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Résumé de l'article

Le présent article explore le vécu émotionnel des professionnels de la santé et des services sociaux lors d'une réforme dans la province de Québec, au Canada. Caractérisés par une « nouvelle gestion publique » ou un « gestionnariat », les services de santé et les services sociaux publics d'un certain nombre de pays ont subi des réformes depuis le début des années 1980 visant à améliorer leur efficacité et à en réduire les coûts (Nadeau, 1996; Hornblow, 1997; Gross, Rosen, et Chinitz, 1998; Anell, 2005; Levine, 2007; Wimbush, Young et Robertson, 2007). Bien qu'il existe des différences entre les contextes culturel et politique au sein desquels de telles mesures sont mises en oeuvre, les réformes sont régulièrement associées à des changements de structures institutionnelles et organisationnelles, à la mise en oeuvre de procédures normalisées et à la mise en place de mesures de rendement. Les réformes, et le bassin de connaissances sur le changement organisationnel, tendent à faire fi de la panoplie d'émotions que vivent au quotidien les professionnels. Le présent article examine les données de 25 entrevues recueillies à l'occasion d'une ethnographie critique d'un milieu de santé et de services sociaux lors d'une période de réforme des soins de santé au Québec (2004-2012). Il s'attarde en profondeur aux répercussions émotionnelles de la réforme afin de comprendre et d'illustrer les coûts humains du changement. Il aborde trois schémas que les professionnels utilisent pour s'adapter au changement et au conflit : l'intériorisation du mandat de la réforme, la rationalisation, et la création d'une distance entre la réforme et le soi professionnel et personnel. Importantes en elles-mêmes, les émotions produites par une période de changement servent de leçons sur les facteurs généraux de stress qui entourent la réforme, et montrent comment les professionnels de la santé et des services sociaux sont souvent pris entre les intentions visées par les politiques, les valeurs professionnelles et leurs ambitions personnelles.

THE EMOTIONAL CONSEQUENCES OF ORGANIZATIONAL CHANGE

Amanda M. Grenier
Elham Bidgoli

Abstract: This paper explores the emotional experiences of professionals in a health and social care setting during a process of reform in the Canadian province of Quebec. Characterized as “new public management” or “new managerialism,” public health and social care services in a number of countries have undergone reforms since the early 1980s that focus on efficiency and cost reduction (Nadeau, 1996; Hornblow, 1997; Gross, Rosen, & Chinitz, 1998, Anell, 2005; Levine, 2007; Wimbush, Young, & Robertson, 2007). Although differences exist between the cultural and political contexts within which reforms are implemented, reforms regularly involve changing institutional and organizational structures, the implementation of standard procedures, and the generation of outcome measures for service. The process of reform, and the body of knowledge on organizational change however, tend to overlook the flux of emotions that take place in the everyday lives of professionals. This paper reflects on data from 25 individual interviews collected from a critical ethnography of one health and social care setting during a period of provincial health-care reform in Quebec, Canada (2004-2012). The paper provides an in-depth focus on the emotional consequences of reform as an attempt to understand and expose the human costs of change. Three patterns that professionals used to adapt to change and conflict are discussed: internalization of the reform mandate; rationalization; and creating distance between the reform and their professional or personal selves. Important in their own right, the emotions produced in a period of change provide lessons on the general stressors that surround reform, and demonstrate how health and social care professionals are often caught between policy intentions, professional values, and their personal ambitions.

Keywords: Health-care reform, social care, professionals, public policy, institutional ethnography, workplace stress, new managerialism

