According to participants, the expectation to have lax personal boundaries was reinforced through mechanisms like acknowledgement and appreciation from other staff and management and by workplace practices like performance appraisals and peer reviews when those practices are emphasized as being "good team behaviours" and "going over and beyond for clients." Transgressing personal boundaries for the sake of working more was a common concern as evidenced by the many participants who described tension between being caught up on work responsibilities and setting a boundary for personal time. As one social worker shared:

> [There is a] tension to do the work beyond the time allocated...I have kids who are growing up and you don't want to be missing [those times]...It was actually easier when my daughter was dancing because I could drop her off, go see a client, then come back

> again and pick her up. It was like...it didn't count as overtime. It was like a cheat I would use...[there is] a pressure that I feel...I actually have a really hard time going on a holiday for just a week now (Participant 13).

Many participants discussed how these boundary transgressions impacted clients as well. At times, health and allied healthcare providers employed in palliative care settings may make decisions in the best interest of their clients or coax the clients to make care decisions that are in their own best interest, especially as it pertains to resuscitation preferences or location of death. This behaviour is an example of the paternalism that is embedded in the medical model. For social workers in this study, these behaviours were at odds with their ethical responsibility to honour client's self-determination and autonomy. As one participant shared:

> It really pisses me off...this is not for healthcare providers...for volunteers. This is not about you. I know this makes you feel good...this isn't your fucking journey. (laugh) This is this person's journey, and we need to really honour this person, and meet them where they're at, and listen to what they identify as being their needs...and I don't think we do it. (laugh)...it's that, we are going to define what they need at the end of their lives, rather than letting them call the shots (Participant 12).

Beyond boundary considerations in palliative care, the medical model itself is a large contributor to tension due to conflicting paradigms. Many participants discussed the conflicting values of the medical model and their idea of social work's approach to care. When the hospice movement gave rise to palliative care, it allowed the integration of the medical system into what was once a community-based response to the care for the dying (Rosenberg, 2011). Today, hospice palliative care more closely resembles an ancillary service of the broader healthcare system than the alternative option the pioneers of the hospice movement initially envisioned (Rosenberg, 2011). Social workers provide a perspective that places medical treatment into a wider context and considers care differently than care in medical settings. This includes assessing for biopsychosocialspiritual and practical needs with a focused consideration of the client's life when they are not interfacing with the healthcare system. As one participant shared,

it is imperative to consider “all aspects of a person’s life” when providing comprehensive, holistic palliative care, which includes:

> Looking at how are they managing. How are they coping? What are their beliefs, their values, their understanding of death and dying? And how is that impacting this journey that they're experiencing? That's the part that moves people and goes from a bad death to a good death (Participant 3).

A large portion of participants voiced their frustration with working within a paradigm that neglects the full context of clients’ lives. Indeed, the medical model presents barriers to exploring the person in the environment and/or the context of clients’ experiences. This creates challenges for social workers in palliative care settings, given the fact that understanding the person in their environment is an essential principle in social work practice. Participants explained that, according to their professional values, they should strive to empower clients to recognize and navigate the variety of environments that impact their overall wellness. This involves taking the time to understand the broader context of clients’ lives. Many participants shared that not only are they not afforded enough time for these exploratory conversations, but the person-in-environment approach is rarely considered by their healthcare colleagues. This is a very apparent source of tension. One participant noted the importance of understanding the whole client, including their environment:

> I feel that [sometimes] the person’s whole self [is] not being considered. Their spiritual self, their mental self, their existential self. They’re having an existential moment where they just don’t feel like they’re being supported. And I’m not trying to completely generalize, but a lot of nursing people struggled to think about [that]...because you haven’t asked them if they’re feeling any emotional pain or you didn’t even consider the fact that their daughter just died this year in COVID times and now they’re dying alone (Participant 6).

Social work activities can include supporting clients to meet their needs, advocating for larger system change, and developing clients’ coping skills. This contrasts with the main goal in the medical model of curing and/or fixing individuals’ ailments. As one participant shared, this

difference in paradigms can be frustrating for nurses and physicians "because they can't fix [some client's] pain" (Participant 13). This was echoed by another participant who stated that they "go head-to-head with the nurses when they feel like that's all that palliative care is; medicalization. When [social workers] know that it's a holistic approach to care" (Participant 6). Another participant suggested that "in medical care [the focus] is to cure and to treat – [and so] it's probably really tough for [nurses] not to fix something" (Participant 8). Many participants suggested the difference in goals of care and values between social workers and their healthcare colleagues can create tension when nurses and physicians do not see the benefit of psychosocial support, especially when they are focused on "fixing the problem." These thoughts were echoed by another participant who described tension they experience when they witness the subjugation of client's voices in healthcare conversations:

> I know that good death and bad death has its own interpretations, but to me, a good death is if the family felt okay, (laugh) no matter which direction they went, even if it's fighting for life in the ICU...if that's what their good death means for them, that's a good death for them. But how would you know that without sitting down and talking to them? (Participant 5).

For social workers, the disconnect between the medical model and social work paradigms can be a great source of tension. One participant contrasted the "qualitative" approach of social work that explores client's experiences and relationships with other people and with systems they are engaged in, with the "quantitative" medical model that focuses on numbers and tests explained. According to this participant, social work "doesn't always fit in...there's a tension there for sure" (Participant 9).

As previously discussed, social workers are trained to have a critical eye for oppressive systems and advocate for the deconstruction of said systems. In palliative care however, the potential to oppress and subjugate clients can sometimes be veiled by the aforementioned

preciousness and scaredness of the work, and the exaltation of end-of-life care professionals as altruistic, benevolent, and all-knowing informants. This was apparent for many participants who believed there was a call to action for social workers to unveil these oppressive structures in palliative care settings. According to one participant:

> We really do put doctors on a pedestal as gods. We really do assuage our power to medical providers. And there really is this idea that medicine holds all the answers...I think we've replaced religion and the power that has been associated with religious institutions with medical institutions...[social workers] are the sole prophetic voice saying things don't need to be this way. And I think that sounds really kind of out there, but I really think that that's kind of the role social works plays in this system (Participant 12).

The Organizational Context of Practice

The second subtheme is related to the context of the organization, which includes the broader environment in which the organization operates, and refers to the internal and external issues relevant to the activity of the organization. Beyond the hierarchal structure of organizations and the lack of social work involvement in high-level decision-making, two additional organizational contextual features appeared to be intrinsically linked to the tension social workers experience in their daily work lives: standardization and organizational priorities.

Standardization. Many of the healthcare organizations where participants were employed embraced the notion that inefficiencies can be removed by routinizing work practices and skills. This standardization involves breaking social work practices down to their smallest possible features and documenting and promoting them as the most economical and effective way to practice (Baines, 2017). For many participants in the study, the move toward standardization not only removed their autonomy and discretion, but it also resulted in a reductionistic and narrow understanding of what social workers do. For example, when discussing the standardization of practice, one participant shared that “there’s a tension there about autonomy and professional common sense” (Participant 7). Rather than viewing a meeting

with a client as an open-ended, reciprocal process of relationship building, participants described meetings that made use of standardized assessment tools. These assessments typically focused on very narrowly delineated aspects of clients' problems and left out most of the larger context that skillful social workers endeavour to understand. Indeed, participants voiced their frustration with the tendency of standardized assessments to leave out important aspects of the client's journey. This was described by a social worker quoted below:

> If I go into a home with a palliative person, especially the first few times, I find I'm mostly just learning about that person and their family. But the expectation is, you go in and you do the assessment day one...I'm counselling a women who's only 43, she's got four children, she's got advanced stage four breast cancer. She's going to be passing and she's got to figure out how to say goodbye to her children. That assessment isn't going to really do much for her (laugh)...communication and legacy work [are] the two most important things, but that assessment would've identified something different (Participant 4).

Another participant lamented the movement toward standardization in general and how it encroaches on fundamental social work activities like case noting:

> A social worker job is...not a check mark. It's not a standardized measure. I feel like we're being now held to a standardized measure...they said that even the way that we're going to fill out case notes, it's not going to allow for much description (Participant 1).

