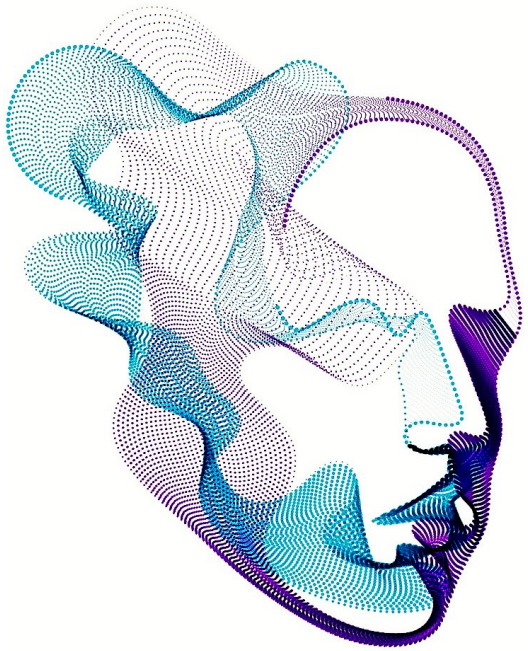

Psychedelics & Palliative Care

A Comparative Analysis of Institutional Logics

MASTER'S THESIS

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Master's Thesis Innovation Sciences - GEO4-2239X

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Abstract

The need for improved treatment options for those dealing with psychological suffering, such as end of life anxiety and depression is critical, particularly for healthcare systems such as palliative care which already tend to such patients. A promising new therapeutic treatment may be found in psychedelics such as LSD and psilocybin, which have already shown encouraging results in clinical trials dealing with such conditions. Their potential for adoption, whilst clearly significant at the macro-, and meso- level, i.e. effects of the market and state, should also, critically, be understood on the more localised micro-level, in that ultimately it is individuals who will adopt these practices. A useful theory with respect to this, known as institutional logics, describes how institutional ideas manifest in everyday practice. In this paper, I conduct a qualitative inductive methodology that draws from previous conceptualisations of institutional logics to a) identify the multiple institutional logics present in both fields, b) explore the intra- and inter-domain overlaps and tensions across fields, and c) suggest what these overlaps and tensions might mean for policy makers and professionals. This cross-case comparison, itself a novel approach to the application of this theory, was conducted through an iterative process between data collection, namely interviews with specialists, and a theoretically driven analysis. The results showed an overlapping array of conflicting logics between the two cases, with encouraging similarities with respect to many of the shared norms, values, and means of operating. For one, the holistic logics, defined by its multi-dimensional patient-centred approach to care, had a strong presence in both domains, as well as a comparable presence of two scientifically backed professional logics: the medical, and research logics. Intra-domain tensions were also consistent, mainly between the professional logics and a business-like managerial logic. A key finding, and stumbling block in the legitimisation of psychedelics, is the presence of what I define as a psychedelic logic, where issues of objectivity, and the misalignment of goals were established. This embryonic logic, mostly composed of cultural-cognitive elements, I argue will be a key factor in the legitimising process, either by aligning itself with more established logics, or becoming more established through activist powers. All in all, insights from this paper suggest encouraging overlaps with respect to the micro-level dynamics of these domains, which is important for the fact that psychedelic therapy may one day become part of the palliative arsenal that deals with serious psychological suffering.

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MASTERS THESIS

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1.0 - Introduction

Psychological and existential distress associated with life-threatening illnesses such as cancer, heart and lung disease, and dementia represent distinct and highly burdensome forms of suffering (LeMay & Wilson, 2008). Available healthcare models prioritise caring rather than curing patients, given that the diagnosis for these conditions is often terminal (Pask, 2019). The growing practice of palliative care best exemplifies this, focussed not only on physical symptom relief that typifies more conventional models, but also recognising other dimensions which require attention, such as psychological, social and spiritual pain (Mount, 1993). Despite its successes, and a growing presence of palliative practice worldwide (Morrison et al., 2005), current treatment options for psychological suffering, like end of life anxiety and depression, demonstrate limited efficacy (LeMay & Wilson, 2008). With a rise in chronic conditions and associated psychological issues globally, there is an inherent need for improved treatments and care approaches (Sleeman et al., 2019). A promising, albeit controversial, line of research lies in psychedelic therapy, which would provide treatment sessions for patients using mostly banned psychedelic substances such as LSD, ketamine, and the fungal compound psilocybin. Known for their psycho-active, sometimes hallucinatory properties, these substances offer a radical departure from currently available pharmaceuticals (Nichols et al., 2017). Rigorous clinical trials have however suggested a highly promising potential role of psychedelic-assisted therapy for a range of psychological conditions, including end of life anxiety and depression (Reiche et al., 2018; Reiff et al., 2020; Pathways, 2018). Considering the prospects for this transformative and novel treatment, the question of whether this radical therapy has a future in existing healthcare systems is an important one, particularly for the likes of palliative care which already deals with these conditions.

The case of psychedelic therapy establishes an approach to care that challenges how current care systems operate, being on the one hand an emerging scientific discipline with its own set of practices and operations, and on the other, a growing multidisciplinary care-giving approach with its own distinct norms and goals. Whether or not there is a potential for adoption within the domain of palliative care is a complex debate that requires a multifaceted understanding of how both psychedelic research/therapy and palliative care work. Whilst the science of psychedelic therapy is becoming clearer and more promising, remarkably little has been written in the social sciences. Be this as it may, theories stemming from sociology and organisational studies are particularly well suited to understand the complexities surrounding the adoption of new practices, and in how care systems change or are perhaps resistant to it. Institutional theory bodes well for such an undertaking in that it attempts to understand processes by which structures, or institutions, establish themselves and direct social behaviour (Cole & Scott, 2000).

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More specifically, in the case of institutional logics, it establishes how institutional ideas, including norms, values and means of operating, manifest themselves in the everyday practice of organisations and individuals (Friedland & Alford, 1991; Thornton et al., 2012). These insights are particularly relevant in the question of the proliferation of psychedelic drug treatments in palliative care in that it can analyse how these individual domains operate, and thus enable exploration of what the overlaps and tensions might be. Consequently, institutional logics theory acts as a tool to speculate on the potential barriers and means to resolve them, ultimately, to create meaningful change in this sector and open clinical and therapeutic doors for those patients suffering from serious psychological conditions. With this in mind, the following research questions are presented:

Q1: *What are the institutional logics of psychedelic research/therapy & palliative care respectively?*

Q2: *Where do overlaps & tensions exist between these institutional logics?*

Q3: *What are the implications of these overlaps & tensions for policy makers & professionals assessing the value of psychedelic therapy in palliative care?*

In answering these research questions, I strive to broaden scholarly debate on the promising initial research being conducted on psychedelic therapy and investigate the future possibilities of what it can offer for palliative care. In order to do so, I present results from a qualitative inductive study drawing from institutional theory that positions each care-giving approach in terms of its institutional logic and then explores the overlaps and tensions between them. The following chapters will elaborate on this. Firstly, by expanding on the two domains of palliative care and psychedelic research/therapy, as well as the theoretical framework of institutional logics used. After explaining as to why this approach is most suitable, and how it will inform the research, the research design and methodology of this paper will be presented. Finally, I will showcase the findings of the research, and build a discussion answering the research questions posed above.

2.0 - The Case of Palliative Care

Aimed at optimising the quality of life and mitigating suffering for patients with life threatening illnesses (Seymour et al., 2005), the interdisciplinary medical caregiving approach of palliative care represents a growing branch in medicine that distinguishes itself from more conventional curative approaches. By

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embodying the principles of multidimensional care for patients, palliative practice expands focus on mere physical pain relief to include the psychological, social and spiritual dimensions of the patient's experience (Pask, 2019). This diverse focus is reflected in the interdisciplinary teams which provide palliative care, which often include physicians, nurses, dietitians, psychologists, as well as occupational and physical therapists who work alongside one another (Quill et al., 2019). Central to palliative practice, and more specifically, care planning, is that decision making is shared amongst the various specialists, and consistent with the patient's values and goals. The patients' families are also attended to, benefitting from the palliative team's support, either through counselling, practical assistance, or even financial or legal help (Seymour et al., 2005).

Palliative care itself remains a niche and still relatively new approach within the healthcare sector. The term palliative care was, for instance, only coined in 1973 with the introduction of the first care wards for the terminally ill in Royal-Victoria Hospital in Montreal (Clark, 2007). Since this inception, the approach has been increasingly implemented across various health institutions worldwide, with successes both in improving the quality of life for patients, and even in reducing costs for certain hospitals (Fail & Meier, 2017). Typifying this trend is The Netherlands, which as of 2017, declared that every hospital within the country was to have a palliative care team (Stichting Oncologische Samenwerking, 2014). Using it as a strategic site for investigating the future of psychedelic therapy is intriguing for several reasons. Firstly, as Dyck (2019) argues, palliative care has already demonstrated its utility in the modern health care system as a space of convergence, across disciplines and ontologies. Secondly, many patients facing terminal conditions experience significant existential distress related to loss of meaning or purpose in life, or a desire for hastened death, which often lie at the core of clinically significant anxiety or depression (An et al., 2018). A Canadian survey for instance showed that nearly 44% of palliative patients suffered from at least some form of depression (Asghar-Ali et al., 2013). Given that one of the principal aims of palliative care is to alleviate such forms of suffering which diminish the quality of life of patients, prospects for new successful treatments are worth exploring.

3.0 - Introduction to Psychedelic Research/Therapy

The use of psychedelic drugs has a remarkably long history, having been used for millennia in traditional healing rituals across the planet (Tupper et al., 2015). These substances, which are known for their capacity to produce altered states of consciousness, have undergone somewhat of a societal renaissance of

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late, most notably in the domains of medicine and politics. Studies conducted throughout the United States, Europe and Canada, have already shown exciting promise with respect to the use of psychedelic drugs; from the treatment of alcoholism using lysergic acid diethylamide [LSD] (Smart & Storm, 1964); to the use of psilocybin for terminally ill cancer patients with depression (Ross et al. 2016). Results from the latter, a trial at John Hopkins University, reported that psilocybin helped as much as 80% of patients feel a decrease in depressed and anxious moods, including heightened cognitive clarity and emotional receptivity (Griffiths et al., 2016). Renewed interest in medicinal psychedelics has particularly accelerated within the last few years, with the US Food and Drug Administration having granted breakthrough therapy designation for psilocybin-assisted therapy in treatment-resistant depression (Pathways, 2018). This interest is also reflected commercially, with significant recent and projected market growth with the associated drug companies involved (Schenberg, 2018). According to one report, the psychedelic research industry is expected to increase threefold between 2020 and 2027 to $10.75 billion (Aday, 2020).