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Abstrégé : Le présent article explore le vécu émotionnel des professionnels de la santé et des services sociaux lors d'une réforme dans la province de Québec, au Canada. Caractérisés par une « nouvelle gestion publique » ou un « gestionnariat », les services de santé et les services sociaux publics d'un certain nombre de pays ont subi des réformes depuis le début des années 1980 visant à améliorer leur efficacité et à en réduire les coûts (Nadeau, 1996; Hornblow, 1997; Gross, Rosen, et Chinitz, 1998; Anell, 2005; Levine, 2007; Wimbush, Young et Robertson, 2007). Bien qu'il existe des différences entre les contextes culturel et politique au sein desquels de telles mesures sont mises en œuvre, les réformes sont régulièrement associées à des changements de structures institutionnelles et organisationnelles, à la mise en œuvre de procédures normalisées et à la mise en place de mesures de rendement. Les réformes, et le bassin de connaissances sur le changement organisationnel, tendent à faire fi de la panoplie d'émotions que vivent au quotidien les professionnels. Le présent article examine les données de 25 entrevues recueillies à l'occasion d'une ethnographie critique d'un milieu de santé et de services sociaux lors d'une période de réforme des soins de santé au Québec (2004-2012). Il s'attarde en profondeur aux répercussions émotionnelles de la réforme afin de comprendre et d'illustrer les coûts humains du changement. Il aborde trois schémas que les professionnels utilisent pour s'adapter au changement et au conflit : l'intériorisation du mandat de la réforme, la rationalisation, et la création d'une distance entre la réforme et le soi professionnel et personnel. Importantes en elles-mêmes, les émotions produites par une période de changement servent de leçons sur les facteurs généraux de stress qui entourent la réforme, et montrent comment les professionnels de la santé et des services sociaux sont souvent pris entre les intentions visées par les politiques, les valeurs professionnelles et leurs ambitions personnelles.

Mots clés : Réforme des soins de santé, services sociaux, professionnels, politique publique, ethnographie institutionnelle, stress en milieu de travail, nouveau gestionnariat

Introduction

HEALTH AND SOCIAL CARE is being realigned by changing organizational structures, shifting care priorities, and an emphasis on cost reduction. Characteristic of “new public management” or “new managerialism” (see Hood, 2002; Ball, 2006), public health and social services in numerous countries have undertaken reform to address the costs of services and the implications of population aging (Nadeau, 1996; Hornblow, 1997; Gross et al., 1998; Anell, 2005; Levine, 2007; Wimbush et al., 2007). Despite taking place in varied international contexts, the reforms similarly focus on altering the structure of programs and standardizing procedures across organizational or geographic boundaries (see Kettl, 2000). Criticisms of such reforms have focused on the political shift toward neoliberal priorities (Hornblow, 1997; Gross et al., 1998; Anell, 2005; Duncan & Reutter, 2006; Irvine et al., 2006; Wimbush et al., 2007), implementation of rational, technocratic and managerial procedures

(see Neysmith & MacAdam, 1999; Grenier, 2007; Grenier & Guberman, 2009), and ageist attempts to justify the re-ordering of public services (see Gee & Gutman, 2000). Academics and professionals alike, particularly in the United Kingdom, have expressed scepticism about the new managerialism, and its claims for efficiency, the feasibility of improving services while reducing costs, and the impact on persons providing and receiving care (see Hoggett, Mayo & Miller, 2006; Clarke & Newman, 1997; Beck & Young, 2005).

With the political impetus for reform focused on the necessity of change, the organizational literature tends to focus on how to improve outcomes (Piderit, 2000; Gulliver, Towell, & Peck, 2003; Fulop et al., 2005; Mizrahi & Berger, 2005). Approaches to reform tend to be quantitatively mapped out in a logical rational formula, directed by desired outcomes or procedures. The main focus is on making reforms “successful” and overcoming resistance in order to achieve stated goals. What is missing from this literature, and further, this paradigm, is the human element of change that includes workers’ actions, the meanings of such changes, and the “mess” of human emotion. The literature on organizational change acknowledges the importance of emotion in workplace satisfaction (Valas, 2006) and successful reforms (Gulliver et al., 2003). However, in the context of health and social services, individual emotions are often considered as a barrier rather than central to the change process; emotions are depicted as one of many impediments to overcome.

This paper reflects on the emotional experiences of professionals during health and social care reform in Montreal, Quebec (Canada). It is part of a series of work based on a critical institutional ethnography of health and social care reform carried out by the primary author (Grenier, 2011). In 2010, we published key findings about the reform process in this journal (Grenier and Wong, 2010). In the current paper, we return to this larger dataset to reconsider the emotional consequences of reform on health and social care professionals. We discuss three response patterns of professionals involved in the reform: an internalization of the reform mandate; rationalization; and creating distance between the reform and their professional or personal selves. Drawing on these insights, we highlight the importance of addressing emotion from the outset of reform, and suggest directions for change that can maintain consistency in professionals’ lives and foster good care for older people.