Not every participant disagreed with standardization. One participant voiced their support by describing a situation whereby, "if a patient goes from one unit to the other, they get different social workers. So yes, there's going to be like a different style, a different personality, but overall, the messaging [remains] the same" (Participant 7). That said, a large majority of remaining participants described frustrating scenarios where they felt the need to justify their practice decisions when they subverted the standardized process. For example:

> Sometimes there's a very big difference in what maybe me as a social worker...has decided the priorities of care would be versus maybe what a medical model, or a nursing model of case management would want to address...I'm having to always explain assessments, ideas, rationales, sourcing, how we're prioritizing certain things (Participant 4).

In general, social workers employed in government-funded organizations are restricted in the amount of time they can spend with each client and the types of services and support they are able to offer. Furthermore, the number of clients they are expected to see and the timelines by which they must see them are dictated to the social workers by administrators, and their performance is monitored via statistical forms. This was also true for a large portion of participants in this study, and they described an intense frustration with this model of work. One participant shared the following:

> Instead of being paid per visit, they decided this time, "you're going to have like 21 hours or 22.5 hours a week. So, you should be able to 32 in-person visits as a social worker in this broad geographic area, three days a week with paperwork and everything else that [is required]."...I'll go in [and] it's an hour...it depends on the client, but you're counting on a solid hour with each person...[nurses] see three in an hour because they go in, they dress the wounds and then they leave...so the numbers are absolutely not equivalent and not understood (Participant 13).

As part of standardization, every social worker in this study stated that they are expected to keep statistics that demonstrate the work they do each day. While statistics often require social workers to keep track of the type of activities they partake in (for example, counselling, facilitating groups, joint client visits accompanied by other professionals, and administrative tasks), participants believed that their true purpose was to quantify their work and surveil their progress toward meeting performance objectives assigned to them by management. For many social workers, these statistics not only take away from their time with clients, but they also fail to accurately capture the work that they do. As one participant described:

> It's all based on how many patients you're seeing. If [I] had somebody who's either dying or the family are really distressed, I might take all morning to see them. But yet I only saw one patient or family. And so that doesn't get looked on well. I think there's some level of understanding, but the bottom line is the numbers. So, I don't think it properly, particularly in palliative care [captures what we do] (Participant 3).

Many participants opined that the statistics they are required to keep ought to reflect the breadth of the work they are doing in palliative care settings. According to one participant, "we're using measuring and tools and evaluating concepts that don't actually show the principles of what we do" (Participant 4). This participant suggested that in order to fully grasp the work social workers do with individuals who are dying and their surviving loved ones, the evaluation metrics must do a better job of "lining up with the principles of what [social work] offers."

This sentiment was echoed by another participant who stated: "there's human presence. There's a caring [social worker]. That's what it all was boiled down to. How do you quantify that?" (Participant 3). Perhaps this was put more eloquently and succinctly by another participant who claimed that "there's nothing that frustrates me more than this piece of shit statistical form that we have (laugh)" (Participant 1). Finally, one participant offered a suggestion on how statistical forms should be more accurate to social workers' work, which would in turn convey more "respect for the work that [we're] doing, like to see it as vital and important and useful" (Participant 4).

Organizational Priorities. The second organizational contextual feature linked to tension was organizational priorities. In general, participants described a disparity between the priorities of the organization where they were employed and the work they do as social workers. Based on Foucault's (1973) writings on discourse, workplace discourse informs and encompasses spoken and written interactions occurring in that setting. Every organization develops a distinct culture and distinctive communities of practice, and workplace discourse produces particular activities and ways of behaving and systems of shared understandings. When employees disagree with these practices or the focus of organizational priorities, it can make the job challenging to complete Similarly, Goffman (1983) wrote that organizational artifacts such

as mission statements, goals and objectives, and strategic plans function as tools to reduce choice rather than guide it. For participants, this reduction in choice creates tension. Participants described three aspects of organizational priorities that contribute to their tension: a misalignment between organizational priority and social work values, a disconnect between management and social work, and the fundraising imperative.

Participants stated that they frequently managed tension between practicing in a way that they believed was aligned with social work philosophies and best supported their clients and following the direction and rules of their workplace. As one participant explained, there was often a misalignment of goals between organizations that are focused on process statistics and system flow and those of the clients:

> I get caught up in the hospital system of getting people out...I feel pressured... I'm the one having to be like, what I'd call the bouncer, [and] that goes against who I am. It's not within my scope of practice or me personally. So it causes me tension. That need to please my institution and my need to provide good care to patients and families within my professional scope - I feel it being compromised (Participant 3).

Many participants who work in hospital settings shared the same feelings. The strong emphasis on discharging individuals to hospice or community-care often came at the expense of taking the time to get to know these individuals, providing emotional support, and working at their pace. As one participant described, that organizational priority compromised the support social workers were able to provide individuals and their families and created a tension between their social work ideals and the actual job they performed:

> Most social workers go into social work to help people, and a lot of social workers that I know who have moved out of discharge planning will say, “I really struggled with that job because what I was doing wasn't always in the best interest of the patient in front of [me]” (Participant 7).

Other participants took umbrage with the tendency of organizational priorities to reflect the preferences and interests of those in administrative positions rather than those who receive

services. Modern palliative care services have long-since evolved from the original vision of the pioneers of the hospice movement, whereby they now reflect the preferences and priorities of professionals who are responsible for fundraising, service provision, governance, and strategic direction. End-of-life care services represent the ideals of those who design, govern, and deliver care, thereby presenting the risk of marginalizing clients who may have alternative or differing priorities, beliefs, and/or values. This created tension for social workers whose focus was to support, advocate for, and empower vulnerable groups who experience marginalization and social exclusion. Working for an organization that perpetuated marginalization via policies and practices was frustrating for social workers, as illustrated by the following quote:

> The board, the agency, our volunteers...a lot of them are lovely white, upper middle-class [individuals]...it's a very small handful who are like, “yeah, I'm willing to go into the home of somebody who might be [using drugs]”...[rather, it is] “I'm [not] able to go into the home where it's not necessarily so clean”... [they are not] comfortable with [those] people [and] don't like going to the mess. But the problem is death and dying is messy. It's dirty. We've Othered the dying. Hospice palliative care was founded on the margins and it pisses me off that it has been appropriated and just aligned with this Western upper middle-class. It's been whitewashed (Participant 12).

Furthermore, the appreciation and admiration of hospice and palliative care services has heightened its attractiveness as a spot for board involvement and career opportunities. Indeed, one participant described how the attractive status and reputation of being involved in end-of-life care draws people into the field for the wrong reasons. They criticized this group of individuals for focusing on their “image” and “making [themselves] feel good about the work that [they] do” rather than focusing on supporting people to live and die in a way that is meaningful to them (Participant 1).

A disconnect between management and social work is another aspect of organizational priorities that can contribute to tension. Managers are responsible for planning, monitoring, analysis, and assessment of all necessities an organization needs to meet its goals and objectives.

These goals and objectives are established under the direction of senior leadership and/or boards of directors. In general, participants shared the belief that management (and organizational priorities as a whole) were disconnected from them and the work they did with clients. These participants experienced role strain and tension when they presented an image harmonious with the organization's expectations that was incongruent with the image they presented to clients and colleagues. For one participant, this created a tension when they were faced with a decision about whether they "value the wellbeing of the organization ahead of the wellbeing of the people [they] serve" (Participant 7). There was an apparent tension for social workers who were faced with a choice of honouring their workplace priorities or supporting clients whose priorities and preferences differed. As another participant stated:

> Do I [prioritize] the wellbeing of somebody else's agenda, the donor's agenda, the donor's perspective, who happens to be the people with money most times? Their values may not align with what is actually in the best interests of...clients who are marginalized. That's where a lot of tension lies (Participant 12).

Participants also described how tension was exacerbated by the fact that management were making decisions about social workers' jobs and responsibilities without their input. According to many participants, decisions were often made in the interest of donors and administration, and those decision-making conversations included professionals who were disconnected from the social workers and the work that they do. It was apparent that tension resulted when power was concentrated among a select few at the top of the organization. Social workers shared stories of having new ideas for programming, promotional messaging, and human resources stifled by senior management and boards of directors. One participant had the following to say when describing a situation whereby their proposal for a new service was denied:

> If there's someone at the director level that does not want the change, it's going to trickle back to us...there's a political agenda that needs to serve the board of directors, and if the board of directors are not in agreement, then guess what? We're screwed (Participant 1).

