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Exploring the Landscape of Hospice Volunteering: an ethnographic study of the lived experiences of hospice volunteers

Liz Dixon

A thesis submitted to the University of Huddersfield in partial fulfilment of the requirements for the degree of Doctor of Philosophy

The University of Huddersfield

February 2021

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I also want to mention my father, whose vision and perseverance were instrumental in setting up the hospice and inspired my own interest in and commitment to hospices and volunteering. I doubt when he first set out to establish the hospice that he would ever have thought it would have led to me submitting this thesis. I know it would have meant a great deal to him.

Finally, and above all, special thanks go to my husband Jonathan, and our three daughters: Lucy, Emma and Clare. Their love and encouragement undoubtedly enabled me to complete this piece of work. This thesis is dedicated to them.

Abstract

This thesis is an ethnographic study of hospice volunteers based in a UK adult hospice. Studies into hospice volunteers often tend to consider volunteers as an homogenous group (Morris et al 2013), but this research takes account of the diversity represented within a volunteer cohort and examines a range of volunteer roles, including specific consideration of trustees and professionals working as volunteers. In the United Kingdom there are at least 125 000 volunteers supporting hospice care (Hospice UK 2020a). As hospices look to expand their services and with an increasing demand for End of Life Care in a variety of settings, the role of volunteers in sustaining that provision is likely to become increasingly important (Scott et al 2018).

The ethnography incorporated participant observation, interviews, specialist focus groups based on the principles of LEGO® Serious Play® and hospice documentation and artefacts. Data from the study are used to investigate the complexities of hospice volunteering.

The thesis draws on theories of situated learning and emotional labour to better understand the work and learning of hospice volunteers and the concept of liminality is used to explicate unique characteristics of hospice volunteering. Acknowledging the liminal space which hospice volunteers populate, helps to articulate the value and importance of hospice volunteers, and their place in the organisation. It explains the characteristics of volunteering which distinguish it from paid employment and implications for management and policy involving volunteers.

The main findings of the research include those relating to less tangible, social and emotional aspects of volunteering, revealing the rich and often hidden complexity of the role of hospice volunteers which contribute to the work of the hospice and End of Life Care. The thesis argues that hospice volunteering affords significant benefits to both the individual volunteers and to the organisation, but these beneficial outcomes are predicated upon the culture and practices which exist within the hospice. There are challenges involved in sustaining and developing hospice volunteering in the future, and maximising the use of volunteers' skills and expertise, especially in relation to volunteers' involvement in direct patient care. Finally, it contends that it is the liminal space of volunteering and the volunteers who occupy that space which help to sustain the unique character and ethos of hospice care.

Table of Contents

Copyright statement *2*

Acknowledgements *3*

Abstract *4*

List of Abbreviations *8*

List of figures *9*

Chapter 1: Setting the Scene *10*

Introduction **10**

Motivations for the research **10**

Background and Context of the Research: Development of the Hospice Movement **14**

Setting **17**

Structure of the thesis **20**

CHAPTER 2: Literature Review - The story so far of hospice volunteering. The known, the unknown and the still to discover *22*

Introduction **22**

Volunteers and Volunteering **22**

UK Hospices and volunteers **25**

Contribution of volunteers **29**

Motivations and reasons **31**

Staff and Volunteers: Boundaries: real and imaginary lines in the sand **35**

Professionalisation of hospice volunteering **36**

Emotional aspects of hospice volunteering **40**

Summary **42**

Chapter 3 Theoretical and conceptual frameworks *44*

Introduction **44**

Why Theory? **44**

Liminal spaces **47**

Volunteers and liminality **48**

Hidden aspects of Volunteers' Work and Learning: Work as described versus Work as practised **51**

Volcanic eruptions and Communities of Practice: how best to characterize the work and learning of hospice volunteers? **53**

Conceptualising Emotion in the work of Hospice Volunteering **58**

Summary **64**

Chapter 4 Methodology *66*
Introduction **66**
Qualitative approach **67**
Ethnography **68**
The research site **71**
Gaining access to the site and establishing relationships **75**
Sampling **80**
Research methods **82**
Participant observation: 'Being there' in the site: when, where and why? **85**
Interviews **94**
Visual research methods **98**
Description of the process 102
Ethics of the research study **110**
Consent 110
Ethical choices and the collection of data 114
Data analysis 115
Positionality: where is 'me' in the research? **117**
Role as researcher: insider, outsider, or a bit of both? **120**
Emotional aspects of the ethnography **122**
A place for thinking: Metaphorical thinking in the research process using visual landscapes **124**
Summary **134**
Chapter 5 The Liminal Space of Volunteering: What attracts volunteers to the space and what are the factors that keep them there? *135*
Introduction **135**
Accessing the liminal space of volunteering **135**
Summary **148**
Chapter 6 Volunteers and paid staff working together: Symbiosis and the liminal space *150*
Introduction **150**
Summary **159**
Chapter 7 The Role of Volunteers and their work in the Liminal Space: What goes on in that space? *161*
Introduction **161**
Work as described and work in practice **161**
Emotion work in the liminal space: support and coping strategies **167**
I'm only a volunteer: everyday conversations and 'just being there' **177**
Summary **180**
Chapter 8 Learning in the Liminal Space of Volunteering *182*

Introduction **182**

Formal Learning for volunteers **182**

Informal learning in the liminal space: been there, done that. The importance of work and lived experiences **185**

Communities of practice: do they work in the liminal space of volunteering? **187**

Learning and unlearning: in the hospice and beyond **196**

Summary **201**

Chapter 9 Conclusion: Bringing it all together and some final thoughts 203

Back to the beginning **203**

Reflecting on the research process **203**

Main findings and contributions to knowledge **206**

Conceptual reflections **212**

Further research **214**

Policy Recommendations for the future development of hospice volunteering **215**

And finally …… **215**

Epilogue: A hospice without volunteers during the Coronavirus pandemic..... 217

References..... 220

Appendix 1: Descriptors of Volunteer roles based at the hospice (adapted from Volunteer Information Pack on the hospice website) 234

Appendix 2: Volunteer Statistics as recorded on Hospice Database August 2020 235

Appendix 3: Record of fieldwork 237

Appendix 4: Information sheet for participants..... 240

Appendix 5: Information poster for the research project..... 242

Appendix 6: Consent form 243

Appendix 7: Interview Schedule 244

Appendix 8: Planning notes - Hospice Lego session with staff 245

91, 930 words

List of Abbreviations

DBS	Disclosure and Barring Service
EOLC	End of Life Care
LSP	LEGO® Serious Play® LSP
NIHR	National Institute for Health Research
SMT	Senior Management Team
TSO	Third Sector Organisation
WHO	World Health Organisation