Literature Review

A review of the literature on emotion in organizational change reveals an emphasis on achieving objectives and a speedy process of implementation (Piderit, 2000; Gulliver et al., 2003, Fulop et al., 2005; Mizrahi & Berger, 2005). An implicit assumption operates: that change is for the better. This literature focuses on mobilizing workers by “bringing them onsite”

and addressing resistant behaviours. Workers are considered to hold the responsibility for implementing reform, with their emotions taken up as either a barrier or a gateway to change. Authors writing about public and private sector contexts have approached emotion as an obstacle to implementing change (see Kiefer, 2002); a barometer of the success or failure of organizational change (Ezell et al., 2002, Ware et al., 2003, Tousignant et al., 2004) a “natural” or “vital” part of the change process (Piderit, 2000; Kiefer, 2002); and a factor shaping how policy will be implemented (Kiefer, 2002; Fulop et al., 2005; Akerstrom, 2006; Vallas, 2006). Yet, there is little focus on the conflicting emotions experienced by professionals.

In organizational change, workers’ emotional responses are often considered as phenomena to be understood and managed (Piderit, 2000; Gulliver et al., 2003; Fulop et al., 2005; Mizrahi & Berger, 2005). This emphasis on “best management practices” is even deeply embedded in insightful reflections on the emotional dynamics experienced by workers in change settings (Akerstrom, 2006; Vallas, 2006). Perspectives focused on healthy workplaces and creating meaningful change through participation are less available. These elements are however, articulated by Piderit (2000), who advocates for a strategy of fostering ambivalence in the changing workplace as a means to create opportunities for dialogue. In this process, workers can constructively make meaning and engage change, as opposed to maintaining a resolutely positive or negative (i.e., supportive or resistant) stance. Piderit’s concern in this process is to “balance the need for ambivalence with the need to limit its debilitating effects” (2000, p. 791). Similarly, Fulop et al.’s (2005) study of the emotional impact of health-care provider mergers in England sought to better understand such events and “anticipate and avoid harmful consequences” (p. 119). These attempts to mitigate the negative effects of institutional restructuring on health and social care professionals provide pathways from which to consider the emotional consequences of reform.

There is however, an emerging international literature on emotion that can inform our understanding of reform in health and social care services in Canada (Thompson & Hoggett, 2012). This literature emphasizes the relational aspects and contradictions of public services (Hoggett, 2009); emotional costs of managerialism (Ball, 2003; 2006), and the impact on the identities of professionals (Hoggett et al., 2006). However, while criticisms of reform and retrenchment exist within Canada, they tend to focus on the increasing demands placed on health and social care workers, the risks experienced, and the impact of the reduction of services for particular client groups (Armstrong & Armstrong, 1999; Armstrong, Armstrong & Fuller, 2000; Kingdon, 2003; Bellot, Bresson, & Jetté, 2013). There is also a tendency toward approaching emotion as “culturally shared” rather than a means to “reproduce or challenge social hierarchy and [focus on] how the meanings of emotion are learned and creatively used by social actors to make sense of themselves and their

lives” (Holstein & Gubrium, 2008, p. 525). Focusing on emotion and the affective dimensions of policies and reform has much to offer to our understanding of health and social care reform in Canada.

Context: Background of the Reform

Initiated in 2003, with the election of the Liberal party, the Quebec provincial government began a major effort to overhaul the structure and delivery of health and social care services. Coined as a strategy to “modernize government services,” the goal was to downsize government interventions and cut public budgets (see Bourque & Quesnel-Vallée, 2014). These changes were enacted through Bill 25 (an *Act of respecting local and social services network development agencies*) which transformed regional boards into health and social services network development agencies; Bill 30 (an Act respecting bargaining units in the social affairs sector and amending the Act respecting the process of negotiation of collective agreements in the public and para-public sectors) and Bill 83 (an *Act to amend the Act respecting health services and social services and other legislative provisions*). Reforms taking place between 2004 and 2012 centralized care facilities (e.g. hospital, long-term care, and local community service centres [CLSCs]) into large community-based health and service networks (i.e. *Centre de santé et de services sociaux* [CSSSs]; community health network) and decentralized budgets to these new centralized centres (Government of Quebec, 2003a; 2003b; 2005). The CSSSs were then mandated to establish “Integrated Health and Social Services Networks” for all persons living in each territory, ensuring local residents had access to primary health-care services (e.g. preventative and diagnostic treatments), support, and institutional-based services. Closely aligned with the new public management approach (see Hood 1991; 2002), the reform emphasized outcome-based management, efficiency, and accountability (see Bourque & Quesnel-Vallée 2014).