Finally, participants lamented the fundraising imperative of many palliative care organizations. With the decline of the welfare state, voluntary agencies have become largely responsible for assisting citizens and providing care. Under neoliberalism, diverse tasks of the government have devolved to community associations and agencies, including end-of-life care. Many community-based and government-funded agencies receive modest, unpredictable, and heavily regulated funding. Not only has this finite, short-term funding contributed to the rise of accreditation - an ideological discourse that reframes frontline priorities to gathering reportable and quantifiable outcomes – but it has also made fundraising a priority in order to sustain services. According to a large portion of participants, fundraising has become the main focus at their organizations, with client care being reduced to a mere story to tell in order to raise more money. As one participant explained:

> I call it the fuckery...something is going on here that doesn't feel ethical to me in terms of ambulance chasing and collecting names so that we can get donations...the closest I can come to describing the fuckery is that sometimes we behave like a fundraising organization that happens to do healthcare, instead of a healthcare agency that happens to fundraise our dollars (Participant 8).

Unfortunately, for many participants, successful fundraising does not always equate to more robust psychosocial support. In general, participants stated that funds were rarely allocated to psychosocial services, nor did they result in more social workers being hired. According to one participant, their workplace was "willing to spend a lot of money on fundraising, but [they] can't give me, like one more of me" (Participant 13). Compounding this frustration was the fact that some organizations asked their employees for donations. Many participants shared that they were approached for donations by their organizations and/or pressured to attend numerous

fundraising events throughout the year. These were the same employees who felt devalued, under resourced, and excluded, and now also felt offended by these requests. As one participant shared:

> They're asking the employees to donate to themselves...I told my boss, if she wants to start paying me for my overtime, I'll think about it. (laugh) I said, "you give me another staff person, so I don't have to work overtime, and I'll definitely think about it. But you ain't getting a penny out of me when you're getting all this free labor" (laugh) (Participant 13).

Ultimately, the following quote sums up the tension created when the priorities of the organization are at odds with the needs of the clients being served. As one participant explained:

> It's that constantly balancing the needs of the [organization name] versus the needs of the patient's family. And then here I am in the middle. Trying to balance the two and it's a balance act. It's like a tight rope sometimes. And it creates a lot of tension (Participant 3).

Managing and Balancing Workplace Tension

The final major theme that emerged from the data was managing and balancing workplace tension. When participants were asked about how they manage tension, three main strategies were discussed: speaking up, coping with it, and using it for change.

Speaking Up

Although some participants felt like it was futile to address tension with their colleagues and/or management (e.g., "knowing that maybe nothing will change, even if you do bring it up, but you're not gonna really be heard anyways" [Participant 2], and "we just bury it" [Participant 8]), others believed that speaking about it was helpful. While a small portion of participants preferred to speak about the tension directly (e.g., "sometimes, I just call the elephant in the room" [Participant 3]), many others discussed having the conversation delicately and approaching the topic gently. According to Goffman (1959) interactions are viewed as "performances" that are shaped by environment and audience, constructed to provide others with

"impressions" that are consonant with the desired goals of the actors. In order to achieve the goal of addressing (and thereby relieving) tension while still maintaining a favourable impression among colleagues, participants described ways in which they soften the conversation. This was exemplified by participant statements such as, "the best thing is to be open and honest about it, but at the right time and with the right attitude" (Participant 1), and, "I will mention it in a very informal and casual way" (Participant 10). Goffman (1959) also described backstage behaviours, which occur when an individual believes they are free of expectations and norms that dictate front stage behaviour. The backstage can be used by individuals to help them prepare for their next front stage performance and can be likened to informal conversations with colleagues. Many participants described how their team played a vital role in helping them cope and manage tension in the workplace, and participants shared how they utilized informal, closed-door conversations with colleagues to discuss tension and strategize how to address it with other colleagues and/or management. As one participant described:

> When I was in [the office] it was the one colleague that I felt comfortable with...one night I broke down...it was the end of the day when no one else was around...I broke down and told her everything and asked her, "you're the veteran here, what would you do?" (Participant 1).

Coping with It

Participants also shared common coping strategies for dealing with workplace tension, such as deep breathing, cognitive reframing, using humour, and ventilating feelings to loved ones after work. Interestingly, a small portion of participants stated that, when faced with tension related to balancing the values of social work with job responsibilities, they used strategies to help them distance themselves from their professional values, likely in the name of job preservation. While role distancing is often an act of presenting oneself as being removed or at a distance from a role they are being required to play, it seemed to also be used to ease tension

when social workers felt as though their behaviours at work were at odds with their professional values. As one participant explained, distancing themselves from the role of the compassionate social worker buffered them from the feelings associated with not being able to practice fully autonomously and/or failing to advocate on behalf of clients or fully meet their needs. According to this participant: "I have a heart of coal. Cause that's the only way I can walk through my day and feel like I've done a good job...if I have a heart of coal...I can be harsh or I can be firm" (Participant 7).

Using it For Change

Finally, participants shared how tension created opportunity for change. For some participants, they managed tension by taking the onus to advocate for change themselves. These individuals took up the mantle to address systemic and/or social justice issues and push for change in order to make a difference. In these instances, tension galvanized these social workers to take action to reduce or eliminate it by advocating for changes in organizational policy and procedures. For example, several participants discussed how they used workplace tension to rally together as social workers and successfully unionize at their organization, something that one participant stated does not happen "if things are going swimmingly at an agency" (Participant 8). The resolve to take action because of tension can be summarized in the following quote:

> I guess you have a choice to make...there's workplace tension and it depends on what you do with it. [Either] you're apathetic and you don't react and don't do anything, or you try and make your voice heard...take that tension to the next level and say, "what can we do to make this better?" (Participant 2).

Summary of the Results

Based on the analysis of the interview data, it appears as though tension indeed remains a difficult experience to define and explain. This can be attributed in a large part to the fact that there seem to be both positive and negative elements to it. While some participants viewed

tension as a helpful indicator that more attention is needed to some detail of practice and/or a necessary antecedent to challenging and/or changing the status quo, others believed it to be a conflict-laden experience. For many other participants, tension simply could not be defined as either a positive or negative experience. Rather, it seems to exist on a continuum between those two spectrums and varies depending on the context and how the user of the term chooses to define the experience and employ the word. Unlike other studies, this study endeavoured to invite participants to define tension and explain their experiences with it free from a pre-defined conceptualization. Regardless, participants described experiences that have caused them workplace tension with greater ease than explaining the term itself.

Participants described tension in their personal accounts of how they perceived themselves in their workplace settings. Many discussed tensions between the personal satisfaction they enjoy from providing end-of-life care and the characteristics of the job that undermine those benefits; that is, the joy they derived from their work was undermined by heavy workloads, high expectations, and minimal resources. They also described feeling devalued and underpowered as the constitution of hierarchies in their workplaces, coupled with an assigned (and seemingly accepted) lower status, not only made them seem to be of less value and importance, but also voiceless and ineffectual. Furthermore, entrenched organizational arrangements such as managers (predominantly from nursing backgrounds) who make decisions about social workers' daily responsibilities without their input, workplace policies that reduce their autonomy, and systemic concerns such as poor funding for psychosocial services, have stabilized the discourse that affirms medical professionals' status and authority and subverts the values, skills, and knowledge of social work. This was an evident source of tension for social

workers who understood the value they brought to their organizations and interdisciplinary teams.

Participants also discussed workplace tension that stemmed from their reflections of how their colleagues view them. Colleagues encroaching on the social workers' scope of practice and those that stigmatized social workers practicing under anti-oppressive practice (AOP) frameworks created tension for social workers who felt pressured and constrained in terms of how and when they can perform their job. In general, it appears that there is a chasm between the ideologies of the medical model and the perspective of social work as an applied social science. This created tension for participants who felt as though they had to subvert their professional values in the interest of self-preservation and maintaining employment. Furthermore, organizational contextual factors such as standardization protocols that reduced participants' discretion and autonomy, and priorities such as fundraising and centralized decision-making about strategic directions, all contributed to the tension that participants experienced. Finally, three main strategies for managing workplace tension were described: speaking up and directly addressing it, accepting and coping with it, and using it to try and change the status quo.