List of figures

1.1 Categorisation of hospice volunteers……....**18**

2.1 Different types of volunteering (Cnaan et al 1996:371)……..**24**

4.1 A summary of the purposes of individual data sets in the ethnography …….**84**

4.2 Room layout for an LSP session……..**102**

4.3 How individual models were labelled in LSP sessions……..**103**

4.4 Large selection of materials for later use in LSP sessions……..……**105**

4.5 Example of a metaphorical build – 'A hospice volunteer'……..**107**

4.6 Collaborative build – The future role of hospice volunteers……..**108**

4.7 Example of initial themes and colour coding used in early stages of data analysis …… **117**

4.8 Desire paths and volunteers……...**127**

4.9 Confidence to navigate the unexpected……**128**

4.10 Different entry and exit points to the liminal space……..**129**

4.11 Erosion of the liminal space……**130**

4.12 Volunteer activity within the liminal space……**131**

4.13 Liminal space within the hospice……**131**

4.14 Regulation and management in the liminal space……**132**

4.15 Liminal space – longstanding volunteers……**133**

4.16 The strange and the familiar ……**133**

5.1 Discussion about risk and governance and the impact on the hospice……**143**

6.1. Metaphorical model 'Working with volunteers'……**156**

6.2 Metaphorical model 'Working with volunteers - Messy to manage'……**157**

7.1 The component parts of Workplace Responsiveness……**164**

Chapter 1: Setting the Scene

Introduction

This thesis uses an ethnographic approach to explore the experiences of hospice volunteers and the culture and practice of a workplace where volunteers and paid staff co-exist. It sets out to conceptualise volunteering and the work and learning of hospice volunteers. The research illuminates challenges and opportunities volunteering affords to both individual volunteers and the organisation and considers implications for policy and practice relating to volunteers within a hospice setting. The research sought to find out how the work and learning of the volunteers in a hospice was both enacted, viewed and understood by volunteers themselves and the paid staff with whom they interact in the hospice. The main aim of the study was to gather rich and detailed ethnographic data, in order to provide new insights into hospice volunteering within a professional workplace which provides End of Life Care (EOLC).

In carrying out this study, my own thinking and pre-conceived ideas in some key areas have been challenged and interrupted. Those areas include: the nature of work; the concept of learning; the purpose of research; and the role of the researcher in relation to participants and the field of study. These have become increasingly significant in my thinking and undoubtedly shaped my final thesis.

The chosen site for the research is a particular hospice, which, for the purposes of the thesis, is called Fernbank. Fernbank is a hospice situated in the North of England, and the research focused on volunteers and staff based within that hospice. The methodological approach was a multi-method ethnography with fieldwork undertaken over a period of four years. The research methods included participant observation, interviews and specialist focus groups. Secondary data was also obtained from documentation and artefacts pertaining to the hospice. The detail of all of this is examined in detail in subsequent chapters in the thesis.

Motivations for the research

My own history and biography are central to this research. As an experienced University lecturer and as part of my professional development I was required by my employer to undertake a PhD in the twilight of my academic career. In choosing the focus for my research, I decided to combine my academic interest in teaching and learning in Further and Higher education, with my professional background in nursing and a long-standing connection with a local hospice. It was with some initial reluctance and considerable

trepidation that I embarked upon the doctorate. My interest in hospice volunteers stems from a personal interest in and commitment to the provision of excellent EOLC, but more specifically it arises out of a longstanding connection with Fernbank, the hospice at the centre of the study. Fernbank opened in 1981, and my father was instrumental in establishing it. As such I had grown up very much aware of a project which evolved from an embryonic aspiration to an organisation being created and subsequently developed to the present day. My personal involvement and connections with Fernbank have been ongoing, since before it opened its doors to patients, to the present day and those connections have without doubt sparked and sustained my interest for this research study. It also means that I have a personal historical narrative which accounts for my awareness and interest in the development of hospice volunteering. More specifically, I had personal knowledge and experience of how volunteering at Fernbank has evolved over time and a 'gut feeling' that there is something unique about the volunteers that distinguishes them from paid members of staff.

As one who has been involved in a modern hospice since it began, I have seen the development of that hospice over time and the changing role of volunteers in that particular organisation. From my perspective (and I am very aware this is a personal view and I am very interested to find out how others see it), volunteers having such a direct role in establishing this hospice has left an indelible footprint which continues to permeate some of the current culture and working practices within the organisation. When Fernbank was first established, one of the intentions was to mimic care in one's home as opposed to a clinical setting and the physical space was more akin to a house than a hospital. That ethos was extended to the way in which individual patients and their families were cared for. In response to the development of Palliative Care as a specialism, the physical space and the building itself has been extended and developed over the years and other major changes have taken place as a result of the increasing professionalisation, regulation and accountability which are now prevalent in all health care services. The original building was a Victorian house where patients were cared for in four bedrooms, with a single office for nursing and medical staff and two lounge rooms (one for smokers). Fernbank now offers a purpose built 12 bedded Inpatient unit, a Day Hospice, designated administrative and fundraising offices and a 'no smoking' policy, with plans in place for further significant expansion and development of facilities and services.

My connections with the organisation extend over 30 years and I have had a direct involvement since it opened, firstly as a volunteer within the Inpatient unit and following that as a trustee for over 25 years. My dual role as trustee and researcher has been a significant

and recurring theme to be considered in the planning and implementation of this research and is discussed further in Chapter 4. The role of hospice trustees is to maintain a strategic overview of the direction and performance of the whole organisation and they also have a significant leadership role (Turner and Payne 2008). The principal function of the Board of Trustees is to ensure good governance and hospices are accountable to both the Charities Commission and the Healthcare Commission (Turner and Payne 2009). As a trustee I was often involved in discussions and decisions of policy and strategy which would impact on volunteers either directly or indirectly. I had a concern that at Board level, volunteers were usually referred to as an amorphous mass – 'the volunteers,' with little if any concern for or acknowledgement of individual difference. Hoad (1991) concludes that it is difficult to generalise about hospice volunteers because of the range of work they undertake, and the differences in the amount of time they commit, their responsibility for decision making and the skills they bring to their work. Furthermore, there were also times when I noticed that staff and volunteers were considered to be one and the same whilst on other occasions volunteers were forgotten or overlooked within policy issues which had relevance to them. Scott et al (2018:217) propose that 'the board of trustees (comprised of volunteers) along with senior staff, in determining the organisation's structure and approach, may empower or disempower volunteering through attitudes and processes'. As a trustee I share that view and would argue that conducting the research within Fernbank was a way of enhancing my personal learning and informing my decision making and strategic thinking.

My experience suggested that there was a rich depth of unexplored data which was waiting to be unearthed by getting in and amongst the world of volunteers and finding out more about their lived experiences. I had some early thoughts which subsequently provided a starting point for my research and informed the development of the research questions of the thesis. I was interested in determining the extent to which volunteers, including those who have direct contact with patients, provided a function distinct from that of paid staff. As a trustee, I was aware that hospices can sometimes be daunting and frightening places for members of the public and it may be that volunteers make hospices and their services more accessible to patients and the wider public in breaking down barriers relating to the services they offer, and the wider concern of death and dying. EOLC is also provided in hospitals and care homes but these typically do not rely upon volunteers and therefore I considered it important to see if the presence of volunteers helps to maintain important characteristics of a hospice which distinguish it from other providers of palliative care. Furthermore, trustees are responsible for strategic management of the hospice and so must consider volunteers in their development of policy and strategy. As a trustee I therefore thought it important to find out more about the nature of a workplace which comprises paid staff and volunteers. These

pre-existing ideas helped to shape the research and were instrumental in developing the overall aims and research questions, with the intention of getting below the surface of volunteering in a hospice.
The hospice website states:

'Volunteers are a vital part of the organisation. They provide an extra level of quality and care for patients, carers and their families and friends.'

