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Dixon, Liz

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# **‘I’m only a volunteer’: unravelling the complexities of the mundane in roles undertaken by volunteers.**

**Liz Dixon, University of Huddersfield, UK.**

## **Introduction:**

Hospice volunteers in this study carry out their role both in the hospice itself and outside in the wider community. They may work independently and alongside paid staff within in-patient and day care, reception duties, fundraising and retail; the board of trustees is also comprised of volunteers. This paper focuses specifically on volunteers working within the hospice setting carrying out what may be considered to be low skilled and in other workplaces usually low paid jobs such as reception, providing refreshments, driving, and administrative duties,

Extensive literature exists which explores the concept of workplace learning including formal, informal and emotional aspects of learning (Billet 2004, Rainbird et al. 2004, Eraut 2004, Duguid et al 2013, Benozzo and Colley 2012, Fuller and Unwin 2010). There is some published research into the work of volunteers (Livingstone 2011, Schugurensky et al 2010) and their informal learning (Morris, et al 2013). This paper draws on data from an ethnographic study which examined volunteers’ work in a professional workplace. The research took place within a hospice over a period of four years, where I immersed myself as a researcher in the setting. This approach helped obtain ‘thick description’ (Geertz 1973), and rich, detailed data from one institution, leading to findings which are likely to be particularistic and even unique to the hospice (Henn et al 2009). One could liken the approach metaphorically to a police investigation into a specific crime, involving finger-tip searching, house-to-house enquiries and use of local knowledge, whilst at the same time, as appropriate, drawing on data from National databases and similar cases elsewhere. The crime itself will be unique but findings and patterns may subsequently contribute to detection of crime elsewhere.

The research suggests there is a shared understanding amongst volunteers and paid staff of some aspects of the work of volunteers and some specific knowledge and skills required to carry out a particular role. These are explicit in artefacts

relating to volunteers such as the hospice website, policy documents and volunteers' induction training. However, there is a difference between the ways in which volunteer roles are described, and the volunteers' practices as they enact their role. Brown and Duguid (1991) explain this as the difference between 'canonical practice' and 'non-canonical practices.' This concept will be explored more fully below with reference to the data.

Aside from the clearly defined learning, volunteers acquire culturally transmitted knowledge about death and dying and find themselves needing to learn about palliative care, forming relationships and dealing with the unexpected. This learning is situated and contingent upon the hospice culture, and characterises the work and learning of hospice volunteers. It is that learning and 'workplace responsiveness' of volunteers associated with the demands and complexities of their work at the hospice which is explored within this paper.

## **Background**

The world's first modern hospice, St Christopher's, was founded in London in 1967. A network of independent hospices was subsequently established across the UK, to provide holistic, palliative care to people in the final stages of life. Palliative care has since developed into a complex medical specialism in its own right and today's hospices employ highly trained, professional specialists in medical, clinical and non-clinical areas. Operating within the charitable sector, their workforce has always included both volunteers and paid staff within all aspects of the service they provide. With a UK volunteer workforce of approximately 70,000 in adult hospices, the economic value of volunteers to independent charitable hospices in the UK is estimated to be over £112 million (Help the Hospices 2014). Volunteers also gift their time, their emotion and their labour to the hospice movement.

## **Methodology**

As a trustee, and a volunteer at the hospice in other various capacities for over 30 years, I decided to undertake an ethnography within the institution in order to quite literally position myself in close proximity to staff and volunteers in a way that trustees would not normally be seen within a hospice. Trustees are responsible for strategic management, major policy decisions and upholding the vision and ethos of the organisation. The role requires trustees to have a degree of distance from the

everyday running of the hospice; operational decisions rest with the Senior Management Team. I recognise I have a pre-conceived notion of the work of volunteers based on my knowledge and experience as a trustee, but the ethnography enabled me to see things as those involved see things and 'to grasp the native's point of view' (Denscombe 2007). Finding out about the experiences of volunteers through an ethnography, also helped to better understand some of the institutional and cultural processes which shape them.

I saw examples of the work of volunteers at first hand, and this is already helping to shape my strategic thinking and consider the impact of management decisions on the people they affect. I feel privileged to have been able to spend time within the hospice, seeing and hearing about the work volunteers do and the stories they tell. It is perhaps something which others in managerial and strategic roles might usefully undertake in their organizations to better understand individual roles and to give voice to subordinates within an institutional hierarchy.

Given my role as a trustee, it has been important for me to establish relationships from the outset and be explicit about the intended approach, encouraging active input and involvement of volunteers and staff. These ongoing relationships and reassurances were established and developed through letters, regular conversations with groups and individuals, email correspondence and posters displayed within the hospice.

To collect data I have immersed myself in the setting over an extended period, observing, shadowing volunteers and attending meetings and events at the hospice. The ethnography also included additional data collection tools: interviews and supported focus groups with both volunteers and paid staff and consideration of visual and textual artefacts.