CHAPTER 5

As previously mentioned, this study was conducted to explore workplace tension experienced by social workers employed in palliative care settings in Ontario, Canada. The final chapter of the dissertation restates the research problem and reviews the major methods used in the study. The major section of this chapter discusses the implications of the findings.

As explained in Chapters One and Two, there is a lack of understanding of how workplace tension is experienced by social workers employed in palliative care settings; thus, the purpose of this study was to gain a deep and rich understanding of tension as it is experienced and understood by social workers and identify its origins and the factors that can perpetuate and sustain it. Given this purpose, this research used a qualitative perspective in an effort to better understand participants' perspectives relative to the interlocking theoretical perspectives of Foucault (1970, 1973, 1988) and Goffman (1959). The key research questions for this study were: 1) How do social workers employed in palliative care settings define and describe the term tension? 2) What are the individual, relational, and organizational sources of workplace tension? and 3) How do social workers in palliative care settings manage everyday workplace tension?

The study included the perspectives of 13 social workers employed in several regions across Ontario, and relied on unstructured, virtual and phone interviews that began with an open-ended prompt to encourage conversation. Homogenous purposive sampling was utilized to recruit social workers in the field of palliative care. The initial call for participants for this study yielded 10 interested participants, and three additional participants who were identified by their colleagues augmented the sample.

Discussion

Even though this study's participants vary in terms of practice setting and time spent in the field, these parameters did not play a significant role in terms of their experiences of workplace tension. As indicated in the findings presented in Chapter 4, the participants overwhelming shared similar thoughts, feelings, and experiences of tension. Interestingly, several sources of tension described in the literature presented in Chapter Two were absent from the commentary of participants and the resultant themes that emerged from the interviews. Little was mentioned regarding societal discourse surrounding death denial (McNamara et al., 1995), one's own beliefs about death and dying (McNamara et al., 1995), and/or one's inability to relieve suffering at the end of life (Rashotte et al., 2011; Stephensen et al., 2019; van der Riet et al., 2009). Furthermore, very few participants described tension between themselves and their clients. Those that did, however, mentioned issues such as disagreements over care decisions, witnessing family conflicts, and poor therapeutic relationships, which was consistent with the literature (Costello, 2006; McNamara et al., 1995; Rashotte et al., 2010; Stephensen et al., 2019).

Indeed, the social workers interviewed in this study predominantly described structural issues when discussing tension. This may be attributed to the fact that the current study sampled social workers exclusively, as opposed to the majority of the studies included in Chapter Two which included only small numbers of social workers in their samples. Social workers are taught to understand the broader context and larger systems that significantly shape clients' behaviours and experiences, and this may have contributed to them describing larger system issues when discussing tension. The responses from social workers throughout this study described work settings where they experienced and navigated formalized relationships of power and structure, and while this arrangement was a source of great tension at times, they seemingly accepted it as

an expected part of the culture, went to great lengths to maintain collegial relationships, and remained grateful for their opportunity to work in palliative care settings. The following discussion will focus on the topics of stabilized discourse, institutional arrangements, and presentation-of-self.

Stabilized Discourse – The Medical Model

According to Foucault (1972), discourse constitutes a body of knowledge and meaning produced by social systems. He also suggested that it is material in effect, and that these material implications shape human bodies and practices. In this sense, discourse frames the contexts within which social workers' interactions take place. Indeed, discourse is a way of organizing knowledge that produces social relations through agreement and acceptance of the discourse as fact or "truth". Power is a central element for producing discourse whereby it prescribes the rules which define the criteria for legitimating knowledge and truth within a discursive order. It also subverts alternative meanings and interpretations. Foucault (1972) described how discourse becomes stabilized, or fixed, when the commentaries of discourse continually reaffirm its meanings. Continual statements become accepted as knowledge, creating an epistemic reality that becomes a technique of control and discipline (Foucault, 1977). Those discourses that do not conform to the enunciated "true" discourse are not only subjugated but rendered inconsequential. In Western healthcare settings, the traditional medical model has become a stabilized dominant discourse whereby medical professionals are considered the legitimate sources of knowledge. This enables them to define social problems and decide how they are to be discussed (Mitchinson, 2013). This is produced and perpetuated by experts who claim expertise in that knowledge/discourse (e.g., medical professionals) and institutions (e.g., media, literature, medical settings where palliative care is provided) that lend prestige to a given body of

knowledge/discourse and give the experts the right to speak within the given discourse. Alternative forms of knowledge, those that do not align with the medical model, are all but disqualified and silenced.

Throughout this study, the majority of participants voiced their concerns about having their knowledge and professional training minimized, devalued, and misunderstood. These participants attributed this discontent to the fact that the medical model is the stabilized, dominant discourse and the perception that the ideologies and principles of social work are subjugated. This is consistent with the findings from Craig and Muskat (2013), who suggested that social workers in healthcare settings are misunderstood and misutilized despite (or perhaps due to) the variety of roles of they fill in the workplace. This belief was shared by participants in the current study, who described a general sense that many of their healthcare colleagues failed to understand and/or take the time to understand what social workers do. Likewise, the literature also emphasizes the role status hierarchies play in heralding some professionals while suppressing others in healthcare settings (Apker et al., 2005; Gellis, 2001; Goldsmith et al., 2010). In the current study, participants described an apparent prioritization and exaltation of nurses and physicians in their workplaces, indicated by the prominent role these colleagues play in the determination of care planning, management positions that are predominantly filled by nurses, disproportionate funding allocation between medical care and psychosocial services, and the overall downplaying of the complexity of social work's job. Furthermore, being rendered voiceless in decision-making conversations and excluded from workplace opportunities was a common experienced described by participants. It seems that because the local knowledge of social work is alternative to the dominant medical discourse, social workers in palliative care

settings are marginalized and subjugated. Indeed, the divide between the medical model and the values and ethics of social work was made apparent throughout the interviews.

Another interesting finding that emerged that did not appear in the literature review involved workplace tension stemming from differing social work practice philosophies. Participants discussed the discrepancy between critical, anti-oppressive approaches and the direct clinical practice, or "mainstream", approaches they are expected to employ. When asking critical questions or challenging taken-for-granted assumptions of organizational structures and practices, many social worker participants described an experience that resembles Goffman's (1963) theory of social stigma. Goffman theorized stigma to be an attribute, behaviour, or reputation which is social discrediting and causes the individual to be classified by others in an undesirable and/or rejected stereotype. Participants using AOP approaches described being labelled as negative or difficult and ostracized from meetings and leadership-level positions. These reactions contributed to role conflict among participants and, when extrapolated, may increase the likelihood that social workers will suppress or abandon AOP approaches and conform to their subjugated place in the medical model paradigm; a challenging dilemma given the apparent incompatibility of these two approaches.

Overall, workplace tensions were exacerbated by organizational hierarchies and the devaluing and disempowering of social workers, which contributed to some participants internalizing the medical discourse and being co-opted into medical dominance in order to maintain and/or have hopes of advancing their career. On the basis of this study alone, it seems that as long as the medical model remains the prevailing discourse in palliative care settings, the contributions of social workers will be minimized and they will be rendered adjunct members of the interdisciplinary team rather than an essential component. Differing value and practice

orientations offer opportunities for social workers to resist the dominance of the medical model, and this may produce tension; however, these differences can potentially catalyze improved collaboration between social work and other traditional healthcare providers. When allowed to practice according to their values and expertise, social workers offer a complementary perspective that can augment existing medical services and increase the comprehensiveness of care. When subjugated, however, that rich potential becomes suppressed.