The research set out to investigate the nature of that 'vital part' within the organisation and better understand what constitutes that 'extra level of quality and care' provided by hospice volunteers.

The main aims of the research are:

- to identify the contribution volunteers make to a hospice.
- to enhance understanding of the volunteering in a professional workplace.
- to contribute to the development of theories of emotional labour and situated workplace learning.
- to inform the policy and practice of using volunteers in a hospice.
- to build the research capacity of an independent organization within the voluntary sector.

Research questions:
RQ1. What are the benefits and challenges to individuals and to the organisation of hospice volunteering?
RQ2. What characterises the work and learning of hospice volunteers?
RQ3. How adequate are existing theories and concepts of emotional labour and workplace learning in explicating the work and learning of hospice volunteers?

In constructing the thesis, the research questions are important in giving focus and clarity to the work. However, it would be simplistic and naïve to think that within the thesis these questions can stand independently of one another and that they will each in turn lead to a neat response. Moreover, given the complexity and nuanced nature of hospice volunteering, it is difficult to signpost and attach discussion and analysis to individual questions. Rather, I shall offer a more holistic approach in my response whilst at the same time ensuring that each of the three questions is given sufficient attention such that the depth and detail that each one merits is not sacrificed.

Background and Context of the Research: Development of the Hospice Movement

Less than a century ago, death in the home was frequent and commonplace (Clarke 2020). Following on from the post-war years, by the 1950s, there were significant developments in medical interventions, drugs and treatments and social trends were changing. Most people died in hospitals rather than their own homes and the medical profession increasingly saw death as failure. However, cancer was seen as a 'death sentence', late presentation was common and survival rates were low. The disease was becoming a burden on the National Health Service and there was widespread public silence about the disease that prevented its name being spoken (Clark 2018). In my own professional life as a nurse, it was not uncommon to hear cancer referred to as 'the C word' and tumours referred to as 'shadows'. The modern hospice movement was a response to the increasingly institutionalized picture of death in the UK. At that time, there was an increasing tendency for doctors to equate death with failure, and all too often when faced with it, lost interest, avoided the subject, and even avoided the patient (Du Boulay 1984:173). I have personal recollections when training to become a nurse in the 1970s of patients on a hospital ward having received a terminal cancer diagnosis being moved to the end of a ward or a side room, their direct care being passed to nurses rather than the doctor. This was the cultural norm at the time and not something I questioned. 'The dying patient was hidden away. Doctors were brought up to think of death as a defeat' (Du Boulay 1984:173). Born out of frustration with the cold, technical, medical deaths many people had in hospital, hospices were radical, innovative institutions offering an alternative model of care and were based upon a holistic philosophy combining top quality medical services with social activities, spiritual and psychological care (Garber and Leadbeater 2010).

Dame Cicely Saunders was the founder of the modern hospice movement. Having first trained as a nurse and then as an almoner (modern day social worker), Dame Cicely then went on to become a doctor. She subsequently founded the World's first modern hospice, St Christopher's, in London in 1967, where she was medical director until 1985. She pioneered palliative care as a new speciality and died in July 2005 at the age of 87 (Shotter 2006). Her unique vision for the hospice was that it would combine research, training and care, either in the Hospice itself or at home (Du Boulay 1984). Since then a network of independent hospices has developed across the UK, within the charitable sector, providing holistic, palliative care to people in the final stages of their lives. Cicely Saunders was also instrumental in forming a global community of activists who promoted hospice ideas, campaigning against the twin undesirables: terminal neglect of the dying on the one hand and the medicalisation of death on the other (Clark 2018).

The World Health Organisation (WHO) defines palliative care as:

> An approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.
>
> (World Health Organisation 2002)

Terminology has evolved over time in relation to palliative care and these different terms are evident in the literature. In the UK at the start of the hospice movement the phrase terminal care was most commonly used, and then palliative care emerged; most recently EOLC has become the preferred terminology (Payne and Morris 2018:17).

In the 1970s and 1980s in the UK, there was substantial growth and development in the hospice movement (Turner and Payne 2009). Many communities set up charities to raise funds to build their own hospice, the hospice in this research being one such example. During that period the early hospice movement attempted to 'escape' from organizations (Hockley et al 2012) and their workforce has always included both volunteers and paid staff in all aspects of the service they provide. Hospices now provide specialist palliative care to individuals with life-limiting illnesses. Initially, the emphasis was on caring for adult, terminally ill, cancer patients during the final stages of their lives (Theodosopoulos 2011). However, hospice care is now also available to patients with a wide range of other life-limiting illnesses including conditions such as motor neurone disease, cardiovascular and lung disease and Parkinson's disease. Hospices are often associated with individual buildings, sometimes purpose-built, but hospice care in UK now extends beyond these buildings, into hospitals, care homes and into the community. The hospice care sector supports more than 225,000 people with terminal and life-limiting conditions in the UK each year (Hospice UK 2020a). It is a common misconception that patients typically come to a hospice to die. Many patients are admitted to an Inpatient unit for symptom control or respite care but then go home again. Fernbank's provision of care extends to the care of inpatients, day care patients and patients in the community.

The work of a hospice is underpinned by a philosophy of care which extends beyond inpatient units in a hospice building. Hospice UK provides a definition which captures the philosophy and scope of hospice care:

> Hospice care aims to affirm life and death. It means working with and within local communities to tailor palliative care around the needs of each adult and child with a

> terminal or life-shortening condition, whatever that may be, and extends to supporting their carers, friends and family before and after bereavement.
>
> (Hospice UK 2020b).

In the UK, hospice care can include inpatient units, day hospices which offer therapeutic and recreational care, as well as access to clinical services and home care in the community. It provides support for families and carers during and after the death of their loved ones through a variety of support groups. Hospices also provide expert advice and support to other clinicians and providers of health and care.

> Hospice care places a high value on dignity, respect and the wishes of the person who is ill. It aims to look after all their medical, emotional, social, practical, psychological, and spiritual needs, and the needs of the person's family and carers.
>
> (NHS 2018)

UK hospices are funded by a combination of government monies, charitable donations and fundraising. An analysis of the accounts of UK charitable hospices for the year ending 31 March 2018 (Hospice UK 2020c), showed that the size of hospices varies throughout the UK, from St Christopher's Hospice with £21.7 million expenditure to those hospices with an annual expenditure under £1 million. The smallest hospice has annual expenditure of just under £200,000. Furthermore, in total, the government funded 32% of the expenditure incurred by independent adults' hospices in the UK. Several hospices received less than 20% funding from government sources while at the other extreme 13 received more than 50% funding (Hospice UK 2020c). Adult hospices receive an average of 30% of statutory funding (Scott et al 2018:212) and so must raise the remainder required to run their services by fundraising. Whilst charitable income streams donated to voluntary hospices are significant relative to government funding, this income is uncertain and volatile (Theodosopuolos 2011; Watts 2012a). Scott et al (2018) considered the impact of hospice volunteering on organisation sustainability and their findings suggested a strong link between volunteering and the ability of hospices to remain sustainable. A questionnaire sent by the hospice to the volunteers at Fernbank in 2014 showed that in total 66,420 volunteering hours were given each year with an equivalent salary cost, based on the minimum wage at that time, of half a million pounds per year. Most of the positions held by volunteers would attract a paid salary well in excess of the minimum wage. The work which hospices do and the services they offer, together with additional demands on those services mean that volunteers play an essential part both in economic terms and in terms of the roles and expertise they undertake in many facets for hospice care. Working with and alongside paid professional members of staff, volunteers augment and in some cases extend the provision of services which hospices are able to offer. Dr Rachel Clarke (2020), recently

published her personal perspective of working as an NHS palliative care specialist. In it, whilst acknowledging the undeniable value of the clinical and medical expertise in EOLC, she also captured the important part that people play in that process:

> The morphine I prescribe, our clever drugs and infusions, all have undeniable value in keeping pain at bay. But when everything you have been and done and meant to the world is being prised away from your grasp, human connections are the vital medicine. It is other people who make the difference.
>
> (Clarke 2020:305)

Volunteers in a hospice setting are examples of those human connections, and as such the thesis seeks to investigate the difference volunteers make in providing a dose of that 'vital medicine'.

Setting

Fernbank is situated in the north of England. It opened in 1981 and has since been developed to provide a purpose built 12 bedded Inpatient unit and a Day hospice, which opened in 1995.The hospice provides a range of highly specialised EOLC, and offers support and advice to other clinicians, health practitioners, care providers and members of the public. There are currently over 700 volunteers registered with the hospice and the longest serving volunteer has been with the hospice for 31 years. Fernbank volunteers include those who are based on site, undertaking a variety of roles in all areas of the hospice, working with other volunteers and paid staff and involved both directly and indirectly with patients, their families and members of the general public. Fernbank volunteers also work within the local community, contributing through their involvement with the ten hospice charity shops and a wide range of volunteer roles and fundraising activities. It is worth noting that in 2016, the Care Quality Commission carried out an inspection of the hospice and in the full report which followed, there was no explicit reference to volunteers or their work in the setting. Appendix 1 provides descriptors of the full list of volunteer roles based at the hospice.

The Fernbank volunteers could be categorised by where and when they carry out their volunteering. The first group are formally registered with the organisation and are offered an induction and any mandatory training relating to their role. These individuals volunteer on a regular basis, either within the hospice itself or in one of the retail outlets commonly known as charity shops. They are line-managed by paid hospice staff. Many of these volunteers are of retirement age or have had to leave employment as a result of health issues. Literature exists which demonstrates the beneficial aspects of volunteering to older people (Principi et

al 2016; Russell et al 2019), including those who are not in good health or who are no longer engaged in work activities (Kahana et al 2003). Of those, some but not all have had previous connections with Fernbank, typically as a result of a friend or family member being cared for at the hospice, whilst others have seen volunteering as a transition from paid work following retirement. The second group comprises individuals who volunteer on an 'ad hoc' basis, typically engaging in one-off fundraising activities and events. This group is not part of any line management system but individuals may be offered an induction and specific training depending on their volunteer role. The voluntary activities of this group often take place in the community and may not require the volunteer to come to the hospice building. Finally, is a group comprising typically school or university students who volunteer in order to gain work experience, usually for short periods as a placement. These volunteers work alongside paid staff and more experienced volunteers at the hospice. Whilst the voluntary placements themselves are short term, that learning experience at the hospice results in some individuals continuing their links with the organisation, whilst for others it can be a factor which informs subsequent career choices. For example, the Counselling services at the hospice are heavily dependent upon volunteers who work with two professionally trained registered counsellors. The volunteers are often people who initially came for a formal counselling placement as part of their final year of university study and subsequently continue to volunteer on completion of their formal studies, to extend their professional practice and experience. The table below lays out the broad categorisation of volunteers, although within each group there may be variation and individual exceptions.

	Where volunteering takes place	**Training available**	**Line management or supervision**
Regular volunteers	Hospice based Charity shops	Yes	Hospice staff
Fundraising and events	Community	Not usually	No
Work experience and voluntary placements	Hospice based Charity shops	Variable	Supervision by individual members of staff

Figure 1.1 : Categorisation of the hospice volunteers.

The start of this research study coincided with the development of a new Volunteer Strategy document by the SMT at the hospice, the aim of which was to evaluate the current position of volunteers and to make informed future plans and strategic goals over a three-year period to enhance volunteering at Fernbank. The overall management of the hospice volunteers was the responsibility of the Volunteer Services Coordinator who was contracted to work 30 hours per week. The role included both strategic and operational management of the volunteers and was not part of the Senior Management Team. As can be seen from the table above, line management of some individual volunteers was delegated to specified paid members of staff but as the research will demonstrate, in practice this delegation of management to paid staff varied across departments and was often dependent upon the role of the volunteer.

For reasons of expediency, this study focussed specifically on volunteer activity within the hospice, although there are many other volunteers who operate outside the confines of Fernbank. However, some individual volunteers contributing to the study undertake roles both in and outside of the hospice building. In part this decision was based upon limitations of resource, time and feasibility. With over 700 volunteers currently registered with the hospice, I decided for the purposes of this study to limit the sample and to focus on the depth and detail of those volunteers' experiences who operate within the hospice itself, whilst at the same time acknowledging the importance of future research to include volunteers involved in the community, fundraising and retail activities of the hospice. Secondary data already held by the hospice provided some preliminary information about the scope of the volunteer role and demographic detail of the volunteer cohort working within and outside the confines of the hospice itself.

I did consider collecting data from a hospice with which I had no direct connection, rather than the setting where I have been actively involved over a long period of time. This would have changed my positionality in relation to the data and the research process and on the face of it be more objective. Chapter 4 includes consideration of the debate within ethnographic literature concerning being an insider/outsider and how this can shape and influence the research. At this point I would just say that in carrying out this ethnography I set out to 'avoid feeling at home …. and aimed to hold back a part of me to maintain some social and intellectual distance' (Hammersley and Atkinson 2007:90). There are obvious benefits to be had from learning from other settings and finding out about practice and strategy elsewhere. However, I wanted to find out more about the volunteers within the hospice where I was a trustee in order to: better understand the intricacies of volunteering; inform policy and practice within the hospice; and help to be a part of an embryonic research

culture at the hospice through modelling and actively involving staff and volunteers in the design and development of some aspects of the study.

In carrying out the research, I immersed myself in the setting, 'being there' (Trondman 2008), over an extended period, undertaking observation, shadowing volunteers and attending meetings and events at the hospice. The ethnography comprised data collection tools including: observation; interviews with both volunteers and paid staff; supported focus groups using metaphorical modelling, based on the principles of LEGO® Serious Play® (LSP) as described by McCusker (2020), and consideration of visual and textual artefacts. Further detailed discussion of the intended purpose and implementation of these methods is addressed in Chapter 4. In summary, the purposes of opening up different modes of communication was not necessarily to reach a single neat answer as 'triangulation' might suggest but to reveal the complexities of lived experience (Clark and Moss 2011). The research, whilst seeking to find out about the lived experiences of individual volunteers through an ethnographic approach, also looked to understand the institutional and cultural processes which shape that experience (Smith 2006). In addition to the 'skills-set' of volunteers, the study was designed to identify if there were institutional practices or assumptions which limit or encourage the contribution, work and learning of volunteers.