Methods

Rationale and objectives

This paper is a detailed exploration of findings from a critical ethnography conducted in one health and social care setting in Montreal, Quebec during the 2004-2012 provincial reform of health and social services (see Grenier, 2011). According to Madison (2012), “critical ethnography is a method concerned with social justice, critical analysis and the ethical demands of fieldwork methods” (ix). “It is a method concerned with analytical and theoretical rigour, and honouring complex subjective and phenomenological meanings—elements that often contrast claims of objective truth and value” (xi). In the case of Quebec, the reform was firmly positioned as striving for objectivity and efficiency; it was also highly

politicized and contested by professional groups and unions. Critical ethnography was selected in order to understand the clash between stated priorities and experiences, identify taken-for-granted assumptions, expose “social relations that have generalizing effects,” and identify opportunities for change (see Clifford & Marcus, 1986; Thomas, 1993; Atkinson & Hammersley, 1994; Willis & Trondman, 2000; Denzin, 2001).

The site was selected for its specialized services for older people—a population deemed potentially vulnerable in the reform. Until reform, the site studied was a stand-alone CLSC (local community health centre) offering services to a predominantly older English-speaking population. Study objectives for the larger ethnography were to identify and understand the reform; document how objectives were coordinated into local practices; and identify issues that arose for professionals and older clients. The ethnographic study produced three main results: 1) the processes of the reform were unclear to those enacting the reform into practice; 2) quality of care was at threat for older people and their families; 3) the reform produced emotional conflicts for health and social care professionals (see Grenier & Wong, 2010; Grenier, 2011). This paper explores in detail the emotions that can surface as a result of large-scale reform, such as that which took place in the province of Quebec—a result that became known through the interview portion of the study (other methods of the ethnography included document reviews, review of public statements, on-site observations, and observation of meetings and public consultation).

Recruitment and data collection

The lead author was on site one day per week for four years, and periodically thereafter, as the reform lasted much longer than anticipated. The interview component consisted of 25 interviews with health and social care professionals ranging from upper management to team managers and frontline workers—all of whom came to know the researcher through her presence on-site. Participants were recruited through on-site announcements that were made by the lead author and the team leaders. The professionals have training in social work, nursing, physiotherapy, occupational therapy, as well as specialized training in eldercare. The professional breakdown of the final sample reflected the composition at the site, with years of experience ranging from junior (two to five years) to senior levels (20-plus years). Actual professional background is generalized in the findings in order to protect the identities of participants. Participants' verbatim quotes are italicized throughout.

Data analysis

The analysis focused on subjective interpretations and experiences of the professionals, including how things happened (i.e., process), levels

of knowledge, and how professionals responded to the changes. Verbatim accounts were considered in line with constructivist methods (see Charmaz, 2000; Holstein & Gubrium, 2008). Interview data were analyzed within and across interviews, noting taken-for-granted assumptions, themes, processes of meaning-making, and emerging contradictions. As the interviews unfolded, we honed in on the conflict, the lack of knowledge about the reform, and experiences of the change process. We then turned to known concepts (e.g., dissonance, rationalization, distance) to help make sense of emergent themes and responses. The literature on organizational change and observational data from the ethnographic study provided a larger context for interpretation. As it progressed, our analysis took on a critical dimension of deepening the analysis of the human dimension of “cutbacks” that are overlooked in organizational change research, and raising awareness of the impact of significant organizational change on the emotional state of helping professionals in health and social service organizations. Funded by the Fonds de recherche du Québec – Société et culture (FQRSC), the study is governed by their guidelines respecting ethics and integrity. The project received approval from the McGill University Research Ethics Board. Professionals voluntarily participated in the study and signed consent forms.