Institutional Arrangements

Based on Foucault's ideas, discourse constitutes organizations insofar that it generates organizational realities (Putnam et al., 2008). The interplay between small-scale, little-d discourse (specific social texts, like those within an organization) and grand, big-D Discourses (large-scale orders) can produce various aspects of organizational reality, as big-D Discourses influence discourse at the various levels within an organization (Alvesson & Karreman, 2000; Jian et al., 2008). For example, and as discussed previously, the stabilization and normalization of the medical model discourse has reified doctors and scientists as authorities in society, positioning them to lead discourses with respect to many aspects of life that deal with the body and mind, especially healthcare (Haegele & Hodge, 2016). In Cottrell and Duggleby's (2016) literature review on "good death" characteristics, the authors argued that there are implications in the literature that strong cultural scripts exist that dictate how death in Western palliative care ought to look like. These authors supported previous findings from Costello (2006), who suggested that a good death is one that involves structure, medical care provider control, and client passivity. These findings are published, disseminated, read, and endorsed by end-of-life care providers and the organizations where they practice. The generally agreed upon attributes of good palliative care become an accepted standard and support the metanarrative that dying

should be well-managed by healthcare professionals. Not only does this contribute to the adopted truth that medical providers are the all-knowing experts of palliative care matters, but it also contributes to how palliative care is delivered and strongly influences how individuals and organizations define and discuss matters related to health.

Indeed, organizations that provide palliative care adopt approaches that align with the normalized medical model because these norms represent an optimal, or favourable, state (Foucault, 2008). Hence, traditional medical professionals are often put into positions of leadership that dictate organizational priorities and practices. Foucault (1973) asserts that those in power set the agenda, and their gaze allows for the identification of behaviours that do not support the norms. For social workers who are subjugated, this appears to have resulted in their exclusion from organizational activities (such as management positions) and their devaluation and disempowerment, which diminished their role and rendered them voiceless at many decision-making levels. It also contributed to workplace tension when the way they were expected to practice and the client outcomes they were expected to achieve did not align with their professional values or social work principles.

Another example of big-D Discourse that influences discourses within an organization is neoliberalism (Holborow, 2012). Neoliberal discourse produces organizational behaviours via policies that expand opportunities for organizations to improve their profit margins and efficiencies while simultaneously shrinking funds and thereby services. These policies prioritize efficiency and cost-cutting measures and result in social service organizations adopting pro-market, business-like management solutions (Baines, 2017). Oftentimes, these organizations adopt management models, organizational values, and work cultures that resemble business approaches rather than care-based approaches (Baines, 2017). This big-D Discourse affects little-

d discourse within organizations vis-à-vis hiring practices, service provision, and the introduction of efficiency measures like standardization and performance metrics. Findings from the current study are consistent with previous studies that have suggested social workers employed in healthcare settings experience tension when working under the constraints of managerialism and neoliberalism (Baines & van den Broek, 2017; Brown et al., 2021). It appeared that social workers experienced tension when they were excluded from decision-making, program planning, and/or program development conversations. They also noted that those in management positions often did not have a social work background and/or were largely removed from frontline work. This tension contributed to role strain, which was exacerbated by the loss of professional autonomy, increased caseloads, high-paced work that accompanied standardized metrics, and performance management.

Under neoliberalism, funding is typically short-term, heavily regulated by the state, cost-effective, and tied to the requirement to record outcomes in order to justify the funds and report cost-benefit analyses. These requirements result in organizational priorities that emphasize processing clients and their concerns as quickly as possible and influence the performance of frontline workers who consequentially tailor their approaches with clients in an to attempt to elicit trackable outcomes and minimize direct contact time. Given the unpredictability of on-going public funding, many organizations place a heavy emphasis on fundraising and ensure their priorities and operations reflect the stabilized and normalized medical discourse in order to demonstrate competency and secure additional funds. In this way, the palliative care organizations where participants were employed frequently emphasized the healthcare services they provided, which often resulted in the prioritization of pain and symptom management. Beyond contributing further to the subjugation of social work knowledge and skillset, this also

created a tension for participants who felt that the priority of their work was to help the organization earn donations. As one participant shared:

> Because of the funding model...[we feel] dispensable. Tension [with] fundraising, is like, "well, we can get a whole bunch of you, but there's only certain people that can get the kind of money that we can get. And if it's not for us, you're not going to have a job." But then the other side of it is, "well, if it's not for us doing as good of a job as we're doing, you're not going to be getting the money coming in" (Participant 8).

Taken together, the principles of neoliberalism and the medical model paradigm resulted in health service provision that emphasized cost-efficiency at the expense of spending, service, and resources. Many participants in this study lamented inadequate funding for psychosocial services that resulted in the provision of only skeletal services and contributed to the narrative that social work services were less important and valuable than other traditional healthcare services in palliative care settings. They also described tension resulting from the misalignment of priorities between themselves and the organization. Furthermore, although social justice is paramount to social work practice, theory, and knowledge (Canadian Association of Social Workers, 2005), the concept was frequently at odds with the "skills" many social workers in this study were expected to demonstrate in their organizational settings. In underfunded, neoliberal workplaces, measurable "clinical" social work practices are viewed and reinforced as the only necessary skills social workers ought to possess. According to many participants in this study, those who have adopted the AOP framework were marginalized due to the perception that these values were largely unachievable in the context of their practice, especially in settings produced by the neoliberal discourse. Beyond their autonomy and practice being constrained, participants also struggled to be authentic to their commitment to social work values.

Foucault and Goffman offer an explanation as to how some participants and the colleagues they described became co-opted by neoliberalism and therefore aligned themselves

with organizational priorities. Both thinkers put forth ways in which individuals are made submissive and their behaviours become controlled via mechanisms of surveillance, discipline, and socialization. Indeed, participants in this study exhibited features of docile bodies (Foucault, 1980) and obligatory participants (Goffman, 1968), whereby their capacity to resist had been diminished.

According to Foucault (1979), individuals in society experience constraints, obligations, and prohibitions that are forced upon them via mechanisms of power. In workplace settings, this can be likened to policies and procedures and other expectations that employees must follow that are assigned to them by those in positions of authority. He asserted that societal impositions of disciplinary power function to control and coerce the efficiency of human actions and practices through the use of specific technologies, like surveillance and supervision in the workplace for example. Through these technologies and the threat of discipline and/or punishment, Foucault believed human beings are subjected to forces that render them docile for the sake of productivity. To Foucault, docility occurs when individuals become so accustomed to being watched continuously that their discipline becomes internalized. Through disciplining, surveillance, and real or threatened punishment, workplaces create bodies (or employees) that are habituated to external regulation. This works to discipline the body, optimize its capabilities, extort its forces, and increase its docility (Pylypa, 1998). Participants in the current study described how their days and work were scheduled for them, how their freedom to practice autonomously was constrained by policy and procedures, how they were required to track and record their daily activities, and how they were concerned with punishment. However, despite their discontent with these mechanisms of control, the participants seemed to accept and conform to them. Many viewed them simply as a requirement of the job they must accept in order to

remain employed. This exemplified the concept of docile bodies and how it applied to participants' experiences.

Foucault (1979) asserted that a docile body is one that can be subjected, extorted, and transformed, and surveillance and supervision assist in creating optimal human beings. Thus, by keeping social workers under surveillance where they can be constantly located and organizing their time so that they progress from one task to the next, they become part of a functioning machine that is the organization. Foucault believed that various organizational technologies such as hierarchal observation and normalizing judgement govern, discipline, and correct abnormal behaviours.

Similarly, Goffman (1968) stated that certain criteria, such as being governed by a shared authority and/or being routinized and following a pre-determined schedule, contributed to obligatory participation with the purpose of meeting the goals of the institution. According to participants, managers determined many of their activities and priorities within the structure of their organizations. Furthermore, formal institutional arrangements (e.g., performance evaluations, policies, procedures, etc.) provided disciplinary mechanisms that served to control them for the sake of accomplishing the goal of supporting clients' deaths under Western palliative care principles while simultaneously presenting the social workers as competent representatives of the agency who abide by organizational policies and practices. Thus, a connection may be developed between Goffman's (1968) theory of total institutions and palliative care organizations based on the intimate nature of palliative care teams/units, the shared workplace culture, and the experiencing of functioning under continual surveillance.