The case for psychedelic therapy in The Netherlands is particularly compelling also, especially when it comes to the fungal compound psilocybin. The compound itself was recently legalised and fully taxed for recreational use as of September 2019 (Belasting Dienst, 2019), with a number of non-medical therapy retreats consequently emerging as a result (Nutt et al., 2020). Aside from this, the nation is also a frontrunner in psychedelic research. The largest research to date, emerging from the FDA approval for psilocybin-assisted therapy, which is currently being conducted in the medical centres of Groningen, Leiden & Utrecht (UMCG, 2020).

Psychedelic therapy itself represents a radical divergence from current pharmaceutical models that treat psychological distress (Tupper et al., 2015). For one, the drugs currently under investigation combine a limited number of treatment sessions with a psychedelic substance, interposed between intensive pre- and post-treatment therapy sessions. The intended outcome being not only symptom control that characterises current treatments, for instance, sedatives like antipsychotics and antidepressants, but in some cases even durable remission. As one can imagine, this will require a new mental health care infrastructure capable of administering powerful psychoactive substances while simultaneously incorporating appropriate psychotherapeutic support (Heifets & Malenka, 2019). The future success of this therapy will as such depend much on how care professionals, managers, investors and policy makers receive this complex and paradigm-challenging treatment model. Particularly is this the case for those care approaches already existing in the healthcare system that act as likely candidates for which this therapy may be implemented. Palliative care exemplifies such a case, being a specialised caregiving approach focused on providing relief from those illnesses currently being studied in psychedelic research (Gramm et al., 2020). Given the

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compelling successes of palliative care in its approach to improving the quality of life of patients (Fail & Meier, 2017), and the encouraging preliminary evidence for psychedelic therapy, research into the possibilities of proliferation is warranted.

4.0 - Theoretical Framework - Institutional Logics

As this paper is interested in exploring the potential adoption of psychedelic drug treatments in palliative care, it is of importance to develop a theoretical framework that can conceptualise these domains in a way that enables one to speculate what will and what will not work. Theory will have to reflect this ex-ante style of analysis, informing speculation by accurately capturing the essence of each domain, and then the overlaps and tensions there are between them. A suitable strand of theory, used in both ex-post and ex-ante studies of this nature lies in the scholarly tradition of institutional theory. Developed over many decades, institutional theory describes a framework used to analyse social phenomena that views the social environment as being composed of institutions (Lawrence & Shadnam, 2008). Although no universally agreed definition exists for the term, institutions are generally understood as the relatively stable sets of mutually agreed rules and norms which are being created and reproduced by people. They not only provide the rules of the game, in setting legal, moral, and cultural boundaries, they also define the available ways to operate by discouraging, constraining or encouraging given behavioural patterns (Scott, 2008; Thornton et al. 2012). In other words, institutions can be seen as the authoritative guidelines for social behaviour (Cole & Scott, 2000).

Scott (2008), in his seminal book on institutional theory, introduces three pillars through which institutions are built, legitimised, and transformed, they are: the regulative, the normative, and the cultural cognitive pillar. The first, regulative pillar, concerns those laws and formal rules that actors adhere to within an institutional environment, for example, medical protocols and government regulation. If the regulative pillar is legally codified, then the second pillar or normative pillar includes those less explicit non-codified attitudes present in societies. It refers to the common norms, appropriate behaviours, and acceptable practices, i.e. what organisations should or shouldn't do. The last pillar, called the cultural-cognitive, is formed on the individual level. It refers to prevailing cultural beliefs of a new practice among its social audience, differing from the normative pillar in that it addresses the symbolic nature of human activities in a society, and in how meaning or sense is made (Scott, 2008).

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Closely tied with Scott's (2008) institutional pillars is the theory of institutional logics, which emerged as a concept to capture how broad institutional ideas, such as those embedded in policy, manifest themselves in the actions of both individuals and organisations (Thornton et al., 2012). Sporadic mentions of the concept existed already in the mid 1980s, although the real scholarly conceptualisation began with Friedland and Alford in 1991. These seminal authors described institutional logics as the systems of cultural elements (of values, beliefs, and normative expectations) by which people, groups, and organisations make sense of and evaluate their everyday activities, and organise these activities in time & space (Friedland & Alford, 1991; Haveman & Gualtieri, 2017). Institutional logics are reinforced because they are taken for granted, normatively endorsed, and backed up by authorised powers (Scott, 2008; Thornton et al., 2012). They are manifestations of institutional ideas that are embodied in practice by individuals and organisations, and are useful for the fact that they allow for the creation of distinctive categories that constitute the social identity of institutions (Friedland & Alford, 1991; Shaw et al., 2017).

The stability of an institutional logic is dependent on the alignment of underlying assumptions, norms, beliefs and rules (Scott, 2008). When this alignment is not present, conditions are likely to establish alternative institutional logics which can result in institutional change (Hoffman, 1999). Generally, those scholars concerned with changes in logics conceptualise this change as replacement, by means of a dominant logic which drives field level practice be abandoned and replaced by another dominant logic (Dunn & Jones, 2010). An example of a study that engages with this idea comes from Rao et al. (2003), who researched how individual autonomy plays a role in how existing institutional logics are replaced by new logics. With the backdrop of the nouvelle cuisine movement in France, the authors propose a number of mechanisms, or identity-discrepant cues, by which actors abandon old logics for new logics and role identities, namely the socio-political legitimacy of activists, extent of theorization of new roles, prior defections by peers to the new logic, and gains to prior defectors (Rao et al., 2003). In providing a practical micro-level approach to understanding institutional logics, Rao et al.'s paper is highly valuable in that it offers a methodology to begin to understand the norms, values and means of operating in the field, as well as how changes in these dynamics might occur.

Research into institutional logics has since broadened to focus not only on the shifts in dominant logics but also in understanding the implications of multiple logics that coexist with one another (Lounsbury & Boxenbaum, 2013). This is because the initial focus on dominant logics assumes consensus among professionals, however in reality institutional environments tend to be fragmented, and have conflicting demands (D'Aunno et al., 1991). This conflict and pluralism within professions may be the motivating force for institutional change instead of pure replacement of logics (Lounsbury, 2007). A particularly

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relevant article that accounts for this, and like Rao et al. (2003) deals with micro-level interactions between actors, is by McPherson and Sauder (2013), who conceive of institutional logics as tools which can be *"continuously combined, configured, and manipulated to serve the purposes of actors"* (McPherson & Sauder, 2013, p.168). Drawing on an ethnographic study of a drug court, they show how actors exhibit agency in interpreting institutional logics and present what structural constraints limit this agency. For the cases of psychedelic research/therapy and palliative care, consideration for this multiplicity of logics is important in that not only are two different domains being dealt with, but as new domains, they will be subject to varied values and demands amongst professionals.

A number of studies have looked into what institutional logics constitute healthcare organisations, which is the setting for this study. Van den Broek et al. (2014) note that health organisations in many countries are confronted with the challenge to simultaneously enhance the quality and reduce the costs of care. Physicians and nurses for instance might be expected to act in accordance with a professional logic, i.e., one that emphasises the quality of care, whilst managers and directors might align with more businesslike managerialism, which is mainly occupied with efficiency and costs (Ruef and Scott, 1998). Here we see how a professional logic, associated with more traditional professional values is combined with a businesslike managerial logic (Noordegraaf, 2007). The values and demands associated with these logics are quite different, with Gadolin (2018) suggesting that those individuals belonging to professionalised occupations have limited ability to engage in the strategic employment of the managerial logic. Healthcare settings generally are seen as an increasing site of contestation between multiple logics (Scott et al., 2000).

A valuable paper that conceptualises institutional logics more specifically to the case of palliative care comes from Cain, (2019). The author posits that hospice care is informed by a relatively equal mix of three institutional logics, that being the professional logics of medicine and holistic care, and finally the managerial logic. Cain (2019) describes that despite palliative care being created as an alternative to conventional medicine, logics stemming from these conventional medical practices are still present. This is represented by the medical logic which prioritises medical tasks such as the diagnosis and treatment of physical ailments of patients, with authority given to medically trained actors (Rosenburg, 2007). The holistic logic is then a professional logic that focuses on identifying gaps in conventional medicine and understanding the complex individual needs of patients (Patterson 1998; Rosenberg 2007). Related holistic tasks especially include seeking acceptance of death, exploring spirituality, tending to the whole family, and treating psychosocial problems (Mount, 1993). Authority in this logic is mainly given to social workers, counsellors, and chaplains (Cain, 2019). The final logic, or managerial logic, is defined by

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concern for costs and profitability. Under this logic, workers are expected to follow bureaucratic procedures, with authority given to administrators and managers who oversee bureaucracy and the costs of care (Jackall, 1988; Van den Broek et al., 2014). In presenting these multiple logics and describing how actors navigate through them, Cain's (2019) paper reflects a growing recognition that conflicting and overlapping pressures stemming from multiple logics create interpretive and strategic ambiguity for professionals in palliative care (Greenwood et al., 2011).