Findings: The Emotional Consequences of Reform

The emotional consequences of reform, a major finding of the ethnographic study, proved crucial to understanding the human dimensions of the change process. As researchers accustomed to interviewing professionals, we were caught off-guard by the high level of emotional conflict expressed by participants, and needed frameworks within which to understand their accounts, and raise awareness of the consequences of reform. Conducting research from “within the agency” revealed the extent of anxiety and confusion that dominated most interactions with professionals at the time. We wondered, how they could continue to do their jobs in such a state of crisis. How do they manage? The following section delves into the patterns that professionals use to cope with the emotional consequences of reform. First, health and social care professionals drew on and internalized a mantra of “making it work.” Second, they seemed to address their ambivalence and anxieties through defence mechanisms such as rationalization. Third, their responses seemed to reflect a process of cognitive dissonance used to resolve the conflict between their perceptions and the actions they were required to take.

Illustrations of Emotional Conflict

The following set of interrelated quotes helps provide a sense of what professionals experienced during the reform process. A discussion of

three visible response patterns follows. The first quote demonstrates the frustration that results from the difficulty in accessing information during the reform process, and how a lack of clear information can obstruct everyday activities. One professional said, "I believe very strongly that if the communication is not better between us, and if we don't educate the staff ... we cannot achieve any goal. And right now we're not doing that."

The second quote illustrates the instability and uncertainty experienced during the reform. In particular, the feelings of role insecurity, a disrupted sense of belonging, and the perception that the reform had failed to articulate a discernible vision for the work environment. Another professional said: "What has changed though is who my supervisor is ... what the overall objectives are ... [in] what direction are we going to go—and those are still big questions that are still unanswered."

The third and fourth quotes focus on how changes in the system were experienced by some as destabilizing on professional and personal levels, including their identity as professionals and their life goals. In the words of one health and social care professional, "... one day you have a responsibility and the next day it is removed from you, the mandates are not clear yet, which can be normal, but it sets a mood, you know, a climate." Another said: "I like to be in control of my life ... so I don't feel that I have much right now because I don't have any information ... and ... when you ask people, they can't answer you."

Quotes such as these paint a portrait of the pressures that characterize the emotional lives of health and social care professionals in the initial stages of a reform. Yet, even within this difficult climate, health and social care professionals continued to carry out their work and maintain commitments to their professions and clients. We now discuss the patterns our participants used to respond to these emotional consequences.

Pattern I: The Internalization and Necessity of "Making it Work"

Interview results reflected a pervasive "making it work," mantra used to respond to the top-down process of this reform. Consider the following statement: "Well, we need to adapt to the changes. It's like changing your frame of mind ... I used to be only in this institution and now I cover lots of institutions—so in that sense the responsibility is much larger and so you have to take it on." This alignment with "making it work" can be seen in their emphasis on adapting to change and their willingness to place the organization's needs ahead of their own. Interview results demonstrate how the success of the reform was taken on as a personal task or responsibility. Throughout the interviews, health and social care professionals articulated their need to adapt their feelings and professional identities accordingly. Hence, the prevalence of such statements as: "I have to find a way to accept that job and do the best I can with my new job." The need to adapt was imposed through a quick restructuring of responsibilities—knowledge which helps to explain their alignment with reform objectives.

Consider the following:

[We] received a letter saying that the job [their job] was abolished and that within the next two weeks ... the director would offer us a position. If you don't take that position ... then you are considered as having resigned, then you have no job [laugh], so the decision is relatively quick to take, really because I need a job.

While considered a successful means to quickly alter an organization, the imposition of new roles in a short time frame ignores the personal aspirations of the individual and professional training. It also places the needs of the organization ahead of those of care professionals. In this context, professionals discussed their attempts to balance the need to adapt with an underlying resignation that deeply affected their morale. In many cases, this was expressed through the idea of letting personal aspirations go, as articulated in the following:

The change for me—I'm not very happy with my job. In my career I was going to be _____ ... and now, I'm in charge of _____ ... it's not where I would like to be, but for the moment ... this is my place. So I have to find a way to accept that job and do the best I can.