Furthermore, participants in this study may have felt obligated to their organization, team, and self to achieve optimal performance. Those who identified with the norms of the

organizational culture, adopted an ideal standard to achieve a desired status, success, or respect by others within the organization. This included distancing from or abandoning professional values that misaligned with the dominant values of the agency, practicing in a way that was incongruent with one's personal philosophy of practice, overcommitting to the job at the expense of self-care or personal time, and so forth. Consequently, they began to regulate themselves as the disciplinary power of the organization was perceived to be omnipresent (Foucault, 1977). Goffman (1968) explained that members of an institution are obligated to be visibly engaged in the activity of the organization and described how individuals can become consumed in activities and exhibit overcommitment to an institution. He believed that overachieving created personal satisfaction for the institutionalized individual. For many social workers in this study, it seemed as though they justified their compliance with the organization's policies and priorities because of their own internalization of the accepted norm and their personal desire for high achievement. That said, although the compliance and productivity of social workers can be explained through these ideas, the loss of the ability to practice autonomously and use one's discretion appeared to have led to high levels of tension.

Presentation-of-Self

Goffman (1959) used the dramaturgical analysis to help explain social interactions. According to Goffman (1959), the social world is a stage upon which all individuals perform. In every social situation, individuals engage in a performance of a specific role, and every individual has many roles they play throughout their lives. In the context of palliative care settings, participants described the different roles they performed including being a care provider to clients, being a member on the interdisciplinary team, being an employee of the organization, and being colleague on the psychosocial team. Associated with each of these identities was a set

of performances; so, in every social situation, the social worker was performing one or more of these roles. Goffman (1959) believed there is an idealized sense of how individuals should act in each of their roles which dictates how they believe they should think and behave. The actual performance can either live up to this idealized performance or not.

In any performance, there is an audience. An individual can be their own audience who judges their own performance, or as is the case in most social situations, the audience consists of others. For study participants, their audiences were comprised of themselves, clients, colleagues, and management. Goffman (1959) believed that with each performance, an individual attempts to gain support or legitimacy for whichever one of their identities they are currently performing. So, in every situation, social workers determined which identity they wanted to act out, determined how they would perform, and then evaluated their performance based on the feedback they received from the given audience. To Goffman (1959), the strength of one's identity is dependent on the support and validation they receive from the audience, and it is distressing for an individual who does not receive the role validation that they seek. This was evident when participants described tension they experienced when their colleagues and/or management devalued, ignored, or negatively appraised (such as when they were excluded from organizational activities due to being labelled "negative" or "shit disturbers") their contributions.

Goffman (1959) asserted that when there is a discrepancy between the idealized performance/self and the real self that appears in performances, the performance is determined to have failed and the person loses face. He believed that individuals want to dramatize that they are a certain type of person (or professional), and those identities need to be validated. When individuals fall short of their ideal and their audience does not give them role support, they feel disappointment and/or shame. Study participants experienced role strain from performing

multiple roles that are seemingly disparate (for example, social workers advocating for their clients and discharge planners meeting hospital quotas) and felt tension when they were unable to receive validation or praise from multiple audiences, whether the audience is themselves or others.

While Foucault's work offers insight into discourses and the formation of structure within the workplaces, Goffman's thoughts on presentation-of-self provides insight into how these discourses and structures are expressed and experienced in day-to-day interactions. Participants in this study discussed multiple roles they play throughout their workday, including the social worker for the client, the social worker among the interdisciplinary team, the social worker among the social work team, the social worker they believe they ought to be, the colleague of other employees at the organization, and an employee of the organization as a whole. Each of these roles were imbued with expectations of exemplary performance; accepted norms that must be captured in performances in order for the performance to be validated and successful. Regardless of the role they were performing, participants indicated they endeavoured to maintain a favourable impression with their audience by practices such as using euphemisms or softening their message, using disarming techniques such as feigning interest and employing niceties, and using role distancing techniques. Participants seemingly experienced tension when the role they were performing was not favourably received among other audiences. This was most noticeable in their accounts of following organizational directions and priorities that contradicted their professional values and acquiescing to their assigned lower rank in the status hierarchy. Not only was it important to maintain a favourable impression with their colleagues and the organization for job security, but many participants also stated that being liked and respected, and maintaining good collegial relationships, was vital for overall job satisfaction.

Implications

Although a single qualitative study with a modest sample size cannot provide a sound basis for dictating the practice of social work in palliative care settings, this study would suggest that social workers in these settings may be experiencing a crisis of professional identity and autonomy. Many participants lamented the apparent divide between social work ethics and values and those of the medical model that dominates palliative care settings. They frequently described scenarios where they were devalued and marginalized insofar that their contributions and presence were diminished. Workplace tension seemed to be attributed to both structural processes that determine discourse and action from the top down and local incidents and idiosyncrasies from the bottom up; thus, the findings from this study have both structural and interactional implications.

As discussed, the medical model is the dominant approach in medical settings where palliative care is offered. For many social workers in this study, there appeared to be an unresolvable dissonance of beliefs and values between their social work education and the medical approach. On the surface, the philosophies of social work and palliative care appear to be compatible, whereby the focus of palliative care is to maximize a person's quality of life by effective pain and symptom control and psychosocial/spiritual support, all while respecting the person's agency and dignity with the intent of allowing the individual to be themselves (Merino, 2018). However, some have suggested that the integration of the medical system into end-of-life care has threatened the founding principles of hospice through medical routinization (Rosenberg, 2011). Today, perhaps as a result of end-of-life care allowing the broader healthcare establishment to redefine its agenda to align with neoliberal principles, the field has permitted the encroachment of medicalization and bureaucratization on end-of-life practices. While a tenet

of palliative care is determining, acknowledging, respecting, and honouring a person's values and wishes (Bakitas, 2005), it is at risk of being characterized by control and management via medicalization, institutionalization, and suppression of alternative end-of-life preferences (Blauner, 1966; Hart, Sainsbury, & Short, 1998; Rosenberg, 2011).

There have been some recent movements in medicine that have attempted to remedy the medical model's shortcomings (Fuller, 2017). For example, narrative medicine and person-centred approaches reject the disease-centred ethic of the medical model and put the clients' stories and experiences at the forefront of assessments and diagnostics. Furthermore, there has been a rise in personalized medicine, a philosophy and practice that focuses on customizing treatment for each individual receiving care, which provides an alternative to the one-size-fits-all standards of the medical model. Finally, the biopsychosocialspiritual model conceptualizes disease in terms of psychological, social, and spiritual domains in addition to the biological. While each of these approaches have gained traction, more advocacy is needed to bolster their use. Social workers are well-positioned to raise consciousness about oppressive aspects of the medical model in order to dismantle them and advocate for change. Social workers can increase clients', colleagues', and policymakers' understanding of these systems and join them to take transformative action.

The findings also imply there is a critical need to reposition social workers employed in palliative care settings in order to reduce tension. There appeared to be a lack of understanding of what social work entails and an undervaluing of the importance of social work among the palliative care team. However, social workers themselves share this responsibility. This study's findings indicate there is a need for social workers to become more assertive and vocal in raising their profile and demonstrating their value in palliative care workplaces. Indeed, participants

described a need for social workers to take a firm stance and advocate more for themselves. Furthermore, social workers simply did not appear to be represented enough in leadership positions. More needs to be done to recognize and broaden the scope of social work skills and welcome their perspectives, and perhaps this begins with removing barriers that prevent social workers from entering management and other decision-making positions. Social workers ought to be provided supervision by social workers who understand what the profession is and appreciate the diverse ways it can be practiced. This can also be accomplished by ensuring social workers are given more input on policy creation and workplace practices. Social workers have critical insight about strengths, limitations, dysfunctions, and unjust practices in healthcare delivery, and their presence should be ensured on strategic direction and policy-making committees.

To address interpersonal tension between social workers and their colleagues, this repositioning should also include doing more to integrate social workers into their teams and recognizing the value that they bring. By repositioning social work on the status hierarchy and valuing the education and skillsets they possess, steps can be taken to ensure service delivery is collaborative and contextual. Social workers ought to have the ability and freedom to link social justice and critical theory with everyday practice, advocacy, programming, and policy. Truly holistic, client-centred service is only made possible by respecting and acknowledging the unique contributions of each profession on the interdisciplinary team.