Structure of the thesis

Chapter 1 provides an overview of the research and a rationale for the study, including my personal motivations underlying it. The reader is provided with an introduction to the background and wider context of hospice care, together with the particular hospice at the centre of the research. The research process is outlined and the research questions which are addressed in the thesis are laid out in full.

Chapter 2 examines available published literature relating to volunteering in general and in particular those studies which focus on hospice volunteers. The review includes research which is UK based as well as studies into hospice volunteering in other parts of the world.

Chapter 3 introduces the conceptual theories and frameworks which have been used to abstract the data. Having discussed the place of theory in research the chapter moves on to provide a rationale for the selected theoretical concepts and their relevance to the research questions and methodology.

Chapter 4 provides a detailed critique of the methodology employed in the research. It includes the rationale for choice and a comprehensive and meticulous account of the implementation of an ethnography in the context of a hospice setting.

Chapter 5 is the first of four chapters addressing the findings from the research. Key themes which emerged from the study are discussed with reference to the reviewed literature and the relevant research questions. This chapter examines initial motivations of volunteers and factors which sustain their volunteering. It also considers the impact of current and historical recruitment and management practices pertaining to volunteers. The chapter discusses the opportunities and challenges of hospice volunteering for the volunteers themselves and the organisation.

Chapter 6 draws on the research data in conjunction with reviewed literature to discuss the extent to which volunteers and paid staff work together and support one another in the workplace. Relevant cultural and organisational factors are shown to be significant: the study reveals how working relationships can be both mutually beneficial and challenging as well as there being difference and variation within the volunteer cohort.

Chapter 7 examines in detail the role of volunteers and the nature of their work, drawing on the data, relevant literature and theories of workplace learning and emotional labour. Analysis exposes the complexity of aspects of volunteer work, characterised by workplace responsiveness and emotion work, both of which are shown to be inherent in the role. The study shows that time, 'being there' and everyday conversations, are important components of care and of particular significance in the context of hospice volunteering.

Chapter 8 is the final part of the data analysis where the data is used to provide an analysis of the workplace learning associated with hospice volunteering. It includes consideration in light of the data of both formal learning and informal, situated learning, with a conceptual analysis of communities of practice in the context of hospice volunteering.

Chapter 9 concludes the thesis. It begins with a review of the background to the study and a brief reflection on the research process. The main findings of the study are then brought together before setting out how the thesis contributes to new knowledge. The chapter also sets out the limitations of the study, policy recommendations and suggestions for further areas of research.

CHAPTER 2: Literature Review - The story so far of hospice volunteering. The known, the unknown and the still to discover…..

Introduction

This chapter provides a review of existing published literature which explores volunteering in general and more specifically, that which relates to hospice volunteers. The aim of the review is to critically analyse the literature and in so doing, determine that which is already known about hospice volunteering and any pervading themes in this area of research. The review will also be used to identify areas which merit further research and issues which may have been overlooked. The literature on hospice volunteers includes research conducted in UK and other countries and both will be utilised in the review. As noted in Chapter 1, the ways in which hospice volunteers are deployed varies in different countries of the world; most notably there are significant differences in the degree to which they are involved, or not, in direct patient care. In recognising the benefits of learning from research into different cultural approaches and practices, the review will include critique of research beyond the UK and consider volunteer work in the community as well as in hospice buildings. In the UK, separate hospices exist for the care of adults and that of children. Whilst there may be general themes which overlap and are pertinent to volunteering in both settings, the children's hospices because of their distinct nature of that specialism within palliative care, will also have very specific issues to them. Therefore, notwithstanding any common themes, the overriding focus of this review will be limited to the volunteering in adult hospices. Within the chapter emerging themes, together with gaps in the literature which are of particular relevance to this thesis have been identified. In brief, these include: emotional and social aspects of volunteers' work; workplace learning in the context of volunteering; and the researcher's role in carrying out ethnographic research in a hospice setting. It was also important when reviewing the literature to ascertain the research methods which were applied and use that information to validate the methodological approach in this study. The review begins with a brief overview of volunteering in general, as represented in the literature, followed by research which focuses specifically on hospice volunteering. Emerging themes together with the methodological approaches will be critically analysed and this systematic review will both validate the choice of research questions and support the methodological approach for this thesis.

Volunteers and Volunteering

The National Council for Voluntary Organisations (NCVO) provides a general definition of volunteering as being:

> Any activity that involves spending time, unpaid, doing something that aims to benefit the environment or someone (individuals or groups) other than, or in addition to, close relatives. Central to this definition is the fact that volunteering must be a choice freely made by each individual.
>
> (NCVO 2020)

Data from the National Council for Voluntary Organisations UK Civil Society Almanac (2020) showed that in UK over a third (36%) people volunteered formally (ie with a group, club or organisation) at least once in 2018/19. This gives an estimate of 19.4 million people who formally volunteered during that year (NCVO 2020). Research carried out by the King's Fund reported an estimated 3 million people volunteering in health and social care, in both the voluntary sector and within public services in England (Naylor et al 2013).

The concept of volunteering is a social and cultural construct and people's understanding of what volunteering is may be influenced by their social, cultural, historical and political positions (Lukka and Ellis 2001). Traditionally however, volunteer work is understood by many as unpaid activity oriented to help others and to improve society (Duguid et al 2013). Rochester et al (2010) similarly contend that the dominant view of volunteering in UK is that it is essentially an altruistic act involving volunteers delivering a service to others within organisations where they provide significant additional resource in the form of unpaid labour. Traditional hospice volunteering models fall into this category, with volunteers being formally managed by paid staff through hierarchical structures (Scott et al 2018). Billis (1993) characterises three forms of volunteering: unpaid work or service, activism and serious leisure. Developing these ideas Rochester et al (2010) underline the complexity of volunteering as a phenomenon by combining these to identify four hybrid forms of volunteering:

- Volunteering as a combination of unpaid work and activism;
- Volunteering as a combination of activism and serious leisure;
- Volunteering as a combination of serious leisure and unpaid work and
- Volunteering as a combination of all three elements

(Rochester et al 2010: pp15-16)

Historically many organisations, including hospices, have come to rely upon the long-term, regular commitment of volunteers. However, in response to societal and demographic changes over time organisations will need to consider innovative and flexible approaches to volunteering to sustain continuing contribution (Guild et al 2014, Scott et al 2018). This position is supported by recent findings from a large-scale national survey of the volunteer experience (McGarvey 2019), involving 10,103 respondents, which found that as people's

lives and priorities change, the ways they get involved in volunteering also change. Furthermore, the authors concluded that the sustainability of volunteer involvement means that organisations face ongoing challenges and a delicate balance in understanding, responding to, and meeting the range of different needs and expectations of current and future volunteers, whilst at the same time delivering services and activities effectively and safely. Howlett (2009:17) discusses the conundrum of providing 'light touch' but well organised volunteering in organisations where volunteers work, against a backdrop of increasing formalisation and tighter management. He expresses concern that growing bureaucracy can be a barrier to some individuals volunteering which in turn adversely affects diversity.