Interview results resounded with the message that “you either work with the reform or you resign.” Not surprisingly, the participants' accounts reflected a profound loss of control over personal and professional decisions. Indeed, loss became a major, if largely under-acknowledged experience of respondents. While job re-assignment was meant to mitigate unemployment, re-assignments were reduced to an ultimatum, with new positions invoking personal dissatisfaction and larger workloads. For some, re-assignment meant letting go of former successes, years of investment in particular teams, and relationships with colleagues and clients. One participant sums up the importance of these relationships and her anticipated sense of loss: “I have invested so much of my management years in this place in terms of ... getting a better quality and a better way to clients that I would find it hard to let it go.” Together, these illustrations help to understand the pervasiveness of the “making it work” mantra, the lack of choice, the personal and professional losses experienced, and the extent to which professionals faced difficult choices between carrying out the reform and the personal toll of resigning from their positions. However, by adapting this mantra, professionals simultaneously become engaged in protecting themselves and their clients (at a personal cost of dissatisfaction) and collusion in a process, which overlooks meaningful involvement and emotion.

Pattern 2: Ambivalence, Anxiety, and the Rationalization of Change

Interview results revealed high levels of ambivalence and anxiety. Many professionals wondered if reforms would make a difference in their clients' lives, and were concerned about potential negative impacts. Ambivalence and anxieties were most present during discussions of structural change, with staff reassignment and moving between institutions increasing these feelings. Participants found themselves torn between reform requirements, professional identities, and allegiances to their clients, teams, and organizations. Many objected to the emphasis placed on structure and asserted the initial rationale for their involvement: that reform would "create a continuum of care that improved access and provided better services." This conflict between the structural changes and the vision of improved client services is articulated in the following quote:

It cannot just be structural, because if it stays structural we didn't achieve the goal. The goal is not to change the structure. [...] Our goal is that we take care of the population [clients], we give better services, faster, and that we take over a patient and we help him, we open all the doors for him, [so] that he doesn't have to knock on all the doors.¹

Interview results demonstrate that participants used rationalization to overcome their ambivalence and anxiety about the changes being enacted. Concerned that the reform would produce no change for their clients, many professionals drew on the overarching ideal of improved client services to maintain professional values of client-centred care, and justify their involvement in the reform. The following quote highlights how this belief was used to reconcile their conflict:

I think if we look at... the objective and who are we doing this for, definitely we are not doing this for ourselves—because everyone would be very happy to leave things status quo. If we are doing it to improve delivery of care to consumers and families ... then it's for a good reason.

While some professionals aligned themselves with the need for change and improvement, others addressed their concerns through a positive perspective on the turbulent reform environment. One professional says,

¹In a bilingual context where workers speak English and French, first language Francophones speaking in English in their interviews tended to use the male pronoun when it is a direct translation (client/patient are masculine). We have not corrected for this.

“We could always say the change brings in chaos—brings in loss; but from chaos other things can come out.” Despite the exact form taken, rationalization proved to be an important strategy in addressing the emotional consequences of organizational change. Rationalization allowed participants to maintain an ongoing commitment to their clients, while at the same time fulfilling reform objectives by insisting on change as positive or necessary. While beliefs about improved services and actual changes were experienced as contradictory, rationalization helped professionals to “get by” in a context where they were afforded little choice between their personal security, defending client needs, and organizational change. In all cases, however, it was the professionals who were charged with the task of sustaining high levels of ambivalence and anxiety.

Pattern III: Reducing Conflict through Cognitive Dissonance

The culmination of poor communication about the reform, little time to react, and the politics of the change itself, created conflict in the lives of the health and social care professionals. Study participants repeatedly discussed the contradictions between the goals of the reform, their professional and personal values, actions, and expectations. Participants felt uninvolved in the process, and the decisions that affected their professional and personal lives. Respondents repeatedly pointed out the lack of consultation: “I think the Ministry ... had developed a committee of experts ... but to say that we were actually consulted on our visions ... NO.” This lack of consultation and poor communication left them feeling directionless, in particular where leadership was concerned. One team manager said, “If we don’t know what’s happening, and if we don’t feel part of what’s going on, how can we tell our staff about that?” This lack of communication and consultation, combined with a rapid and impersonal reform process, also left health and social care professionals at a loss with regards to client services. Despite having little sense of the direction within which to proceed, professionals felt obligated to participate and grew increasingly sceptical of outcomes. Consider the following quote about time, “[when] the law came ... we had very little time to react,” and further how the speedy process could impact what was required for effective change: “I think that the speed at which they are trying to do it is for political reasons and I think that, like anything, if they do not invest money it is not totally going to work.”