One participant discussed how they successfully unionized at their place of employment. Perhaps the creation of a social work union would safeguard the practice autonomy and preserve the identity of social workers in palliative care settings. Unionized social workers may benefit from bolstered support in their quest to interrogate and deconstruct the unquestioned dominance

of the medical model that has constrained their ability to practice and address structural inequities and barriers that exist in the current system. Unionization could support social workers to make their own decisions about service criteria (e.g., eligibility, length of service, wait times, acceptable modalities and assessments, etc.) and client prioritization, have meaningful input on continuity of care, and receive support from a social work supervisor. Furthermore, surveillance via metrics and statistical data collection forms and mandated paperwork could be regulated in an effort to provide social workers with more control over their work.

Findings from this study also have several implications for social work education. First, curriculums could endeavour to better prepare students for practice in complex interdisciplinary settings such as those in the healthcare field. This should also include necessary education on the history and evolution of social work practice. Social work students must receive the knowledge necessary to describe clearly and accurately what the values of the profession are and how they give rise to ethical obligations as members of a regulated profession. Additionally, social work education should equip future practitioners with the skills and knowledge necessary to resist and challenge hegemonic discourses that subjugate and localize their knowledge and skillset.

Second, focused attention could be given to problem-solving, assertiveness, and communication skills. There was an expressed need for social workers to speak up and advocate for themselves more, especially when navigating through workplaces where they are devalued, disempowered, and marginalized. While social workers are taught these foundational skills in relation to empowering clients and teaching coping skills, focused attention should be given to how social workers can use these skills themselves when interacting with colleagues while working in secondary settings where they support individuals who are receiving services rendered by other professional groups (for example, physicians in hospitals).

Lastly, coursework could ensure an emphasis on the importance of advocacy, policy development, and the need to establish and strengthen the social justice identity of the profession among social workers and other colleagues in the workplace. Based on the findings of this study, social workers have a keen eye for organizational, social, and political structures that marginalize, diminish, and subjugate allied healthcare providers' and clients' perspectives. Social workers should be taught how to translate critical anti-oppressive practice skills such as consciousness raising and organizing for the purpose of social action into practical application; thus, adequately preparing them to challenge the dominance of these structures. The suitability to hold administrative positions and the importance of these positions for creating new policies and challenging taken-for-granted organizational processes must also be emphasized.

Limitations and Recommendations for Future Research

There were several limitations to the present study that must be discussed. Given the modest nature of this study to fulfill the requirements of a doctoral degree, it was limited in terms of its sampling design and therefore concentrated on only one province with an abundance of hospices and palliative care settings. Despite efforts to recruit as many frontline social workers employed in palliative care settings as possible, this study presents findings derived from the experiences of 13 social workers. The modest sample size of this study makes it difficult to ascertain whether similar findings would appear in different areas across the province and/or country.

Furthermore, social workers who did not provide frontline services were excluded from the study. In future studies, social workers who serve in different capacities within organizations, particularly those who assume supervisory or management roles, should be included irrespective of their role. Social workers in supervisory, management positions are responsible for shaping

the workplace environment, which may in fact confront and/or reinforce oppressive policies and practices which in turn contribute to tension experienced by those working on the frontline of service. By including all levels of service providers, a more complete picture of the context impacting experiences would potentially be gleaned. Indeed, social workers in management, community- and program-development, and policy positions presumably experience workplace tension as well and their experiences would provide additional context and perspective.

It is assumed that the experience of social workers employed in palliative care settings varies greatly with the context of their work; including their position, the type of organization and its composition and structure, their colleagues, the region of the province where they live and work, their own individual dispositions, and where they obtained their education. Furthermore, social workers' experiences of workplace tension could vary tremendously based on the intersection of the worker's own social identities. These contextual factors play an important role in a social worker's professional socialization and how they create meaning from their work experiences. Given the aim and methodology of this study, there is one encompassing limitation to note: individual experiences are not generalizable. The reader should be cognizant of this fact when contemplating the findings that emerged from the interviews.

The findings and high level of enthusiasm and interest from the participants suggest that social workers in palliative care settings want an opportunity to discuss their experiences with tension and have valuable insights about ways to improve current workplace structures and practices. Further opportunities, using a larger and more diverse population, should be provided to enable social workers within palliative care settings to share their knowledge and practice wisdom and offer suggestions for challenging the status quo. Social workers are valuable assets to the service community and play an important role among teams. Their perspectives and

experiences must be acknowledged and celebrated rather than minimized, even by social workers themselves. Further articulation of their roles and skills may be one way to accomplish this needed education. Perhaps openly discussing expectations and roles among the interdisciplinary team may be a useful step toward empowering social workers to actively structure their own work. Ultimately, more attention should be focused on understanding what social workers do in palliative care settings in order to help administrators and even fellow social workers understand the strengths that the profession brings to these settings.

Conclusion

The findings from this study highlight elements of power and social control and ways in which social contexts produce social practices and daily interactions. The social workers who participated in this study experienced varying degrees of tension as they navigated their daily interactions at work. It was apparent that these interactions were framed by social and organizational discourse that has been stabilized and made part of the structure via control of activity, surveillance, and observation in the palliative care settings where these social workers were employed. The works of Goffman (1959) and Foucault (1970, 1973, 1988) converge to help us understand what the formative structures of these workplaces were, what knowledge was touted and accepted as true, and how these structures have become part of the everyday lives of social workers. For participants in this study, their workplaces supplied the fronts, appearances, manner, and routine necessary to deliver the necessary work of the organization, and elements of resistance appeared in the way these social workers selectively presented their performances.

Based on the findings of this study, it appears as though tension remains to be a difficult concept to define clearly and accurately. For some participants, it provided useful information about their day-to-day performances, and for others, it represented strife within their workplace

relationships and turmoil in their personal and professional values. However, it appears there is one common characteristic of tension among all descriptions: there is a strained relationship between ideas, qualities, or values which results in forces acting in opposition to each other. This presents in a variety of ways, such as differing ideologies and practice paradigms, conflicting values between professional disciplines, and disagreements with organizational priorities and direction.

In palliative care settings, it seems as though the knowledge of social work is subjugated, which diminishes the role of these practitioners, reduces their scope of practice, and minimizes their position on the status hierarchy. Indeed, findings indicate that the medical model and neoliberalism continue to reign supreme in these workplaces, which devalues the knowledge and skillset of social workers, conflicts with their professional values, and forms a barrier for those social workers interested in advancing into leadership positions. The dominance of the medical model also appears to determine which services are acknowledged, celebrated, and funded, leaving social workers to feel underappreciated and forcing them to work with skeletal resources.

Despite these challenges, it is evident from the interview commentary that these social workers love the work that they do. Many described a personal passion for palliative care and shared a common belief that they were honoured to do such special and meaningful work. Many participants discussed the extent that they go to in order to avoid conflict, maintain good collegial relationships, and receive positive appraisals from their managers. Perhaps this was the greatest source of tension of all: balancing the love and passion for and commitment to the job with feeling devalued, disempowered, and marginalized. There was a very evident tension between how much the job meant to each participant and the opportunities they felt they were denied. As one participant stated:

> I think feeling that the organization is not appreciating [us]. In my experience, and I'm only five years in, I've never met somebody who left palliative care because of a client or because of money. It's only ever been because of the organizational politics...from my experience, I would say it's just organizational tension (Participant 6).

There is a noticeable marginalization that is experienced by the social workers in this study. The current findings illuminate the pervasive issue in palliative care of professionals on the interdisciplinary team working independently rather than collaboratively. Social workers are committed to principles of inclusivity and empowerment; therefore, they have a professional call to action to advocate for themselves when their contributions are not acknowledged. Indeed, there is an apparent need for advocacy in relation to the findings of this study, such as the need for increased autonomy and respect, clearer scope of practice, and a collective voice and identity. More work is needed to acknowledge social workers' voices rather than perceive them as simply thoughtful contributors to palliative care provision. This would be an important step in validating their expertise. Social workers are skilled researchers and practitioners, and their perspectives deepen the understanding of the intersecting aspects of clients' identities and concerns. There have been persistent efforts over the years to legitimize the field of social work, which include discussing the importance of valuing social work's principles and philosophies and exploring social workers' roles among, and the processes of, interdisciplinary teams. It is my hope that this study amplifies social workers' voices and contributions in palliative care settings and chips away at the established hierarchy. Until then, we must remain rebels against the established norm.