Cnaan et al (1996) provides a categorisation of different types of volunteering. The emboldened characteristics seen in the table are those which apply to the hospice volunteers in this study.

Dimension	Categories
Volition	**Free choice**
	Relatively uncoerced
	Obligation to volunteer
Renumeration	**None at all**
	None expected
	Expenses reimbursed
	Stipend / low pay
Structure	**Formal**
	Informal
Intended beneficiaries	**Benefit / help others / strangers**
	Benefit / help friends / relatives
	Benefit oneself (as well)

Figure 2.1 Different types of volunteering (Cnaan et al 1996:371)

The term ‘volunteer’ is therefore itself contested (Duguid et al 2013) and highly dependent upon context. Rochester et al (2012:37) assert, ‘multiple points of view make the task of producing a round-earth map of voluntary action extremely difficult’. While debate of the ‘bigger picture of volunteering’ is valid and important it falls beyond the scope of this thesis where the focus is directed specifically on the volunteering in the context of hospice care.

UK Hospices and volunteers

The literature on voluntary hospices is fragmented and scattered within academic and practitioner discourses (Theodosopoulos 2011:118) and hospice volunteers remain an under-researched aspect of palliative care (Harland 2016). Despite volunteers having been found to play an important part in its delivery (Scott et al 2018), specific research into volunteering in palliative care is still patchy and often focuses on the individual traits of volunteers (Payne and Morris 2018). One of the defining features of Third Sector Organisations (TSOs) is the involvement of volunteers, both at board and service level (Billis and Harris 1996). The complexity of volunteering is captured by Rochester et al (2012) describing their vision of volunteering as: ‘a broad, heterogeneous and untidy field of activity’ (2012:8).

In England and Wales, hospices provide specialist care and support for patients and their families who are approaching the end of life and have specific palliative care needs. Typically, hospices are small, independent organisations, operating within the Voluntary sector and only part-funded by the State. According to Hospice UK (2020a) there are at least 125,000 volunteers supporting hospice care throughout the UK. Furthermore, there is an increasing demand for volunteers as hospices expand their services amidst increasing social, economic, demographic and political demands (Morris et al 2017).

Goossensen et al (2016) define volunteering in hospice and palliative care as:

> The time freely given by individuals, with no expectation of financial gain, within some form of organised structure other than the already existing social relations or familial ties, with the intention of improving the quality of life of adults and children with life-limiting conditions and those close to them (family and others).
>
> (Goossensen et al 2016:186)

It should be noted that hospice volunteers in UK includes those who work within hospices in a variety of different roles (Watts 2012a), and also many volunteers who are engaged in fundraising and retail activities outside the hospice in their local communities. Indeed, ‘the word ‘volunteer’ does not adequately convey the complexity of volunteering in hospices’

(Scott 2015:80). Many hospices in UK, including the one in this study, originated in a particular building with a relatively small group of staff and volunteers based on site. Over time, many hospices have expanded their provision so that typically, they now have much larger numbers of volunteers both on site and also dispersed across a much wider geographical area (Field and Johnson 1993).

Research presented to Help the Hospices Commission (Help the Hospices 2012) found that within the volunteer workforce, around half had direct contact with hospice patients and their families. Within a hospice, volunteers may work independently and alongside paid staff in all areas of the setting, including: in-patient and day care, reception duties, gardening, housekeeping, administration, fundraising and the board of trustees. EOLC in a hospice is commonly provided by an inter-disciplinary team including paid clinical and non-clinical staff, and volunteers are integral to those teams. As hospice services look to expand in response to an increasing demand for EOLC, in order to provide and sustain that service, volunteers are likely to play an increasingly important role in both clinical and community settings. Indeed in 2010, the think tank Demos published a report entitled 'Dying for Change'(2010), in which it suggested what it described as:

> Radical innovations; a new infrastructure of home hospices, the creation of a compassionate care benefit and a properly trained volunteer support network providing care – a perfect opportunity for the Big Society.
>
> (Leadbeater and Garber 2010:136)

In a large-scale quantitative survey Burbeck et al (2013) gathered data about volunteer activity from two-thirds (194) of adult hospices and specialist palliative care services. The study found that hospice volunteers in the UK reduced the hospice costs by an estimated 23%. The study looked at key areas of volunteer contribution, including day care, counselling, core EOLC and support for patients and their families, which were considered to be highly skilled and emotionally demanding roles. With a UK volunteer workforce of approximately 125 000 involved in hospice care, the economic value of volunteers to independent charitable hospices in the UK is estimated to be over £200 million (Hospice UK 2020a). Volunteers also gift their time, their emotion and their labour to the hospice movement, particular areas of interest in this thesis, and the findings of Scott et al (2018:218) suggest that there is a strong link between volunteering and the ability of hospices to remain sustainable. With an aging population and more people living longer with chronic disease and co-morbidities, the demand for EOLC will increase and to help with that

demand there is a strong case for using volunteers more imaginatively and using the voluntary workforce to scale up at reduced cost (Help the Hospices 2013).

It is a significant challenge for hospices to signal that hospice volunteering is not an elite activity, practised by a privileged few (Watts 2012b). Hospices in the UK, including the one in this study, although able to attract and sustain their volunteer cohort, often have difficulty recruiting volunteers which reflect the local demographic, in terms of both age and ethnicity. The Volunteer Statistics compiled by the hospice in this study (Appendix 2) shows the statistical demographic amongst the cohort and older age volunteers (age 60+), represent the largest number in the age category. Help the Hospices (2012) recognised the difficulty hospices may have in recruiting a diverse range of volunteers, especially when recruitment was largely by 'word of mouth'. They suggested that more formal approaches to recruitment can be successful in extending the range of volunteers, including those from minority communities. Exploring links between sustainability of hospices in UK and volunteering, Scott et al (2018) stress the importance of developing community engagement and diversifying volunteering and volunteers can be instrumental in providing those connections between hospices and communities.

The use of volunteers in modern hospice care is not uniform across the world and volunteers are deployed differently in different countries (Morris et al 2013). As noted previously, in the UK, the work of volunteers is generally centred around hospice buildings (Davis-Smith 2004; Morris et al 2017) and they are rarely involved in direct care of patients in the community (Goossensen et al 2016). In contrast, in Canada, the USA and India volunteers are widely used to provide care and support to patients in their own homes (Claxton-Oldfield 2015; Taub et al 2019), including rural communities where volunteers were found to inhabit a unique third culture of care that fuses elements of formal care with the informal visiting of friends and neighbours (McKee et al 2010). This difference in approach across the globe may be a consequence of many contributing factors including: the way in which hospice care has evolved over time, social and cultural attitudes towards of death and dying as well as geographical and economic factors (Morris et al 2013). Whilst it is important to consider and learn from international literature concerning hospice volunteers, and to recognise the different ways in which hospice volunteers work globally, it is crucial to continue to explore the policy and practices of UK hospices, the ways in which hospice care evolves in this country and their use of volunteers.