What the work of McPherson and Sauder (2013), and Cain (2019) provide is a resource from which to understand the intra-domain contention and alignment between multiple logics that exist within an institution. This multiple logics framework is especially valuable in that it allows for focus specifically on those areas of contention and overlap that could become the starting point of institutional change. This is particularly effective in the cases of psychedelic research/therapy and palliative care, in that by drawing out their respective multiple logics, one can then compare which logics align and which do not across these domains. This will be the basis from which I formulate advice for policy makers and professionals, and understand the opportunities and barriers for change. More specifically I will focus on what underlies the regulative, normative, and cultural-cognitive elements of both care approaches (Scott, 2008), and not as some other authors of institutional logics describe, the macro or meso elements such as markets, and the state (Zajac & Westphal, 2004; Thornton, 2001). This will mean exploring the micro-level practices & identities which define each approach, including for instance: their respective socio-political legitimacy, their value orientation and professional goals, the role identities formed around them, and the rules & regulations established in each domain. By examining their content in a focussed social exploration of these logics, I can then establish points of overlap and conflict between the various institutional logics of psychedelic research/therapy and palliative care, and further speculate as to what these overlaps and tensions might imply looking forward. This approach is important firstly because these concepts are feasible to explore, pertain to the individuals active in these forms of care, and can be investigated ex-ante. Important to note is that these concepts will inform, and crucially be informed by the data, so a constant comparison will be at play between data collection and data analysis. The following section outlines this methodological approach in more detail.

5.0 - Methodology

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Establishing institutional logics, and then comparatively assessing overlaps and tensions between domains is challenging, so it pays to pick and justify the most suitable methodological approach. In light of this, a qualitative research strategy holds great promise in using such concepts in that it plays into the very nature of these theories and captures the nuances of what this socially constructed and value laden scholarly tradition has to offer (Reay & Jones, 2016). It is also more appropriate than the quantitative alternative, in that subjective views on norms, values, and means of operating are problematic to research with such an objective approach.

For this research paper, I collected data through the use of semi-structured interviews conducted with both palliative care and psychedelic research/therapy specialists. This was achieved using an interview guide, whereby participants were encouraged to elaborate on their experiences, norms and values prescribed to their work, and the means and challenges by which they operated in their specific roles (see Appendix 1 & 2). Questions were asked such as: *How would you describe the work that you do? What is the most rewarding aspect of your job? What are the main challenges in your line of work?* Attention was given to asking probing questions which helped elicit further discussion or clarify statements made previously by participants. The overarching focus being to understand the respective institutional logics of each domain, which was influenced by previous studies on micro-level logic interactions (Rao et al., 2003; McPherson & Sauder, 2013), as well as those papers focussing on the empirical setting of palliative care (Cain, 2014; Van den Broek et al., 2014; Rosenburg, 2007). Some questions were also tailored towards an explicit discussion on the use of psychedelics in palliative care, whereby psychedelic researchers were asked to discuss overlaps and tensions between these two distinct domains. Palliative care specialists were meanwhile given a hypothetical scenario in which psychedelics were already medically approved so that overlaps and tensions could also be explored.

Study participants involved in the interviews were chosen based on their considerable expertise in palliative care and psychedelic research/therapy. More and more experts were eventually identified and interviewed using the purposive sampling strategy known as snowball sampling. This approach is often used to find and recruit hidden populations, ie. those not easily accessible to researchers through other sampling strategies (Suri, 2011), which was particularly beneficial for the case of psychedelic researchers in that the professionals in this field were not so easily identifiable. The idea behind this strategy was to get to the point where theoretical saturation of multiple logics within these two domains could be reached. Overall, fifteen online interviews were conducted: nine with palliative care specialists ranging from doctors, nurses, to spiritual caretakers, as well as six interviews with psychedelic researchers and guides, all of which had a coordinating or guiding role in one or many of the clinical trials being conducted in

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The Netherlands. This sample size has its credibility and validity ensured by establishing study participants who not only have adequate expertise, but best represent the research topic (Vasileiou et al. 2018; Morse et al., 2002). With a broad selection of participants from both multi-disciplined domains, different perspectives were well represented. Although a larger sample size would be informative, the data collected in this study resulted in a satisfying degree of theoretical saturation, which was sufficient to draw valid conclusions from and is adequate for the research aims presented. Table 1 below provides more details about the participants involved in this study.

Palliative Care Participants (PC)	**Expertise**	**Work Experience**
PC Participant 1	Anaesthesiologist	9 years
PC Participant 2	Nurse	35 years
PC Participant 3	Network Coordinator	31 years
PC Participant 4	Pharmacist	33 years
PC Participant 5	Nurse	4 years
PC Participant 6	Doctor	1 year
PC Participant 7	Nurse	42 years
PC Participant 8	Network Coordinator	8 years
PC Participant 9	Spiritual Caretaker	12 years
Psychedelic Research/Therapy Participants (PR/T)	**Expertise**	**Work Experience**
PR/T Participant 1	Psychiatrist / Psychedelic Guide	4 years
PR/T Participant 2	Coordinator Clinical Trial	15 years
PR/T Participant 3	Coordinator Clinical Trial	2 years
PR/T Participant 4	Psychiatrist / Psychedelic Guide	15 years
PR/T Participant 5	Coordinator Clinical Trial	6 years
PR/T Participant 6	Psychiatrist / Psychedelic Guide	4 years

Table 1: Study Participants

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Given the difficulties associated with identifying ideal-type institutional logics empirically (Reay & Hinings, 2005), data analysis was an iterative process whereby concepts that embed institutional logics guided the interviews, and a constant comparison between data collection and analysis was achieved. Derived from the interpretivist tradition, this bottom-up approach, more broadly described as a qualitative inductive methodology, means that patterns associated with, in this case, multiple institutional logics, emerge inductively from the data, and then as part of a constant comparative analysis provides for a thick description of the phenomenon (Van Maanen, 1995). In practice, this meant developing a series of questions based on the distinct regulative, normative, and cultural-cognitive elements used in the micro-level analysis of previous authors, such as the associated organisational structure of the institution, the role identities embedded within that, as well as how these individuals experienced their work and dealt with corresponding challenges (McPherson & Sauder, 2013; Cain, 2019). As time progressed, I was able to frame these interview responses in conjunction with extant theory, to create codes pertinent to elements of these multiple logics, allowing for further theory development to take place (Reay & Jones, 2016). In doing so, the assumption was made that meaning is tightly intertwined with context, drawing from Myers (2019; 38) who suggests that *"the only way to understand a particular social or cultural phenomenon is to look at it from the 'inside'"*. The idea behind this iterative analytical approach was to develop a framework from the underlying structure of the raw data using selective coding. In the question of challenges associated with palliative care practice for instance, a number of respondents noted an increasing workload intensity. Through further elaboration in consequent interviews and insights by Van den Broek et al. (2014), I was able to establish that these challenges were related to tensions with a managerial logic, ie. one focussed on efficiency and cost minimisation. In coding terms, this meant that text segments were initially grouped under *Challenges*, then more specifically *Workload Intensity*, and finally under the umbrella *Managerial Logic*. The process of analysis was deliberately time-consuming so that patterns of behaviours and beliefs associated with particular logics would not be confused within the ambiguity and contestation between multiple logics. Time spent in interpreting the regulative, normative, and cultural-cognitive elements became vital in capturing the most suitable institutional logics as such, with attention and care provided throughout the analysis to identify potential alternative explanations.

The methodological process as a whole played out as follows: initially, the fifteen interviews were first recorded online, lasting between 20-50 mins. Recordings were then transcribed verbatim from English in the case of the psychedelic researchers and transcribed and later translated from Dutch into English in all of the palliative care interviews. From these transcripts, a 93 page narrative document was created. Coding was then carried out using the qualitative data analysis software package known as NVivo, which allows for the classification and arranging of non-numerical data, in this case, the raw textual data from

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interviews, into a brief summary format. From this, I was then able to capture the multiple logics present in these domains, as well as the intra-domain tensions existing within each case. The focus being on capturing rather than measuring or operationalizing logics because scholars who employ qualitative inductive methodologies seek to do exactly that, to capture a phenomenon through thick description (Van Maanen, 1995). Once the logics and intra-domain tensions had been established, I could then focus on describing the inter-domain overlaps & tensions, which were created as an amalgamation between explicit discussions on the matter, as well as a cross-case comparison of the identified multiple logics. Speculation on the basis for institutional change, as well as advice for policy makers and professionals, was consequently built upon the intra-, and inter-domain findings of multiple logics.

Considerations had to be made in conducting the above methodology. Ethical issues regarding consent and confidentiality needed to be well accounted for, so the respondent was completely aware of the intentions of the research and well informed in how they would participate. As such, when potential interviewees were approached, they were informed of the intentions behind the research, including how their interview data would be collected and stored. For instance, before the interview would begin, I established with the participants that only I would process the recordings, after which they would be promptly deleted and the transcriptions would remain anonymous. They were also required to complete an informed consent form to confirm this understanding (see Appendix 3). This transparency is particularly important given the intimate topic which the research touched upon. Questions regarding death, depression, and what it means to care for those in these situations are of direct relevance. As such it pays to be mindful and respectful of these topics, and how one goes about approaching them in conversation.

6.0 - Findings

Interviews conducted for this paper have sought to understand the distinctive norms, values, and means of operating behind palliative care and psychedelic research/therapy. The results, establishing the multiple institutional logics behind each domain are presented in the following sections, firstly for the case of palliative care, and consequently for the psychedelic research/therapy case. These sections not only describe results pertinent to individual logics in the field, but also the intra-domain tensions, which in some cases was the basis for establishing the existence of certain institutional logics. Given that this identification of institutional logics was only part of the initial research questions posed, the final section

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will then focus on inter-domain overlaps and tensions existing between the multiple logics across cases. These overlaps and tensions were derived from more direct discussion regarding potential implementation of psychedelics in palliative care, as well as evident conflicts between the logics themselves.

6.1 - Palliative Care: Institutional Logics & Intra-Domain Tensions

Palliative care is fundamentally a multi-disciplined care approach, with many professions from diverse medical and non-medical backgrounds working simultaneously on a case. This was reflected in the pool of interviewees, including more medical front end specialists, such as doctors, nurses, an oncologist, and an anaesthesiologist; as well as roles considered more behind the scenes and non-medical, such as network coordinators, pharmacists, and a spiritual caretaker. In probing the norms, values, and means of operating within palliative care practice, a clear dominant institutional logic, the holistic logic, was evident. Anchored in the idea that the needs of individual patients are complex and subjective, the holistic logic looks beyond the conventional focus on the symptoms of disease, to include the wellness of the patient. This ideal is reflected not only in the core philosophy of palliative care but also in the discussions had with the specialists in how they saw their work. Despite this influential holistic logic, indications of the medical and managerial logic, as described by Rosenberg (2007) and Cain (2019), were also present. Unlike these studies however, findings from the semi-structured interviews present a different situation than a relatively equal mix of these three. Instead, the findings conceptualise palliative care as largely a holistic logic, complemented in decision making by a medical logic, with the managerial logic remaining mostly in the background.