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APPENDICES

APPENDIX 1: RECRUITMENT EMAIL TO PARTICIPANTS

HOSPICE AND/OR PALLIATIVE CARE SOCIAL WORKERS, SHARE YOUR EXPERIENCES!

PARTICIPANTS INVITED TO TAKE PART IN AN INTERVIEW

Michael Bennett, PhD. Candidate from the University of Windsor, School of Social Work, is conducting voluntary interviews for a doctoral dissertation examining tensions in the delivery of palliative care. Interview participants will be asked about their personal experiences of tension. The study has received clearance from the University of Windsor Research Ethics Board.
The interviews will be private and will last approximately 1–2 hours. You may participate via video conferencing (Zoom) or telephone. The interview will be scheduled at a time and place that is convenient for you. You will not have to travel to participate.

You will be compensated a $20 Visa gift card for your participation.

If you are over the age of 18 and provide direct social work support in a hospice and/or palliative care setting and are interested in taking part in this study, please contact:

Michael Bennett - bennetf@uwindsor.ca.

Thank you very much - your perspectives are meaningful and important, so I hope you will consider participating!

APPENDICES

APPENDIX 2: LETTER OF INFORMATION

Study Title: *Examining Tensions in the Provision of Palliative Care: Social Workers' Experiences*

You are asked to participate in a research study conducted by Michael Bennett, Doctoral Candidate, University of Windsor, School of Social Work. This study and dissertation are under the supervision of Dr. G. Brent Angell, Professor Emeritus, University of Windsor, School of Social Work.

If you have any questions or concerns about the research, please feel free to contact Michael Bennett at bennetf@uwindsor.ca**.**

Purpose of the Study
The purpose of this study is to explore everyday workplace tension in the delivery of palliative care social work services. The researcher is interested hospice and/or palliative care social workers' lived experiences of tension. As a participant in this study, you will be asked to participate in an interview to talk about your experiences with tension and how it impacts your everyday work life.

Study Procedures
If you choose to participate in the study, the researcher will schedule an interview with you that can be completed via video conferencing (i.e., Zoom) or telephone. The interview will be scheduled at a time and place that is convenient for you. You will not have to travel to participate.

This interview will be audio-recorded and will last approximately one to two hours but can take more or less time depending on you. Only an audio recording will be kept. If you choose to complete your interview over Zoom, you can choose to keep your video camera off. Your interview will remain confidential; upon registering for the study you will be assigned a unique Participant ID.

You will also be invited to participate in an optional peer validation session which will also occur via Zoom. The researcher will present the group with preliminary results and ask for feedback. Once again, only an audio recording of this session will be kept. If you choose to participate in this session, you can choose to keep your video camera off and use any pseudonym you'd like.

Potential Risks and Discomfort
You may feel uncomfortable or anxious speaking about tension you have experienced. In your one-on-one interview, you may need time on your own to process the information that comes out. If so, you will be given as long a break as you need, or we can reschedule the interview for another time that is convenient for you. During the peer validation session, you may feel uneasy disclosing your thoughts and perceptions in front of other attendees. You will be given the

opportunity to use a unique username and have the option of not sharing your camera during the peer validation session. Although I will keep the information confidential, I cannot guarantee that information will not be shared outside of the peer validation session.

Potential Benefits to Participants and/or Society
Through participation in this study, you may benefit from self-reflection about tension you have experienced and how it may be addressed. You may also feel a sense of pride knowing that your participation in the study will create new knowledge that may promote system change.

Compensation for Participation
You will receive a $20 Visa gift card for participating in an interview, and an additional $20 Visa gift card for participating in the peer validation session.

Voluntary Participation and Withdrawal
Your participation in this study is completely voluntary. If you choose to participate in the one-on-one interviews and peer validation session, but do not want to answer some of the questions, you do not have to, and this won't affect your participation in the study. If you begin the study but choose not to continue, you may withdraw at any time without repercussions. If you decide to stop the interview, you can choose how you would like the researcher to handle the data collected up to that point. If you decide to withdraw from the peer validation session, the researcher will not be able to remove your responses from the audio recorder because it will contain the entire group discussion up to that point. You do not have to answer any questions that make you feel uncomfortable. You do not have to share any information that makes you feel uncomfortable.

Confidentiality
When registering for this study, you will be assigned a unique study Participant ID. This number is only attached to your personal information in a master file that is located on an encrypted, secure, password-protected external hard drive. Only the researcher and dissertation supervisor will have access to this hard drive. Only your Participant ID will be attached to the audio file of your interview.

Audio recordings of the interview and peer validation session will be transferred from the audio recorder to the encrypted, secure, password-protected OneDrive site (hosted by the University of Windsor) for transcription and analysis, and the files will be deleted from the audio recorder once the file transfer has taken place. Electronic records will be stored indefinitely for use in future studies, publications, and presentations. Your interview and peer validation session responses will not be identifiable in any publications or presentations resulting from this study. No identifying interview or peer validation session data will leave the encrypted, secure, password-protected external hard drive.

Feedback of the Results of This Study to the Participants
A summary of the results of this study will be presented to the participants at a future peer validation session. If you choose not to attend the session, you can request to have these summarized results shared with you by contacting the researcher.

Subsequent Use of the Data
These data may be used in subsequent studies, in publications, and in presentations.

Rights of Research Participants
If you have questions regarding your rights as a research participant, contact:
Research Ethics Coordinator
University of Windsor, Windsor, Ontario, N9B 3P4
Telephone: 519-253-3000, ext. 3948
e-mail: ethics@uwindsor.ca

APPENDICES

APPENDIX 3: VERBAL CONSENT TO PARTICIPATE IN INTERVIEWS

Verbal Consent of Research Participant/Legal Representative
I understand the information provided for the study *Examining Tensions in the Provision of Palliative Care: Social Workers' Experiences* as described to me. I understand the procedure, risks, confidentiality considerations, and withdrawal options. I also understand that audio-recording is required. My questions have been answered to my satisfaction, and I am providing my verbal consent to participate in this interview. I have been provided a copy of this form.

____ _____ _____

Name of Participant Date

Signature of Investigator
These are the terms under which I will conduct the research.

_____ _____

Signature of Investigator Date

APPENDICES

APPENDIX 4: CONSENT TO AUDIO RECORDING AND TRANSCRIPTION

Examining Tensions in the Provision of Palliative Care: Social Workers' Experiences

Michael Bennett, MSW RSW, PhD Candidate, University of Windsor

This study involves the audio recording of your interview/peer validation session with the researcher. Neither your name nor any other identifying information will be associated with the audio or audio recording or the transcript. Only the researcher and the dissertation supervisor will be able to listen to the recordings.

The audio recording will be transcribed by the researcher and erased once the transcriptions are checked for accuracy. Transcripts of your interview may be reproduced in whole or in part for use in presentations or written products that result from this study. Neither your name nor any other identifying information (such as your voice or picture or the name of your workplace) will be used in presentations or in written products resulting from the study.

By providing your verbal consent, you are allowing the researcher to audio record you as part of this research.

Name of Participant: _____Date:_____

APPENDICES

APPENDIX 5: *AIDE MEMOIRE* QUESTIONS

Understanding Tension

- How is it understood?
- What does it feel like?
- What distinguishes it from stress?

Sources of Tension

- Where does it come from?
    - Personal responses to work situations/events?
    - Interpersonal exchanges/encounters?
    - Organizational factors?
    - Social/political factors?
    - Professional (social work) factors?

Managing Tension

- How is it managed it in the moment?
- How is it managed once removed from the moment?

Addressing Tension

- Available supports to help get through tension?
- Specific strategies?

Consequences of Tension

- What are some consequences from tension?
    - Resolved
    - Unresolved

Using Tension

- Can tension be used to create change?

VITA AUCTORIS

Michael R. Bennett was born Mary 14, 1984. He is the son of Deborah and John Bennett of Windsor, Ontario. He graduated from Cardinal Carter High School in 2004. From there he went on to the University of Windsor where he graduated with honours with a Bachelor of Arts in Psychology, Criminology, and Sociology in 2007. Michael graduated from the University of Windsor in 2012 with a Master of Social Work degree. He is currently a candidate for the doctoral degree in Social Work at the University of Windsor and hopes to graduate in Fall 2022.