Goossensen et al (2016) uses three different categories of hospice volunteers to explore the substantial variations within and between European countries regarding volunteers' tasks

and roles in hospice care. The three categories were (i) disciplinary based, (ii) community based and (iii) unpaid board members or trustees. Applying these three categories to this research study, each is represented by the participating volunteers. The first category they identified was 'disciplinary based' who are volunteers working within their discipline without being paid. Within the volunteers in this study that included, for example, nurses, complimentary therapists and counsellors. In the UK, they found that the percentage of volunteers involved in direct patient care at the very end of life is smaller than in some other European countries.

The second category was 'community-based' volunteers involved in direct care or indirect roles. At Fernbank, there are few volunteers involved in direct patient care in the community but examples from this study which do fall within this category include the day hospice drivers. Looking to the future sustainability of hospice care which can meet the needs of an aging population, and more people living longer with chronic and life-limiting illnesses, Help the Hospices (2012) recommend hospices aim to expand the use of volunteers in the community and other health care settings, as part of a broader team but that 'such a shift may challenge the health care professionals' notions of accountability and 'ownership' of patients' (2012:12). On that theme, Hartley (2018) offers an interesting, if challenging explanation for the limited involvement of volunteers in palliative care outside of the hospice, within the community:

> It is true to say though that involvement in the community has lagged because there is the unspoken benefit of keeping volunteers within sight of staff and volunteer managers and administrators within the hospice building. In essence, it provides a much simpler and potentially safer way of observing, supporting, and guiding the tasks that volunteers are expected to undertake. Therefore, on the one hand, the volunteer is valued and respected, and on the other most professional staff would rather keep them where they can see and control them.
>
> (Hartley 2018:172)

This suggests there may be underlying issues of power and control and contradictions in terms of the ways in which staff perceive volunteers. This merited further investigation, which this study responded to, as the use of volunteers in the community is seen as important for the future development and sustainability of hospice care (Help the Hospices 2012; Scott et al 2018). Furthermore, the methodological approach used in this study, whereby volunteers and staff are both listened to and observed was valuable in discerning if such issues are evident in the research site in question.

The third category are the unpaid Board members or trustees who Goossensen et al (2016) suggest are often seen quite differently to other volunteers and carry significant

responsibility for the organisation's strategic direction and effective management. Scott (2015:83) highlights 'the importance of recognising the significant responsibility that volunteers carry in governance in their role as trustees'. Furthermore, Turner and Payne (2008) argue that trustees are often not recognised as volunteers and that there is a need for a better understanding of what they term 'these hidden volunteers'(2008:973). This study does include amongst its research participants, trustees of the hospice, whose views were important in securing answers to the stated research questions. In some cases, these trustees' volunteering activity is limited to their role as trustee, but other individuals combine additional volunteering with their trustee role.

Doyle (2002:9) makes the important point that hospice volunteers do not constitute a group of 'untrained people, with hearts of gold and with some time to spare to help those less fortunate than themselves'. Rather, as this study will demonstrate they make up a diverse group of individuals, many of whom are highly qualified and experienced in a range of clinical and non-clinical areas and with significant life experience and knowledge which they bring to their role. Understanding the complexity of volunteers' experience, as Scott et al (2020) make clear, helps to 'prevent the undervaluing of their contribution' (2020:1).

Contribution of volunteers

The literature suggests that volunteers make a unique contribution to hospice work (Patchner and Finn 1987; Parrott and Egbert 2003; Guirguis-Younger et al. 2005; Help the Hospices 2012; Vanderstichelen et al 2020). The importance and value of volunteers is emphasised in the executive summary of a paper commissioned to explore the future of hospice care (Help the Hospices 2012), in which it was asserted that the hospice volunteer may be as valuable to the organisation as a financial donor or clinical professional. However, with the growing sophistication and medical advances in palliative care and the increasing professional expertise of paid staff in hospices, it could be said that there is a growing distinction between the paid professional and the volunteer. Nevertheless, the work which hospices do and the services they offer, together with additional demands on those services mean that volunteers play an essential part both in economic terms and in terms of the roles and expertise they undertake in many facets of hospice care. More broadly, to counteract the technical aspects of dying, volunteers remain a representation of a human community's desire to reach into the formal care system, such as a hospital or a hospice, to bring care and support to their members who are dying (Guirguis-Younger et al 2005:144). Vanderstichelen et al (2020) identify the important part volunteers can play in 'combating the social isolation associated with being ill' and 'the value of light day-to-day conversations with

both patients and their families' (2020:6). This resonates with Doyle's (2002) description of the aims of hospice:

> To provide an atmosphere tailored to the needs of the dying, a place where it is safe to laugh as well as to cry, where it is safe to 'be yourself' and, as so many people have said, a safe place to die, paradoxically as that may sound.
>
> (Doyle 2002:2)

The literature would suggest that volunteers could play a significant role in achieving those aims and it is an aspect of volunteering which this thesis addresses within the data analysis.

Another important contribution volunteers can make to palliative care is highlighted by Scott et al (2020) where volunteers can act as advocates between patients and their families and care professionals, and help people to come to terms with life issues whilst at the same time 'enabling them to feel heard, seen and acknowledged as a unique human being, rather than as a patient' (2020:6). This is referred to by Vanderstichelen et al (2020) as the 'liason role' of the volunteer (2020:6). Furthermore, they play a part in: building links with communities and educating the public so making communities aware of the work of hospices and making hospices more accessible (Doyle 2002; Naylor et al 2013; Morris et al 2017; Scott et al 2018). Burbeck et al 2014) suggest that what characterises the volunteer role is the inherent social component, over and above the tasks the volunteers may undertake. It was both a motivating factor for the volunteers themselves and an important aspect of palliative care, a view shared by Guirguis-Younger and Grafanaki (2008) who argue that 'the presence of volunteers restores the human relationship to palliative care' (2008:16). In a wide-ranging study involving eleven EOLC sites in England and 205 interviews with volunteers, staff, patients and carers, Morris et al (2017) concluded that volunteers provide an important two-way connection between hospice and the community but there is scope to 'exploit that boundary position of volunteers to educate, recruit and raise awareness' (Morris et al 2017:1704).

Goossensen et al (2016) highlight the notion of 'being there' as an important concept to be considered in hospice volunteering, especially for some hospices in the UK who have a business-oriented approach to volunteer management and focus on numbers and tasks, rather than the value of volunteers 'being there'. Furthermore, they do not view 'presencing' and 'performing tasks' as contradictory. The notion of 'being there' is also explored in research by Vanderstichelen et al (2020) in a qualitative study of the work of volunteers in Belgium. Their research included volunteers, clinicians, family caregivers and patients in a range of settings delivering palliative care: home care in the community; hospital; and day care. They found that 'the immediate psychological needs of the person took priority over

any practical tasks they may be involved in' and that, together with the unique relationships they were able to develop with patients they termed 'being there' which was at the centre of the volunteer role (2020:5). This study focused particularly on volunteers who had direct contact with patients which would not always be the case for hospice volunteers in the UK. However, this distinctive role of volunteers may be at risk if, as discussed below, there is evidence of increasing professionalization and bureaucracy within the hospice. Guirguis-Younger and Grafanaki (2008) argue that a balance needs to be struck between the institutional requirements and the needs of volunteers as natural helpers to protect the sustainability of the volunteer resources, given that 'the vitality of palliative care is in its humanity, and that is what volunteers bring (2008: 22)'. Rachel Clarke (2020) captures so powerfully the importance of the human presence she has observed in her capacity as a palliative care consultant:

> What I witness, over and over, in the hospice – in this digitised age in which wifi, data and connectivity reign supreme – is that there is nothing more powerful than another human presence, old-fashioned, instinctive, composed of ancient flesh and blood, reaching out with love and tenderness towards one of our own.
>
> (Clarke 2020: 305)

The concept of 'being there' emerged in the study as an important aspect of the work of some volunteers at Fernbank and is discussed further in the data analysis chapters.