A key feature of the holistic logic is the focus on the differing dimensions of care, i.e. in treating physical, psychological, social, and spiritual pain. Every respondent at some point discussed this as fundamental to their work, with no exceptions. Given the fact that the guidelines of palliative care in The Netherlands (Pallialine) highlight attention to this so clearly, it comes as no surprise that these ideals are deeply embedded as norms within this practice. This focus is operationalised in the multi-disciplined teams which make up hospices, palliative care centres and home care. In action, multi-disciplinary work consists of consultations between medical and non-medical specialists regarding the treatment of a patient. Nurses would typically lead the patient case discussions, noting the importance of engaging the expertise and perspectives of the different professionals, and with them discussing medical and non-medical issues surrounding the patient's needs. The basis for decision making is driven in large part by the quality of life of the individual, as one doctor suggested:

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> *"We don't necessarily add days to patients' lives, but add life to their days. So the focus is not on prolonging life, but more the quality of life and the quality of dying" (PC Participant 1).*

This focus on quality of life within the multidisciplinary environment meant that on occasion decisions could sometimes work around regulation and protocol:

> *"As a healthcare provider the focus should always be on what is appropriate care, even if that means you think less in terms of protocols and frameworks, the focus needs to be on what is good for the patient" (PC Participant 5).*

What is good for the patient is a complex challenge in itself, however, given the subjectivity of each patient within these dimensions of experience. Both an anaesthesiologist and a pharmacist mentioned that a great deal of pain that their patients experience remains unexplainable. *"The pain of one is not the pain of another" (PC Participant 4)*. The experience of pain can also be indistinguishable, for instance after hearing of one's terminal condition, there may have been physical pain until that point, psychological pain, and perhaps even anxiety for pain itself. As the anaesthesiologist noted, *"you can not really relieve pain without attention to these other aspects" (PC Participant 1)*.

The palliative care specialists that took part in this study were notably empathetic when discussing their work with patients, being particularly attentive to their individual, emotional, social, psychological and existential needs. When questioned about the values ascribed to their work, the responses were overwhelmingly positive, with a strong sense of pride associated with their duties. This was mostly the case with specialists considered more front-end, or patient facing, suggesting that much satisfaction came from situations whereby their help made a notable difference to their patients' lives. One individual noted with great satisfaction how she and her palliative team were able to organise a wedding for a terminal patient in accordance with their final wishes. Despite this, the work remains challenging:

> *"It's very difficult to see when people are alone. We had a man at the hospice recently and for three months nobody came to see him, so yes you are confronted with a lot of troubling moments, which is a challenge" (PC Participant 5).*

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Given the intensity of the work itself, in dealing with terminal patients and supporting their families, in itself a hallmark of quality palliative care, recognition of this effort was a reward well worth it, even for those roles considered more behind the scenes.

Interviews also hoped to understand the position of the respondents towards psychedelics, itself providing insight into the dominant holistic logic positioning palliative care. A surprising finding from the interviews, confirmed by a number of participants, is that some patients will themselves recreationally take psychedelics to help deal with certain discomforts, come to terms with their illness, or as pain relief for example. Remarkably, despite some concerns over the lack of awareness of the drugs, the carers who had noted this had little problem with such decisions. Considering the focus that palliative care workers have for the wishes of the patients, this helped confirm the position that if a patient decides to use psychedelics recreationally, if the patient believes it can help them, whether it be through actual benefits, placebo, or otherwise, that is for them to decide. When presented with the possibility that psychedelic research offers more concrete positive conclusions on the effect of such substances on end of life anxiety and depression, for instance, respondents generally responded favourably to its use if it had beneficial effects for the patient.

> *"The intrinsic motivation for the palliative doctor to relieve suffering for a patient is very high. And if psychedelics could help relieve suffering then I think we will certainly use it if it is accepted in all the medical guidelines. Palliative care would certainly be the practice that would be more open to it" (PC Participant 8).*

Despite the strong basis for the holistic logic in the responses given by the palliative specialists, there were some indications of the conventional medical logic, emphasising more the treatment of physical ailments of patients, and the managerial logic, which focuses on bureaucracy and costs. In the scenario of multidisciplinary working for instance, the level of cohesiveness in this environment was viewed differently depending on the position of the actor. For example, a hospice nurse indicated:

> *"I have the feeling that the focus is mainly on cooperation because the situation with most patients is quite clear. People arrive with less than three months left and in most cases that's right. So your goal is basically all the same, to focus on the quality of life. Reduce the symptom burden as much as possible and provide them with the best possible life whilst they are still in hospice care. Of course we do have a difference of opinion, but that is always about details not in the fundamentals" (PC Participant 5).*

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The spiritual caretaker on the other hand found this dialogue particularly difficult, suggesting that more authority is in general given to those medically trained actors, indicative of the medical logic.

> *"Well, there are certainly different visions on approach. What I notice myself, of course multidisciplinary collaboration is important to everyone, but that is still quite challenging, and I don't want to complain, but as a spiritual caretaker it is quite difficult to participate in these discussions" (PC Participant 9).*

The medical logic was not explicit in the palliative care findings and had to be deduced more through the tensions existing between dominant holistic logic and patterns of sense-making outside that holistic field of thought. Tensions in the role identities between medical and non-medical staff were noticeable but not as explicitly as in the prioritisation of certain dimensions of care. The most noticeable indication of the existence of a conventional medical logic was when the discussion turned to psychedelics and the resistance to it. Despite the general accepting consensus of the substances under the right conditions, many respondents, particularly those responsible for administering and prescribing medication, saw the potential side effects of these substances, for example, hallucinations and mania, as high risk. These respondents also tended to suggest more resistance to the use of these drugs recreationally. The unknown being the main concern here, particularly when there lies a responsibility of care for a patient directly. Palliative care remains of course a highly regulated medical field, and this response to lack of knowledge is more indicative of the conventional medical logics where informed scientific reasoning provides the basis for care. Palliative care specialists were noticeably reliant on these frameworks and protocols when it comes to scenarios where the specialists lack confidence in certain areas.

> *"My work is based on Pallialine. This is a kind of a data network with all kinds of guidelines about symptoms, diseases and how to provide quality care in the palliative setting. It's all based on research and as a healthcare provider it's a lot easier to take responsibility with these guidelines in the background. There is a self-confidence needed to prescribe medicines yes, but it's all based on something" (PC Participant 2).*

According to a doctor, uncertainty towards certain substances is helped by making use of more medical specialists within their multidisciplinary teams.

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> *"We always have a pharmacist at the ready in a palliative care team, so I can always ring if there is uncertainty. I often do so if I'm unclear what needs to be done. So yes if someone terminal stands to benefit from a medicine then you see whether that's possible, of course" (PC Participant 6).*

Aside from indications of a medical logic consistent with more traditional care approaches, a managerial logic focussed on bureaucracy and costs was also prevalent, although less so than initially expected. One of the potential reasons behind this finding being that whilst the conversations included more backend, managerial specialists e.g. consultants, pharmacists and network coordinators, all subjects had previous experience as on the ground specialists. Again, this was evident more through the intra-domain tensions with the dominating logic of holistic care than as a clear pattern of managerial sense-making. Many respondents suggested, for instance, that decisions stemming from a managerial logic, usually related to cost minimisation, were the most challenging aspects of their work. The high work intensity was given as an example, as well as challenges associated with the funding and training of staff.

In terms of discussion regarding psychedelics, managerial logic tensions were also noted. In this case, the focus was on challenges associated with the bureaucracy behind palliative research. Considering the amount of regulation in dealing with highly sensitive patients, research tends to be a lengthy affair before any hard conclusions can be made. Getting ethical approval also was seen as a difficulty. Given the scenario whereby psychedelics were medically approved, the concern was that it could still take a lengthy period of time before palliative patients could stand to benefit from the drugs.

All in all, the results of the interviews suggest palliative care to be a care approach built upon multiple institutional logics that contend & complement each other. Crucially, these logics are hierarchically ordered, with a dominant holistic logic focussed on patient wellness and subjectivity as part of its primary decision making. For the most part, the other medical logic established as a more traditional means of medical operations (Cain, 2014), and the managerial logic, focussed on costs and the bureaucratic process (Rosenburg, 2007), were observed in contention with the dominant logic, either in concerns for, or as a challenge to their daily practice. Unlike previous scholars who show a balanced multiplicity of logics, the results from these findings would indicate that palliative care practice is perhaps more embedded within its core care ethos than other studies would suggest.

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6.2 - Psychedelic Research/Therapy: Institutional Logics & Intra-Domain Tensions

Interview respondents from the psychedelic space were specialised in either a coordinating role in the clinical trials or as therapists/psychiatrists within the same trials, guiding patients through their psychedelic experience as well as in pre and post treatment therapy. The one exception was a trained psychedelic therapist who guided in a retreat within The Netherlands. The clinical trials themselves were quite varied, ranging from a stage 3 clinical trials for the use of psilocybin against treatment-resistant depression, a study for the use of MDMA with PTSD patients, and a ketamine study for cancer related depression. All were described as international multi-site trials, financed mainly through pharmaceutical companies, and regularly screened by ethical and medical bodies.

Unlike the palliative care case where the holistic logic was quite clearly at the core of sense-making, the psychedelic research/therapy case proved to be more balanced between a research logic, anchored in the principles of science, scientific rigour and objective truth, and a holistic logic bearing great resemblance to palliative care. This logic multiplicity, although expected, also provided some new insights which have yet to be established in other literature.