## **Discussion**

The hospice website lists the various options for volunteering, with a succinct descriptor of the roles. These role descriptors would be examples of what Brown and Duguid (1991) term 'canonical practice' in which, 'the role of the volunteer as espoused by the organisation, is presented'. The roles are descriptive, highlighting specific skills and qualities as a prerequisite of the job. Non-canonical practices' are

the actual practices that staff, or in this case, volunteers engage in and learn through to get the work done.

For example, the description of the receptionist role is:

*Good interpersonal and telephone skills are essential. The reception desk is the first port of call for most people visiting the hospice; therefore, a warm and welcoming manner is required.*

The reception area in the hospice is run by volunteers. Located near the hospice's main entrance and directly in front of an office where paid administrative staff are based, reception is the first point of contact for all visitors to the hospice. It is a central point for telephone enquiries, deliveries and is adjacent to a seating area for patients and visitors.

Volunteer receptionist AB talked about her first day on the reception:

*The first Sunday I was on, then somebody died, so of course all the relatives are coming out, so I have to sit them down, would you like a cup of tea, bring round the tissues and you know, behave appropriately and then some child brings in some money and they're going oh look at me, I've brought all this.....*

Volunteer receptionist, AS spoke of an incident which captures both the mundane and the complex:

*I do think it's difficult for them to come through the doors for the first time. .... yesterday, when I was on reception, she probably was only in her late twenties, thirties, and she'd come in with her partner and she was looking a little bit, you know, nervous and she'd obviously sort of was visibly upset and I said, you know, are you ok, and she said oh, we've just come to see the leaf and they'd bought a leaf for the mosaic. ....Next thing, she's walking back, obviously after the school had finished, with her three children. So she said I've brought them to see, you know, the leaf. Well the older child was visibly, she was visibly upset. The two younger ones were more interested in what we had for sale in the fridge and by the time we'd finished, I was going round to the kitchen to get spoons for them because they ended up buying chocolate cake and cream. So they were all sat in reception, but it's nice that they can feel that they can do that, because how could you do that at the hospital?*

The extract demonstrates a complexity which I will refer to as 'workplace responsiveness': comprising elements of spontaneity, intuition, cognition and emotion in dealing with the situation. An immediacy was required which did not allow for consultation or reflection; there was knowledge and understanding of the context and the practices of the setting, and an engagement with the emotional demands. This aspect of the work was not reflected in the description of the role as laid out in

the hospice documentation; data provided similar examples of that dissonance between role descriptors and actual practice.

Volunteer receptionist MR described her first day:

*I did Reception for one, one day and there was a really awful case, ... I had to go into see one of the patients, with the phone, because what they did in those days, they, if somebody wanted to talk to them, they'd ring us and we'd say right can you ring the mobile phone and then we'd take the mobile phone in there and there was like a five minute gap and I was sat with this girl, who was only in her twenties, desperately ill, very, very upset and it was horrible and raining outside... I can talk to anybody about anything. I hadn't a clue what to say to her, I just didn't know, I couldn't say isn't it a nice day, have you watched television, you know, what are you doing, how are you feeling, because I could see and I just said I can't, I can't do that, I don't want to do that anymore,..... No, I hadn't expected that, well I didn't know,...I didn't realise that you did things like that.*

The description of the Day Hospice driver role on the hospice website is:

*We require careful drivers to bring our patients to Day Hospice (using their own cars) and take them home again. Mileage/petrol costs will be reimbursed.*

Volunteer drivers are usually the first point of contact for a new day hospice patient. Typically, a patient will come to day hospice when they are within the final stages of their illness but are still able to continue to live at home. Volunteer drivers are allocated a patient and usually that driver will become their main driver for the days they attend the hospice. The first contact is a telephone call by the driver to the patient to make arrangements for the first visit.

*You never know what you'll find when you get there. You just have to use your initiative. They might have gone to hospital.. They might have just gone out ...they might have died and nobody let the hospice know....*

(DS: volunteer driver)

The drivers have talked about the conversations they have with patients and the ways in which they support and encourage them on occasions. They described when patients make the decision to come to day hospice. It can be seen by some as a turning point in patients' lives as some know little about hospices apart from the connection with death and dying. Patients were described as being 'nervous', 'apprehensive' and in one case 'terrified' during that first journey to the hospice.

Some of the journeys are some distance from the patient's home to the hospice and place the volunteers for considerable periods of time in a confined space on a one-to-one basis with some very poorly and vulnerable people.

*And they chat to you on the way home.... There was an empty chair for a couple of sessions and she asked me where x was. I had to tell her he'd died. She'd waited all day to ask.....*

(NM: volunteer driver)

This highlights some of the challenges faced by volunteers which are often not anticipated or planned for. Again, the dissonance of described and actual practice is apparent along with the 'workplace responsiveness' aspect of the role.