In this context of imposed change and minimal choice, inter-related responses of “making it work” and rationalization can be interpreted as mechanisms to reduce daily stress, and are reflective of a process of cognitive dissonance whereby individuals strive to be consistent in their attitudes and behaviours. When individuals sense an inconsistency either between two or more attitudes or between their attitudes and behaviour, they experience dissonance; that is, they feel frustrated and/or uncomfortable with the situation (Festinger, 1957). The response to this

dissonance is to seek a stable state with minimum dissonance. Our study participants expressed experiencing high levels of discomfort during the reform process. The alignment with reform, rationalization of the changes, and positive spin can thus be read as attempts to seek stability. It is here that reflecting on the emotions produced during a period of reform can help to better understand the everyday experiences and conflicts that characterize professionals' lives.

Discussion

Professionals' accounts clearly demonstrate the emotional consequences of reform and the strategies used to accommodate change and reconcile conflict. In the case of Quebec, reform was pursued through a process that positioned change as positive, with workers considered to be barriers or facilitators to success. However, this approach is not unique to Quebec—the emphasis on altered structures, results-based measures, and quick change has become the dominant model of organizational change embodied in new public management (Piderit, 2000; Gulliver et al., 2003; Fulop et al., 2005; Mizrahi & Berger, 2005). The problem that emerges for health and social care professionals in such contexts, however, is how an emphasis on structure and success can overlook meaningful involvement, relational processes and emotion. Yet, while one might expect a direct clash between what appears as an imposition of change and professional integrity, the tensions experienced are much more complex. Emotions such as ambivalence, anxiety, and uncertainty can come to characterize the workplace, and create a high level of conflict as professionals struggle with reconciling expectations of reform, client needs, and their personal and professional values. At the same time, coping responses—especially as they appear “successful” from the outside—sustain the negative social relations created by managerial reform. Worse still, they do so at a personal toll.

The need to address emotions within health and social care is not new. This presence of complex emotion in public institutions such as welfare and care services has caught the attention of several scholars (see Menzies Lyth, 1960, 1988; Clarke, 2006; Hoggett et al., 2006). For example, Hoggett et al., (2006) highlight how public institutions express and uphold a necessary contradiction—on one hand they must contain and respond to the voices of service users and local communities, while on the other, they must attempt to embody principles of impartiality, fairness, consistency and reliability in their work. As a result, part of the worker's task in these institutions is to “live this contradiction” (Hoggett et al., 2006). Indeed, past research has found that public sector workers often incorporate aspects of their work into their identity (Super, 1980; Carr, 1998). This was certainly the case in our study where professionals aligned themselves with their work, their connection to teams and clients,

and the changes being carried out. Defense mechanisms have also been addressed in such settings. Brown and Starkey (2000) argue that individuals, organizations and groups employ defence mechanisms in order to maintain collective self-esteem and the continuity of existing identity. In our study, participants detailed the everyday conflicts, with professionals juggling the contradictions between the reform's intentions of better client services and cost containment. As such, defense mechanisms were used to help them "get through their days." Rationalization in particular, was used to justify impulses, feelings, behaviours, and motives that one finds unacceptable, and mitigate the anxiety caused by their contradictory allegiances (see Brown & Starkey, 2000).

Similarly, experiences of cognitive dissonance are also not uncommon in the field of health and social care, where professionals participate in emotionally disturbing situations on a regular basis. Particularly rife is the ongoing struggle to reconcile personal values and the professional moral stance of aiding clients, with the conflict between individual and discretionary responsibilities (Peterson, 2003; Mackintosh, 2007). With such conflicts already present during periods of stability, professional anxiety unsurprisingly rises during reform, as workers strive to renegotiate their role with new organizational policies and practices. Within the context of organizational change, Burnes and James (1995) identified two key factors necessary to ensure minimum dissonance: clear communication between leaders and employees, and the involvement of staff in change projects. Yet, neither of these techniques were formally integrated into the reform process in Quebec. Interviews and our ethnographic study demonstrated a lack of information, poor communication, and minimal involvement between professionals and decision-makers, which appeared to contribute to, rather than reduce, the experience of cognitive dissonance (see Grenier & Wong, 2010). Burnes and James (1995) point out that in situations where employees are required to change in ways that clash with their attitude, dissonance will only decrease "if [employees] believe, rightly or wrongly, that they have a choice as to whether to adopt the new behaviour or not" (p. 17). Our interview results lead us to believe that a lack of perceived choice contributed to the conflicts and dissonance experienced.