Findings from professionals working on the psychedelic clinical trials throughout The Netherlands show a distinctive research logic that solidifies their work, a logic centred on the scientific method and obtaining observable and measurable evidence on the effects of psychedelics. This was evident in the way their work was undertaken, how they viewed the work, and what was considered a success within the clinical trials. This logic was also evident when framed in the challenges associated with coordinating these trials.

Many of the respondents were part of, or founders of the OPEN foundation, established with the aim to emphasize the importance of rigorous, high-quality scientific research on psychedelics. *"We figured this would be the only way to convince people that there is value in interest in psychedelics" (PR/T Participant 4).* This focus on legitimising psychedelics through academia is perhaps the strongest indication of a research logic from these findings. This was reinforced with their considerable expertise in the respective fields, in psychiatry and psychotherapy for instance, with most interviewees having or working on PhD's in these relevant fields.

Evidence of a research logic was also found in the visions of success that respondents ascribed to their work. Generally, interviewees expressed optimism regarding the success of their respective clinical trials, and more broadly the use of psychedelics for medicinal purposes. Success for them seems to balance the

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scientific rigour in their trials, and the drug having the intended effect. Many respondents also noted success to quite simply be a greater understanding of psychedelics, noting: *"So really success for me would be to have a firmer understanding, a more valid understanding of which psychedelic substances can be used in which context to treat which disorders (PR/T Participant 4)"*. When questioned about the timescale with which they expect some of these drugs to be available on the market, they also seem rather optimistic compared with related literature on the topic. Stating 2-5 years in both cases, for the use of MDMA and Psilocybin for PTSD and treatment-resistant depression respectively.

The strict screening of patients for exclusionary criteria was consistently mentioned as an existing but necessary challenge by those with a coordinating role. Considering the mind-altering effects of these compounds and the associated risks of side effects, vetting is understandably crucial. Related to this, many interviewees expressed concerns over the effect of the framing of the drug's benefits. With psychedelic retreats in NL creating their own form of therapy, some more legitimate than others, the risk is that misinformation works detrimentally with the ongoing research by influencing public opinion and policy. As such care must be taken to provide this distinction, legally or otherwise, if psychedelics are to continue to be researched for medicine whilst also growing recreationally.

> *"They are now starting to market them more as therapy or treatment for different disorders, which I think is problematic because they're not very well regulated. There's no code that people have to adhere to, and there's no specific training that those people guiding the sessions have to do" (PR/T Participant 3).*

Other challenges framing psychedelic research more in terms of a research logic included the lack of understanding of the substances themselves. Despite ongoing efforts and some considerable work in the past, it remains a very underdeveloped medical research area. For many, this drove the decision to start studying psychedelics in the first place. With such a contemporary study area, comes risks however, highlighting the constant need for quality vetting and assessment:

> *"It's a very new field of course, and then if something goes wrong it could set the field back. If someone who has a heart condition gets problems, or someone goes into psychosis, or someone commits suicide for example after participating in the study, that could be a real problem" (PR/T Participant 3).*

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Balanced with this research logic was a clear undercurrent of care towards the trial patients, not too dissimilar from the values and practices ascribed to palliative care. For instance, psychedelic respondents often showed a deep understanding of the different dimensions of care requiring attention. Although perhaps not as embedded in its core ethos necessarily, this understanding of the dimensions, as well as the subjectivity of the patient's experience meant that these specialists had to be particularly sensitive in dealing with often troubled patients. Respondents also noted the importance of having these considerations when dealing with the substances themselves. A psychedelic guide for one of the clinical trials shared the array of scenarios that he would face whilst guiding someone through the psychedelic experience, from processing traumatic experiences, and exploring spirituality, treating various psychosocial problems, and even in seeking acceptance of death. Having this holistic understanding of a patient thus bodes well in competently guiding them through often very varied experiences. One interviewee was identified for his unusual role as a specialised psychedelic guide, a psychiatry academic focussed on psychedelics, as well as an individual with previous experience working in hospice care. This made for an interesting discussion on the role of the psychedelic therapist as compared with those treating patients already in the clinical trials, offering also personal insights on the opportunities and overlaps that palliative care and psychedelics offer.

> *"I think the best way to work with a patient is also by having this multidisciplinary team that is looking at who someone is from these different angles. And it's important to have this sort of spiritual dimension as well, or this excess attention if you will. So I think the hospice model is offering us a template to actually think about psychedelic care, and psychedelic care might actually be offering very fruitful insights into how we can think about the end of life process" (PR/T Participant 1).*

Multidisciplinary working appears to be a key aspect of the clinical trials, not unlike palliative care in how these differing dimensions of care are operationalised. This holistic logic was also noticed in what some respondents considered a successful trial, whereby success would mean that their patients would fare better with their respective conditions, in this case, PTSD and treatment-resistant depression, or that the drug proved to eradicate the problem altogether.

> *"You get involved on many levels, right. The suffering is palpable. And a lot of these clients have had a lot of other therapies, and this can be their last resort so to speak so of course you want to see the depression scores go down" (PR/T Participant 5).*

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Intra-domain tensions between the holistic logic and a managerial type logic were also evident, mostly with respect to the disparity of goals between pharmaceutical companies and the researchers. Multiple interviewees noted that despite the considerable funding into psychedelic research offered by corporate interests, by focussing on investment opportunity and profitability, the risks are that *"corporate intellectual property be prioritised above patients interest" (PR/T Participant 2)*. The fact that this was a credible concern for some participants suggested at least an indication of the managerial logic, conceptualised as driven by costs and profitability (Jackall 1988; Van den Broek et al., 2014), was present in the psychedelic research/therapy space.

> "*For me, it's important that it's collaborative, and it's transparent, and it's open; those are also the qualities that psychedelics often generate in people. But in this kind of capitalistic company with its for profit structure I saw those opposite kinds of qualities starting to appear, and it was very much of a clash between two different worldviews at that point" (PR/T Participant 2).*

The research, holistic, and managerial logics, however, fall short in explaining the full picture of psychedelic research/therapy. A residual observation was noticed that did not conform with the other well established logics, concerned with sense-making around the psychedelics themselves. This sense-making was evidenced mostly in terms of the motivations for researching psychedelics, and a fondness for the substances being studied. Given the incompatibility with the established research, holistic, and managerial logic, I would like to term this a psychedelic logic, which became visible as an emerging, and probably still fragile institutional logic in my research. Whilst one can speculate that this logic might be present with more psychedelic researchers and therapists, the fact that this pool consists of only a few individuals with no substantiation from other literature, means that this residual observation is best described as an emerging institutional logic, or fledgling psychedelic logic. Much of this new logic seemed to crystallise around a passion for psychedelics, with the majority of respondents being deeply convinced of their potential despite the research of the substances being in its preliminary stages. At times the sincere belief in their potential came across as very patient centred, noting the occasions where individuals had had life changing outcomes from the experience. Although this left some ambiguity with the holistic logic, it was yet quite clearly centred on the psychedelic substances themselves. A reason for this belief may have been due to the respondents having had experiences with the drugs recreationally, which in many cases further solidified their distinct efforts to legitimise psychedelics for medicinal purposes. Some even suggest that this profound experience motivated the decision to start researching in the first place.

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> *"I had my first psychedelic experience when I was 17 and immediately got interested in the question, what is consciousness if such a small quantity of foreign substance can so radically alter your entire experience of yourself, the world around you, and all the relations within it" (PR/T Participant 1).*

When describing the unique characteristics of the substances, many participants noted the boundary dissolving effects that the drugs have, not just in terms of the experience of using them, but also in how the research was being conducted. For one, psychedelics do not conform with medicinal drugs in the traditional sense, in that they affect all senses, alter persons thinking, and generally trigger non-ordinary states of consciousness. Secondly, the trials themselves are somewhat unconventional in that for psilocybin for instance, they cannot undertake double blind trials due to the unique effects of the psychedelic. Given the lack of understanding regarding these substances and their known effects, the drive to legitimise psychedelics in society and medicine was nonetheless strong. With this came some internal tensions with the other observed logics, namely with respect to questions of objectivity in the clinical trials. If the goal embodying the research logic is to conduct a scientifically rigorous study, whilst those aligning with the psychedelic logic relate more to strong conviction for the drug's benefits, and a desire for legitimacy, then within this lies contention. As one respondent suggested, objectivity for those with recreational experience of the drugs might potentially be problematic in studies looking forward.

Overall, the institutional logics observed for psychedelic research/therapy balanced a research driven set of norms, values, and means of operating, with a holistic logic of care similar in many respects to the palliative care findings. Along with this push for rigorous scientific enquiry and care for patients, was a noticeable passion for the psychedelics themselves. Whether driven through recreational use, or the possibilities of what these relatively unknown substances can do, this residual observation which encompasses a new institutional logic defined here as a psychedelic logic, suggested a motivated culture for legitimising these drugs. A set of norms & values distinct from the holistic and research based sense-making, and in some cases in contention with them.

6.3 - Inter-Domain Overlaps & Tensions

The semi-structured interviews were designed in such a way as to infer the institutional logics behind palliative care and psychedelic research/therapy. Additional to this was the goal to understand the specialist's stance on the use of psychedelics in the palliative care setting. For instance, the psychedelic

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research respondents were questioned as to whether they saw this as a potential future possibility, and if so what the challenges and overlaps were. Palliative care specialists on the other hand were called to discuss their stance on a hypothetical scenario in which psychedelics were already medically approved, and proven to have beneficial effects on patients with depression, end of life anxiety etc. The explicit overlaps and tensions drawn from these interview questions, as well as those inferred from the cross-case comparative analysis, are the focus of the following section.