Some staff did recognise challenges volunteers may need to deal with:

*They [the volunteers] probably know a lot more than sometimes that patient shares with us and also we've had a few where, you know, they're going to the home situation, it's a bit of a crisis point, because our patients are poorly ..... a bit of a 999 situation. So it's reassuring the volunteers we're there. But they're fantastic, couldn't do without them.*

(Sister: Day Hospice)

The dissonances of the role as described and the actual practices also raise issues relating to training and support available for volunteers. A volunteer who distributes refreshments on the Inpatient Unit described his training for his role:

*How to use the, ..., erm, I call it a pot wash, ....., I've got one at home ...: dishwasher..., that's it, how to use that. .... Which bins to empty, which routine to use, where to put the recyclables, de da, de da, de da. .. and then come round and meet some patients. If there's any pots on, take them away and so on and so on. So it was generally helping the nursing staff, taking something away from them, if you like. And then when there's sort of nothing to do, she said you can go and chat with the patients if you want. I said yeah, fine, I've no problem with that. so I got my training off her and she said right, I'll let you loose on your own now.*

This contrasted with his description of experience:

*A few weeks ago there was a gentleman and he's been in twice now, erm, for respite, you know, he has Motor Neurone Disease. I used to play rugby with him, you know. So it's, it was strange at first, you know, me, you know, how are you doing, oh you know, and he wanted to tell everybody, all the nursing staff, I used to play rugby with him. Unfortunately (x) can't do anything for himself. So I gave him his tea, ... one of the nurses said will you be alright? I said yeah, fine, so I gave him his tea and one thing and another, which is fine by me..... and I do get a lot out of it..., this is strange, some years ago, I*

*could never accept death, or I couldn't talk about it and I couldn't, I'm perfectly honest about it, if it was ever brought up in conversation, I would either go out of the room or I just wouldn't speak about it , but since I've started at (the hospice), it's not so much acceptance of it, but I can talk freely with people, about it, if you like.*

All volunteers were able to describe Induction and some mandatory training but there was little awareness of other training available to them in the hospice. Some described learning from other volunteers when they first started their role, working alongside a more experienced volunteer for their first few sessions. There was no mention of volunteers being made aware of or trained for the 'workplace responsiveness' aspect of their role as captured in the data.

When asked about support available to them, with some prompting, the volunteers were able to name someone within the hospice who they would go to if they needed support in carrying out their role. They often interpreted 'support' as pertaining to help from a paid member of staff in dealing with a particular set of circumstances which required knowledge or skills the volunteer didn't have at the time, or aspects of the job they saw as beyond their remit. When prompted about other aspects of support, some volunteers, despite the demands of their role, talked about not requiring support or that in their role it was unmerited.

*Well I haven't felt as if I've needed it, to be honest, you know, sort of if you came in and it's in a morning, usually somebody's died, oh gosh, you know, so you've talked about it in that respect. No I didn't feel as if I needed to sort of come in and weeping about it, because that's not why you're here, you're only upsetting other people if they see you doing that..... That doesn't mean to say you don't feel it because you do, you do, over the years, I've got attached to a lot of people.*

(LM Volunteer driver)

Having variously observed, shadowed and spoken to volunteers, the formal descriptions and in many instances the volunteers' own awareness oversimplify the role they actually perform, and those descriptions belie the complexities of these volunteers' work. Orr (1990) suggests that many organizations are willing to assume that complex tasks can be successfully mapped onto a set of simple, Tayloristic steps that can be followed without need of significant understanding or insight, and thus without need of significant investment in training. That seems to imply a conscious and informed strategic decision on the part of those organisations.



However, in the case of the hospice, whilst this is possible, some staff and volunteers are clearly unaware of the complexity, and have needed considerable prompting during the research process to describe it. Furthermore, there was an apparent 'unknowing' or 'unconscious naivety' on the part of the volunteers as to the nature of their work. They required prompting to elicit descriptions of their work beyond the basic skills and often underplayed the impact of the demands and importance of the role: 'I'm only a volunteer' was a recurring phrase in their narratives.

## **Conclusion**

As both a researcher and hospice trustee one of the most rewarding aspects of the research has been witnessing and making more explicit the rich and often hidden complexity of the volunteer role. Having uncovered that 'workplace responsiveness', the research presents certain dilemmas. The dichotomy between role description and role enactment highlights the importance of further discussion about the extent and nature of any training and support required and/or made available to volunteers to prepare and sustain them in their role. The duty of care of an organisation should include the offer, or indeed requirement for wider and on-going training for its volunteers but formal training focusing on 'workplace responsiveness' could lead to a reductionist outcome. It may be counter-productive to make volunteers explicitly aware of the possible complexity of actual practice, since some volunteers might feel daunted and shy away from the role, thinking it would be something they should not or could not do.

Finally, the 'unknowing' or 'unconscious naivety' of volunteers about the nature of their work, does somehow seem to enable the sophisticated 'workplace responsiveness' characteristic of their work and learning, so confirming the value and unique contribution of volunteers within a professional workplace.

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