Interview results seem to suggest that the practice of ignoring professionals' emotions can be maladaptive to effective change and harmful to mental health. Although such contexts produce few palatable options, the emphasis on success or "making it work," can lead to complacency and/or an inability to question the soundness of policy decisions, which is a significant impediment to organizational learning (Janis, 1972; Brown & Starkey, 2000). Although focusing on achieving success can in the short term diminish anxiety or dissonance, collective rationalization by professionals has been shown to be an impediment to organizational success, especially where a transformation of identity may be required in order

to create lasting change (Brown & Starkey, 2000). In the context of our research, the reform required a number of independent organizations with individual identities to unite under a single, common identity. Without attention to the identity shift that this restructuring required, proponents of reform may find the lack of a new collective identity to emerge as a problem for the new “networked” organization. Further, overlooking the professionals’ emotional responses during the reform may mean the goal of effective change that affects clients’ lives may have been hindered. Past research has shown that if left unchecked, emotional distress in health-care professionals can lead to moral distress, compassion fatigue, and burnout (Collins & Long, 2003). Our findings lead us to believe that the process of this reform placed health and social care professionals at risk.

A number of limitations exist. While a critical ethnography allowed an in-depth exploration of the issues affecting professionals during the process of reform, emotion was not the initial focus of the research, and emerged only during the interviews and observations. As such, the complete trajectory of emotion was not captured by our study. Furthermore, limited to professionals targeted by the reform, including high, middle, and low-level managers as well as front-line professionals of various disciplines, the study did not include ancillary aides (e.g., those responsible for giving showers) or contract agencies (e.g., cleaning and meal preparation), as changes to their work and roles had not yet been determined. The decision to group professionals together for the purpose of protecting their identities may have also resulted in losing the nuances related to the particular profession of our respondents. Further, the study did not include the clients of services who were also yet directly unaffected. Although originally intended for inclusion, their lack of involvement in the reform process required that the research be modified. Finally, the emotional responses experienced by various actors in other sites of the health and social care system warrant examination, as they may significantly differ from those illustrated in this paper.

Conclusion

This paper has brought to light the emotional struggles of being caught between the goals of multiple systems—clients, staff, and organization. It has discussed three response patterns of internalization, rationalization, and dissonance that emerged in the responses of health and social care professionals. In particular, it has exposed the conflict that can exist between personal/professional values and the requirements of the reform—clearly documenting the subjective experiences that exist within seemingly objective and managerial reforms organized around efficiency. As such, it adds to a growing literature on the emotional impacts of reform, and the consequences of new public management and managerialism. While this paper explored the emotions during the

initial phases of the reform, it is important to note that responses continue to develop and change over time. What remains however, is that the emotions of health and social care professionals need to be more fully addressed throughout reform processes. Involvement and consultation are key. Professionals deserve to be informed and involved in the change process, and not simply consulted and re-assigned without their consent or input. At the same time, the findings of our ethnography, lead us to advocate for the importance of addressing emotion and working with (not against) subjective connections to teams and clients at the outset of reform. Integrating these processes into reform would represent a step toward maintaining consistency in professionals' lives and ultimately fostering good care.

While the organizational literature emphasizes the need for speedy change in order to achieve the successful implementation of a reform, the short and long-term impacts on the helping professions in health and social care settings may actualize as quite the opposite. Our research suggests that pursuing organizational needs while being blind to the emotional neglect and non-involvement of dedicated professionals, leads to internal conflicts and responses that can produce damaging effects. Viewing emotions as important in their own right, involving professionals in a meaningful way, and addressing emotions during reform become important to long-term stability and success. Policies and practices that create the space for professionals to express their expertise and their ambivalence to change can ensure the organization a healthier, and thus more successful process of change. More importantly, such frameworks build and model practices of concern for mental health, respect for professional values, and personal goals, and develop programs and organizations that reflect the needs of health and social care professionals as well as the clients and populations they are meant to serve.

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