On many occasions did the psychedelic researchers describe overlaps between the practice of palliative care and their own work. For the trials and indeed psychedelic therapy in general, the setting is important, pre and post therapy sessions are of importance, and in this intersection, it was noted by many interviewees that palliative care might be well placed. Not only for the fact the infrastructure offers possibilities in this respect, but also that palliative care workers have the comfort of the patient as one of their primary goals. One respondent described this as a recognisable principle of *"caring not curing" (PC Participant 9).* Although heavily protocolised, the goals and means of therapy shown in the clinical trials seem to diverge from the typical clinical nature in taking part in such a study. Hospital rooms are made to look more inviting and warm, playlists have been selected to provide a relaxed ambience, and therapists & counsellors are present at all times to help guide the experience. A clear overlap thus exists between these holistic logics, as described by the psychedelic guide with previous experience in palliative care:

> *"I have not met a single person working in hospice that did not have a profound capacity for genuine care, empathy and compassion. Everyone wishes to alleviate the suffering of the people that they serve, and many people who are offering psychedelic care are equally occupied or concerned with the suffering of the people that they serve. The people that work in hospice I think are already so informed about the sensitivities, the vulnerabilities and the levels of care that people in such a state need that there's quite some overlap with how people in psychedelics work" (PR/T Participant 1).*

This overlap in holistic logics was also justified by palliative care workers, who when questioned on the possibility of the use of such drugs in palliative practice tended to show an openness to the idea. One respondent had the following as her main justification for the idea:

> *"Well I certainly see possibilities yes, but mainly because I think that people should have freedom of choice, and that people should have their last phase of life as comfortable as possible" (PC Participant 3).*

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A shared intrinsic motivation to care for the patient seems to prevail in both domains, representing a particularly compelling argument for why psychedelic therapy could work in the palliative setting. The values associated with care are virtually indistinguishable, and the means by which this is operationalised in the medical setting also, both having a multidisciplinary working style that accounts for the various dimensions of the patient's experience. What constitutes a successful outcome of care is also consistent across cases, that being improvements to patients' wellbeing and quality of life. Indeed, from both discussions on the matter and a comparison across cases, the shared basis for a holistic logic is significant and represents a key finding in this research.

Aside from the overlap between the holistic logics in both cases, more were also noted from the discussions. The medical & research logics for instance are particularly comparable to one another. Although the primary drivers differ, sense-making for both logics is fundamentally scientifically backed, rigorous, and provides those with the professional knowledge the most authority. One key insight into this came from the discussions regarding the risks of psychedelics. Both groups of professionals seemed convinced that more scientific enquiry was required, but also noted the current known risks of the substances. One of the psychiatrists working on the trials described it in the following way:

> *"I'm deeply convinced of the potential of psychedelics, but with emphasis on their potential. I'm also deeply convinced that psychedelics can really be dangerous and awful in some cases so I'm not interested in questions of should we or should we not but in questions of how. The why is clear to me, I'm interested in how we can integrate these powerful substances into mainstream society" (PR/T Participant 1).*

One way to counteract this risk, again aligning the medical and research logics between both cases, was in building quality assessment and screening tools which help establish which groups of patients fall under the exclusionary criteria i.e. what types of mental and physical issues might predispose people for more challenging experiences. In this way, the scientifically backed application of the research and medical logic acts as an opportunity in legitimising the use of these drugs. An interesting case study relating to this legitimising process concerned another initially controversial substance now prescribed to some palliative patients. CBD oil, a derivative of cannabis, is known for its use in pain and symptom relief and was recently legalised for medicinal use in The Netherlands, now often prescribed for patients in their terminal life phase (Van Laar & Gestel, 2017). A discussion with a pharmacist specialised in CBD noted that controversy surrounding the use of CBD oil was never that noticeable thanks in large part due to the

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established research, the use of such assessment tools, as well as the appropriate implementation into guidelines and protocol. Simply put, the case suggested that once enough evidence was available through the research logic, and consequently implemented through regulatory instruments in the medical logic, the once controversial cannabis derivative was successfully in use.

> *"So the controversy surrounding the drug is not all that relevant here anymore. The fact that we deliver these drugs at the scale that we do means that our mindset has already changed quite a bit." (PC Participant 4).*

The findings regarding inter-domain tensions across cases tended to reflect the internal contention between logics. An example of this was the managerial logic, focussed on efficiency and costs and the pursuit of administratively established productive goals (Gadolin, 2018). In the case of the two domains studied, the disparity between the managerial logic and other professional logics was reflected as a conflicting one, which is important to consider if psychedelics were to be implemented in palliative care practice. Palliative professionals noted the daily difficulties in having a system directed towards efficiency maximisation, describing the effect that this had on the quality of care given to patients. Psychedelic researchers, on the other hand, suggested that profit maximisation, not cost minimisation, was a key strain on psychedelic therapy, with some describing how corporate interest in psychedelics may again undermine providing quality care, or that *"corporate intellectual property be prioritised above patients interest" (PR/T Participant 2).* At this intersection, it seems that for those specialists whose role identities are more 'front end', managerial thinking tends to compete against the ideals and goals with which they themselves attribute. From this internal finding, potential conflicts between the managerial logic and other professional logics can be anticipated between the two domains.

Another important inter-domain tension present in the interview findings concerns a debate ongoing within the psychedelic community relating to the psychedelic logic, that being the question of whether guides should have had experience(s) with the compound they are guiding people through. A controversial idea certainly, with some serious practical challenges in terms of potential assimilation into palliative or regular care. Because these substances are known for having such boundary dissolving and in some cases 'mystical' experiences attached to them, this debate carries some significant weight. In favour of the idea, one respondent likened the idea to the choice of going to see two sex therapists to discuss kinks. In the weigh up of having someone who has personal experience with kinks vs a therapist that had never actually had sex before, the choice would then be quite clear. How this can be facilitated in palliative care, and whether or not this would need to be an obligation however is a big question.

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> *"There's a difference between having that understanding, mentally or intellectually and having the experience. And because people are in a very suggestible state, they are also incredibly attuned to how you, as a guide, respond. So if I see a client in panic, and the client looks at me, and I don't know what to do, they're going to pick up on the fact that I also don't know, and I'm also going to intensify the fear in them" (PR/T Participant 1).*

This debate on substance experience presents quite a unique conflict between the professional logics in palliative care, and the fledgling psychedelic logic taken from the field of psychedelic research/therapy. For one, it acts as a stumbling block for assimilation from a logistical standpoint, and presents new problems in terms of ethics, legality, the boundary between patient and doctor, as well as recreational and medicinal use. This boundary was also presented as a challenge posed to psychedelic research in general. As some respondents mentioned, the 50s and 60s proved to be a very promising period in terms of research into the use of psychedelics for medicinal purposes. At the same time, the use of recreational psychedelics ballooned, with the associated counter cultures such as the hippy movement. What respondents mention is that when this boundary becomes unclear between recreational and medicinal use, the risk of history repeating itself becomes quite high. That is that ongoing stigma, the occasional unfortunate accident and ultimately public policy change, such as the Nixon era policies captured by the 'War on Drugs', severely affecting the implementation of psychedelic medicines and its research. If psychedelics are labelled in a certain way based on recreational & societal use, it is hard to prevent this stigma from spilling over into the research.

Overall, it seems from explicit discussions on the topic that there is indeed considerable overlap between the institutional logics of both psychedelic research/therapy and palliative care. For one, the holistic logics were noticeably similar, and the scientifically backed research and medical logics also shared many normative and cultural-cognitive elements. The tensions are also of vital importance in this debate however, in that they are relatively unique given the nature of the substances being discussed. This was most evident in the discussions with psychedelic researchers regarding guides requiring personal experience with the substances, and the risks of recreational use more generally. Other factors that were noteworthy include the unsurprising need for more hard conclusions to be made from psychedelic research, thus legitimising the use of psychedelics in the medical sphere. Legitimacy for palliative specialists was represented by the authority given through the medical guidelines & protocols which establish appropriate practice. This legitimacy, particularly in the regulative and normative sense, was a vital aspect of the debate on the future of psychedelics in palliative care practice.

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7.0 - Discussion

Empirically, the interviews conceptualised the norms, values, and means of operating within palliative care and psychedelic research/therapy as consisting of multiple institutional logics. This logic multiplicity was very much clear from the offset, especially considering the rich array of literature establishing this notion (Reay & Hinings, 2005; Scott et al., 2000). Indeed as Kraatz and Block (2008: 243) suggest, professions, of which there are many in both of these cases, are *"subject to multiple regulatory regimes, embedded within multiple normative orders, and/or constituted by more than one cultural logic"*. The consequent micro-level comparison across domains presented an overlapping array of conflicting logics between psychedelic research/therapy and the palliative care case, showing novel and sometimes surprising insights in the process. With this comparative exploration complete, it is now possible to answer the final research question on the implications for policy makers and professionals assessing the value of psychedelic therapy in palliative care. In this next section I will examine this, first by establishing what the findings mean on the micro-level, and then by speculating about the opportunities for institutional change, i.e. what the possible future pathways might be with respect to psychedelic use in palliative care. This will be followed by a discussion regarding the contributions of this paper, as well as recommendations for future research.

7.1 - Implications for Policy Makers & Professionals

In order to structure these implications in a satisfying way, I would like to draw attention back to the theoretical basis for institutional logics, and Scott's (2008) three pillars from which institutions are built: the regulative, normative, and cultural-cognitive. Starting with the implications from the regulative pillar which accounts for perhaps the most substantial barrier in the medical sphere, being concerned with the laws and formal rules which actors need to adhere to (Scott, 2008). Here the barriers are quite evident, palliative care will simply not benefit from psychedelics until the compounds are legally ratified for medical use. Approval will need to come from multiple regulatory bodies before it is even possible to use these substances as a medical therapy for palliative patients, which in the end will be completely reliant on the conclusions drawn from current and future clinical trials. On top of this, the time and costs associated with its implementation, and the logistical efforts required are considerable, as respondents

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from both domains agreed. As this was very much clear from the beginning of this research, questions on this matter are not that intriguing. What is intriguing is questioning what this means in terms of the micro-level results. As the palliative care findings showed, protocols and guidelines form the basis for decision making for all palliative specialists, regardless of prioritisation of the holistic logic. Some actors may deviate from this rule book, but for the most part, specialists obey them, given that they provide the formal means to operate, interact with other specialists, and issue accountability for these appropriate means. If psychedelics were medically approved, palliative care specialists would fall on the substance specific protocols to carry out their work. As the results of this paper suggest, this is directly because they seek legitimacy through the scientifically backed and highly regulated medical logic.

Unlike the regulative pillar that is legally codified, the normative pillar includes non-codified elements, referring to common norms, values, and acceptable behaviours. Findings from the interviews were generally focussed on this normative element within institutional logics. What was the preferred or desirable way by which palliative care and psychedelic therapy work was undertaken, i.e. what were the standards against which existing behaviours could be compared. This includes also the role identities, duties, responsibilities, which these specialists had in their domains. The normative implications of the findings are very much in line with the inter- and intra- domain overlaps and tensions already discussed. For professionals across both domains, the realisation should be encouraging that more often than not, the norms, values, and means of operating in palliative care and psychedelic research/therapy are remarkably similar. There is a conventional, scientifically backed, approach to patient care and research, as well as a more modern, niche, multidimensional holistic approach spanning both cases. Given that, as Besharov and Smith (2014) suggest, institutional logics provide a coherent set of organising principles for a particular realm of social life, the fact that there is so much overlap in logics should be promising. Specialists from both domains were notably emphatic individuals that were forthright about the challenges they saw with the use of psychedelics. Again these views tended to be aligned, noting the current lack of empirical evidence, the basis for use given medical approval, and the difficulties that would come from it. Even the intra-domain tensions should to some extent be recognisable for specialists across cases, with both suggesting contention between professional logics and the managerial logic, each requiring a different set of behaviours from actors within the field. This in itself constitutes a convincing argument for the implementation when the norms and goals, and even internal tensions, are aligned as well as they are across domains. If as Greenwood et al. (2011) state, institutional logics are expected to determine the appropriateness of practice, results from this micro-level exploration should be encouraging. Policy makers and managerial professionals should thus play into these overlaps in the event of psychedelics being medically approved for palliative use.

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The final pillar, the cultural cognitive, is formed on the individual level. It refers to prevailing cultural beliefs of practice amongst its social audience, addressing the symbolic nature of human activities in society, and the frames by which meaning or sense-making is made (Scott, 2008). The most significant implication of this study with respect to these cultural-cognitive dimensions concerns the fledgling psychedelic logic found in the clinical trials. Although also captured by normative elements, the main facet of this logic at this point concerns sense-making around psychedelics, or perhaps even the frames of meaning created as a consequence of the use of these substances. Attached to this cultural-cognitive element are implications for policy makers and professionals moving forward. Whether sense-making surrounding psychedelics comes through recreational use or not, the implications from a logistical and ethical point of view are quite significant, particularly in the debate over personal psychedelic experiences for guides. If indeed psychedelic therapists were required to have had experience with the drugs, this would need substantial resources to achieve, to the extent where this would seem unrealistic to roll out in every palliative team. Given the radical nature of this experience, it is safe to assume that many current caretakers in palliative practice would decline it. Consequently, new roles would need to be created, again at great cost in time and resources. Facilitating this resource demanding endeavour would certainly be a key stumbling block if substance experience is truly necessary.

The existence of this fledgling psychedelic logic also suggests something quite important about the contention between multiple logics. Indeed it enacts a completely different set of goals and frames by which meaning is made, which might not just contest the scientifically backed medical logic, it may even be incompatible in some ways. This is also relevant for discussions regarding objectivity, which itself is a vital component of the scientifically based medical logic, and yet is questionable in a cultural-cognitive system of thought that seems very focussed on the successes of psychedelics. As Kooijman et al. (2017) suggest, logic contestation often creates scenarios whereby the less dominant logic is not regarded as legitimate, is not taken for granted, and is not supported by authorised powers. This was evidenced to some extent by the spiritual caretaker who noticed that less authority was given in the decision making process, thus indicating a predisposition towards certain roles in palliative care. Indeed, there certainly lies a risk here for those aligning most with the psychedelic logic if they aren't seen as legitimate. Conversely, legitimacy towards the psychedelic logic may be established if the substances are framed beneficially by those embedded within the holistic and medical logic. An encouraging sign with respect to this came from discussions on recreational use by patients, by which some respondents were very tolerant. These findings indicated that there is already a lot of leniency towards the wishes of the patient, with or without medical approval. All in all, the cultural-cognitive pillar shows how preconceived ideas regarding

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the framing of drugs, or lack thereof, decide how patients will be treated. This shows that although the logics available to actors are structured by the institutions in which they are embedded (Thornton et al., 2012; Battilana and D'Aunno, 2009), actors still have partial agency that allows them to use logics as they judge appropriate to the situation (McPherson & Sauder, 2013).

Fundamentally, the assimilation of psychedelic drug treatment in palliative care is contingent on legitimacy. The micro-level dynamics of this are quite clear and coherent throughout the findings of this study. Medicinal psychedelics will not be regarded as legitimate and supported by authorised powers without regulative backing. Norms and role identities attributed to the normative pillar will also not legitimise this new practice unless aligned, which is as relevant on the individual level of sense-making, or the cultural-cognitive pillar. Findings from the exploration into institutional logics positively endorse this idea, given that they themselves define legitimate from illegitimate activities (Scott, 2008; Thornton et al. 2012). What does this mean about the future pathways which we might expect from these cases however?

Given the findings of this paper, I speculate two scenarios of how this legitimacy will play out. The first and perhaps most likely scenario is that through further clinical studies, and more scientific backing, psychedelic therapy will slowly start to fit the model of established palliative care practice. Regulatively backed, and embedded within palliative guidelines, psychedelics will legitimise themselves amongst the holistic, medical, and managerial logics, as a new form of treatment improving the wellbeing of patients, much along the lines of the CBD oil case. This will require the alignment of normative and cultural-cognitive elements, which this paper has already shown to have much overlap already. The second scenario I foresee draws from the paper of Rao et al. (2003) regarding the replacement of dominant logics. In this paper, the authors develop the notion of change from within, where actors at the core of logics use identity-discrepant cues as the sources of change, for instance in theorising new roles and legitimising those activists who defect from previously dominant logics. The new insurgent logic then becomes progressively accepted as these identity discrepant cues accumulate (Rao et al., 2003). As the findings from the palliative case have already shown some leniency with respect to the use of recreational psychedelics, in this case, framed in terms of patient freedom of choice, activist tendencies against the dominant professional logics have already been established. This identity-discrepant cue suggests a possibility that activist powers within palliative care could in fact change its underlying medical logic by aligning itself more with psychedelic sense-making. If certain recreational psychedelics are legal for instance, then perhaps this may already act as an alternative to medical approval. Compassionate use could then, through this activism, become more legitimised within the medical logic, thereby slowly

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changing it. Establishing programs or policies that expand access to recreational use, or compassionate use, might provide this identity-discrepant cue with more legitimacy for example. This scenario shows that regardless of the goals set by policy makers and professionals, either in the importance given to scientifically established treatments, or the freedom of choice of the patient, an awareness of the potential for internal change by activists is important. Indeed this reflects a valuable implication of these insights more broadly, that by understanding how specialists experience and legitimise their work, one can foresee the possibilities of how these dynamics will interact with new practices, and therefore even how these institutions might change in future.

7.2 - Contributions & Recommendations

Reflecting on the theoretical insights of this study provides cases of multiplicity in logics that solidify and build on earlier micro-level studies (McPherson & Sauder, 2013; Cain, 2014; Van den Broek et al., 2014). Like these authors, this study displays the agency, interdependency, and situational constraints of actors within multiple logics, and provides evidence that institutional logics reinforce established practices. Interviews with psychedelic researchers and palliative specialists showed that institutional actors are active participants in interpreting multiple logics in ways that are guided by, and shape, their social position. Analysis of these interviews also presented some novel contributions to institutional logic literature. For one, the case of palliative care in The Netherlands suggested a divergence from other previous studies focussed on the same empirical setting (Cain, 2014; Van den Broek et al., Rosenburg, 2007). Despite the relatively equal mix between the medical, holistic, and managerial logics presented in these studies, findings from this paper would suggest otherwise. Although consistent in the identification and multiplicity of logics, a clear hierarchical prioritisation for the holistic logic was also evidenced. Previous studies it seems are not specific enough to the Dutch case, which this study has suggested is more embedded within the core ethos of palliative care than previously suggested. Insights from the psychedelic domain were also novel in institutional logics literature. Whilst conceptualisations of the research and holistic logic were demonstrated in other empirical settings (Cain, 2014; Dunn & Jones, 2010), the existence of these within the psychedelic space are insightful. Not more so was this theoretical novelty shown than in the establishment of a fledgling psychedelic logic, which in its distinct set of cultural-cognitive and normative elements represents perhaps the most interesting contribution of this paper.

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Another important theoretical contribution to consider is the cross-case comparison of institutional logics presented in this research. Whilst scholars understand with greater nuance the multiplicity of institutional logics which pervade organisations, exploration of multiplicity across domains is relatively underexplored in institutional logics literature (Besharov & Smith, 2014). Despite this, cross-case comparisons have a lot of value with respect to ex-ante cross-case application, and more generally in how theoretical insights from institutional logics can be applied in practice. In cases where the adoption of a new practice is being explored, understanding the logics behind each domain and comparing the overlaps and tensions across them not only anticipates potential barriers in the future, it helps identify leads to resolve them. This is particularly the case in comparing logics on the micro-level, in that by linking the norms and values of actors with their actions and behaviours, one can speculate who potential allies and activists might be if these logics were to interact in future. In the same spirit, cross-case comparisons of logics can act as a bridge across cases that typically do not speak to one another, not just to open new channels for theory development, but also perhaps more importantly to anticipate cross-case partnerships and collaborative challenges. I believe that looking at this unexplored aspect within the institutional logics approach will deepen its applicability to those policy makers and professionals who might need to assess the internal dynamics of an organisation or explore the potential of a new practice. In this sense studies of this nature are undervalued from a practical standpoint within this theoretical frame.

Despite the contributions of this study, there are some limitations that ought to be discussed to contextualise these findings for use in future studies, focussed mainly on capturing the institutional logics. The interviews attempted to do exactly this and were driven by respondents' experiences, challenges, and thoughts on their respective specialisations. No further substantiation could back up these responses, however, which came with the risk that answers were perhaps idealistic, or given the timeframe for the interviews, that responses were not fully established and lacked information. By substantiating claims through observed actions and behaviours of actors in the field, i.e. through field research in both domains, this risk would have been mitigated. Despite the potential for incomplete information, the approach remains valid given that this paper was interested in how individuals explain their own behaviour, seeing reality as constructed through the meanings created by people (Walsham, 1995). Whilst I sought to be sensitive to the ambiguity and contestation among multiple logics in the consequent analysis, it should be recognised as indeterminate, relative, and time and context-bound (Van Wynsberghe & Khan, 2007).

As for practical recommendations as to where further studies can continue; it is clearly evident that more scientific knowledge on the use of psychedelics is required in order to legitimise the substances in the medical sphere. Assumptions specific to this notion had already been predicated at the start of this

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research as the intention was more to contextualise the current state of affairs across domains. Findings from this paper and other studies have shown these domains to be institutions that are constantly changing, and with the temporal snapshot of palliative care and psychedelic research/therapy provided in this study, it would be particularly insightful to see how this multiplicity in logics changes over time. Thus to conduct a similar study that follows changes in these overlapping arrays of conflicting logics would be beneficial in this regard. Another valuable additional study would be to conduct comparative research across different nations. The Netherlands was chosen for this paper given the expertise in these domains, and the relative ease with which interviews could be organised. For a more comparative perspective of the potential of psychedelics, a study of this nature could also be run in other countries. The UK and USA would for instance be a beneficial sites for further analysis. For one, they are also locations conducting multi-site international clinical trials, and they each have distinct and well established practices in palliative care. Further studies that broaden the theoretical scope used in this paper would also be appropriate, such as elaborating the linkages between micro-interactions, meso-level organizing, and macro-level institutional features and policies. All in all the opportunities for further research are considerable and worthwhile, given that these new drug treatments may provide relief for the psychological suffering of palliative patients in future. Understanding the differences and overlaps in institutional logics may ease the process if these substances were to ever be implemented into practice and is, therefore, a valuable undertaking now and in future studies.

8.0 - Conclusion

Driven by the need to improve available treatments for palliative patients (LeMay & Wilson, 2008) and the promising results stemming from psychedelic research in this field (Reiche et al., 2018; Reiff et al., 2020), this research paper set out to determine the potential for overlap by conceptualising the micro-level institutional logics of both palliative care and psychedelic research/therapy. In doing so, I identified a hierarchical prioritisation for a holistic logic within palliative care, defined by its multidimensional, patient-centred approach to care (Cain, 2014). Complementary to this were indications of a medical logic, conceptualised as the more conventional approach to medical practice (Rosenburg, 2007), and a business-like managerial logic, well developed in institutional logics literature (Jackall 1988; Van den Broek et al., 2014). Overall, findings from this domain constituted a novelty in relation to previous studies, suggesting that Dutch palliative care practice is deeply embedded within its core principles, where holistic values and norms are dominant. The psychedelic research/therapy findings on the other

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hand presented some equally original findings, and constituted uncharted territory with respect to institutional logics. Here the field was conceptualised as a mix between a holistic logic, largely identified in line with the palliative case, and another professional logic, the research logic, centred on the scientific method, and the search for objective truth. A residual observation, which I label as the psychedelic logic, explained the remaining sense-making surrounding the clinical trials, defined by the distinct motivations for studying psychedelics, beliefs surrounding their potential, and a general passion for the substances that could not be explained by any other logic.

The aim of this paper was not only to identify institutional logics but also to explore the overlaps and tensions within and between cases so as to provide policy makers and professionals with practical insights derived from theory. This approach in itself was a significant theoretical contribution to institutional logics literature, with the key takeaways from this exploration being as follows: Firstly, both fields showed a promising alignment of norms and goals in their approaches to care, suggesting considerable overlap between the identified holistic logics. Second, the scientifically derived medical and research logic also showed many similarities, both providing legitimacy towards actors in how they carried out their work. Third, intra-domain tensions with the managerial logic and the professional logics were also identified in both cases and were mainly concerned with the misalignment of goals regarding efficiency and costs. Finally, representing the most significant stumbling block in the proliferation of psychedelics, as evidenced in the debate on substance experience, is the tension between the psychedelic logic and the scientifically based logics. Whilst indications of activist powers within palliative care suggest some alignment with this psychedelic sense-making, for the most part, its implications, its goals, and the issues surrounding objectivity, challenge the assimilation of psychedelic drug treatments.

As Greenwood et al. (2011) posit, understanding how actors value, understand, and undertake their work has implications on the adoption of new practices, so in establishing what the tensions and overlaps are between these elements, one can better understand the stumbling blocks posed by new practices. This highlights a particular strength of the micro-level approach used in this paper, in allowing for speculation based on sound empirical analysis. It is also justified ex-ante to any medical approval in that practical insights from these overlaps and tensions can be postulated before time and resources are invested into such an endeavour. So where does this leave policy makers and professionals assessing the value of psychedelic treatments in palliative care?

It remains uncertain whether or not psychedelic drug treatments will become part of the toolkit of palliative care. Despite real risks, early-stage studies suggest significant therapeutic potential for those

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plagued with serious psychological suffering, so further exploration is therefore certainly warranted. What the findings from this paper present with respect to its potential in palliative care is equally encouraging. For one the alignment of many of the norms, values, and means of operating amongst the various specialisations is significant, even with regard to overlaps in the internal logic tensions. Legitimacy will be key here, either backed through the professional logics and the regulative instruments that provide this legitimacy or potentially even through the activist powers present in palliative care. Depending on the position of policy makers and professionals, either stressing the rigorous testing of treatments, or the importance of freedom of choice in dying, the insights from this paper are quite clear. A deeper awareness of how specialists across domains carry out and view their work is critical in understanding how these substances could become legitimate. Ultimately, it is these specialists, with their distinct experiences, values, and frames of meaning, who will determine how psychedelics will be adopted into palliative care practice. Being on the cusp of a number of medical approvals for psychedelics, with a critical advancement in the field (Tupper et al., 2015), this temporal snapshot of two rapidly changing domains is significant. By providing meaningful insights into these prospects for adoption, I hope that this paper throws light on an encouraging potential partnership, which may one day offer a novel and transformative new treatment for those dealing with serious psychological suffering.

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9.0 - References

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10.0 - Appendix 1: Interview Guide (Palliative Care)

Interview Guide (Palliative Care Specialists)

Determining Institutional Logics - Norms, Values & Means of Operating

~ 30 - 60 mins ~

Just to clarify before we start. Do you consent to take part in this research as explained in my previous mail, and for this interview to be recorded so that I can review the responses later? I will send an informed consent form later to confirm this after the interview.

Do you have any questions before we begin?

NORMS AND DAILY OPERATIONS

How long have you been working in palliative care?

How would you describe the work that you do? what role do you play specifically?

prompt: multidisciplinary working - who do work with day to day?

prompt: leading to your current role - what have you worked in previously?

What are in your opinion the most important features of palliative care as a practice?

prompt: what's the difference with other care approaches?

VALUES

Are you proud to work in palliative care? if so, what makes you proud?

What is the most rewarding aspect of your job?

CHALLENGES

What are the main challenges of working in palliative care?

prompt: examples / anecdotes you are willing to perhaps share?

What is an aspect of day to day operations which you would like to improve?

THE FUTURE

Do you see palliative care changing in future? if so, how?

prompt: Are there any notable changes in the time that you have worked in

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palliative care? were these changes for the best?

At the moment there is considerable research being done on the use of psychedelics for medicinal use. Are you aware of this research at all?

prompt: What is your position on the use psychedelic drugs as a medicine?

If psychedelic drugs were medically approved, could you see the possibility for the use of such drugs in palliative care practice. why / why not?

prompt: What are some of the challenges which would need to be overcome?

CLOSING POINTS

do you have any questions?
possibility for colleagues to take part in research?

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11.0 - Appendix 2: Interview Guide (Psychedelic Research/Therapy)

Interview Guide (Psychedelic Research Specialists)

Determining Institutional Logics - Norms, Values & Means of Operating

~ 30 - 60 mins ~

Just to clarify before we start. Do you consent to take part in this research as explained in my previous mail, and for this interview to be recorded so that I can review the responses later? I will send an informed consent form later to confirm this after the interview.

Do you have any questions before we begin?

NORMS AND DAILY OPERATIONS

How did you end up in psychedelic research? what led you to it, was it a longtime goal or rather by chance?

Can you tell me about the research that you are conducting?

prompt: can you describe the setting you provided for your patients?

How would you describe the work that you do? what role do you play specifically?

prompt: how is the organisation structured?

What are in your opinion the most important aspects of the research you are undertaking?

VALUES

Do you find the work you do rewarding in any sense?

What would you see as a success in the research you are doing?

CHALLENGES

What are the main challenges of the research you are undertaking?

prompt: what are some of the challenges regarding the testing of such drugs

prompt: examples / anecdotes you are willing to perhaps share?

THE FUTURE

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If the results from the trial could be confirmed on a larger scale, do you think this kind of therapy could become generally available, and if so, how long could it take?

Could you see the possibility for the use of such drugs in palliative care practice for. why / why not?

prompt: if so, what are some of the challenges which would need to be overcome?

where would the obstacles lie?

Do you have any plans for future psychedelic studies you would like to carry out?

If you had absolute freedom, what kind of research would you like to do with psychedelics?

CLOSING POINTS

do you have any questions?

possibility for colleagues to take part in research?

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12.0 - Appendix 3: Informed Consent Form

INFORMED CONSENT FORM

Psychedelics & Palliative Care

A Comparative Analysis of Institutional Logics

I confirm that:

- I am satisfied with the received information about the research;
- I have been given opportunity to ask questions about the research and that any questions that have been risen have been answered satisfactorily;
- I had the opportunity to think carefully about participating in the study;
- I will give an honest answer to the questions asked.

I agree that:

- the data to be collected will be obtained and stored for scientific purposes;
- the collected, completely anonymous, research data can be shared and re-used by scientists to answer other research questions;
- video and/or audio recordings may also be used for scientific purposes.

I understand that:

- I have the right to withdraw my consent to use the data;
- I have the right to see the research report afterwards.

Name: _____

Signature: _____ Date: ____ / ____ / _____

(sent by mail)