Motivations and reasons

People who are interested in becoming a hospice volunteer come to their volunteering through different routes, and this was confirmed by speaking with the volunteers at Fernbank. Doyle (2002) categorised these routes into three groups and each group was represented by participants in this study:

1. Actively recruited by the hospice for either a specific role or a general appeal for more volunteers.
2. Unsolicited applications from individuals or groups who may or may not have a particular task in mind.
3. Work experience most commonly for a placement or practical experience prior to moving into work or further study.

(Doyle 2002: 35)

A large-scale national study, by Lowe et al (2007) termed 'Helping Out' carried out by the National Centre for Social Research and the Institute for Volunteering Research found that the most common reason for getting involved in volunteering, identified by 53% of current formal volunteers, was to improve things or help people. In order to address the research

questions as stated in Chapter I and specifically RQ1, it was important to explore the motivational factors which give rise to volunteers choosing to become involved with hospice volunteering in particular. In terms of sustainability of hospice volunteering, it was also important to ascertain, having first become a hospice volunteer, what then motivates people to continue with their work. A better understanding of these issues will be helpful to the hospice in recruiting future volunteers and also in supporting their current volunteer workforce. That said, Rochester et al (2012) raise important caveats as to the reliability of volunteers' responses when questioned about motivation; particularly in relation to altruistic and egotistic motives, do volunteers say what they really think or give the response they think the questioner wants to hear? I will need to consider this when collecting and subsequently analysing my own data for this study. Furthermore, Locke et al (2003) in reviewing existing literature about volunteers' reasons for continuing to volunteer, concluded that 'there is no 'factor X' that explains why some people continue volunteering' (2003:95). This suggests a complexity underpinning motivation and volunteering and inherent challenges in asking the question: 'Why do you volunteer?'

Motivations to engage in hospice volunteering are various but broadly may be seen as altruistic and personal (Starnes and Wymer 2000). In her study of hospice volunteers, Watts (2012b) found motivations could be categorised under two broad headings: instrumental gain and altruism, although she argues that neither was mutually exclusive. Claxton-Oldfield et al (2004) identified four motivational themes, namely: leisure, personal gain, altruism, and civic responsibility. In a study of British hospice volunteers, Claxton-Oldfield et al (2013) used those four motivational themes, plus an additional one of 'self-promotion' in a demographic questionnaire which was completed by 162 hospice volunteers from 3 adult residential hospices. Their research found the most influential motive for becoming a hospice volunteer was altruism and the least influential was personal gain, which showed a direct comparison with their previous study of Canadian volunteers (Claxton Oldfield and Claxton Oldfield 2012). Planalp and Trost (2009a) in their survey of 351 volunteers from 32 hospices in the US which identified altruism. social relationships and career motivations as the most common motivators, with the latter being most prevalent with younger volunteers. This suggests there may be some variation, depending upon the age of volunteers. In this study, as is discussed in chapter 5, it was the case that some individual volunteers were initially motivated by their future career aspirations and these were younger volunteers; however, not all younger volunteers were motivated by career, and those who were, talked of changing motivations over time. Motivation can also arise from personal satisfaction as discussed by Guriguis-Younger and Grafanaki (2008) whose study found that volunteers derived a great deal of meaning and personal growth from their work in palliative care

(2008:22) and this was also clearly evidenced in the data for this research. Such motivations are more likely to be associated with on-going volunteering as opposed to motivators linked to a person's initial choice to become a hospice volunteer and this was evident in speaking to the volunteers in this study. The benefits that volunteering can afford in terms of well-being, especially in the case of older volunteers has been recognised (Kahana et al 2003; Russell et al 2019) and was evident in this study. However, when long serving volunteers, especially those in the older age range derive such ongoing benefit from their volunteering role, it can present difficulties and challenges for the volunteer themselves and those who manage them, when the prospect of retirement from their role needs to be addressed (Russell et al 2019).

Other factors which volunteers felt were significant in them continuing to volunteer was they 'believed what they were doing made a difference' (Claxton-Oldfield and Claxton-Oldfield 2012: 529). In a study of prison inmate hospice volunteers in the United States, Cloyes et al (2014) discussed the transformative nature of hospice volunteering and the complexity of motivations in such settings, where broadly, motivators included personal growth, social responsibility and ethical service to vulnerable peers. This piece of research also serves to highlight the increasing demand for EOLC with an aging population and just as importantly the extent of its reach into a range of settings beyond a traditional hospice.

A significant motivator for a number of volunteers, which again developed over time, was a commitment to the hospice in which they were volunteering and its organisation: its mission, and more specifically 'flexibility, professionalism, compassion, caring, appreciation of volunteers, support, lack of politics and dedication to patient care' (Planalp and Trost 2009b : 293). It is therefore important to be aware of and responsive to volunteers' changing motivations, not least because it may well be important in keeping them in the organisation (Howlett 2009). Exposing the individual differences which motivate volunteers and the changes that can take place over time were important considerations in this thesis, contributing to my argument that volunteering is not homogenous but is characterised by its diversity and complexity.

Hospice volunteers sometimes offer very particular professional skills, such as hair dressing, complementary therapies and financial or administrative expertise. That said, some volunteers prefer that their role is not linked to their professional experiences and qualifications. Guirguis-Younger and Grafanaki (2008) discuss the sense of freedom, choice and agency which can be associated with volunteering and in particular the notion of 'natural helping' (2008:19). Some of the volunteers preferred that approach so that their volunteering

was not an extension of their professional life, but rather there was the flexibility so they could do what was needed in order to be most helpful to staff and patients at the time, rather than being restricted by skills-based tasks of a particular role. This would require a degree of flexibility on the part of the organisation and an engagement with individual volunteers to determine their interests and motivation. It may also throw up a dilemma for an organisation where they may be looking for a particular skill set or area of expertise from an individual volunteer but that does not happen to correspond with the wishes of that volunteer, despite them being in possession of those skills and expertise. This could be problematic in an organisation where the priority in the recruitment of volunteers is for a specific identified role (as would be the case for paid employment), as opposed to recruiting a volunteer primarily as a volunteer, and then determining their role through negotiation.

Studies have found that some volunteers are motivated to become involved in hospice volunteering following the death of a family member or friend who may have been cared for in a hospice (Field and Johnson 1993; Phanalp and Trost 2009b). Indeed, Baugher (2015) in his work with hospice volunteers in US and Germany found that most of the individuals in his study became hospice volunteers following a death in their own life. This finding was not replicated in this study; although it was indeed a motivation for some of the volunteers, it was by no means the case for all of the volunteers in the sample. However, importantly, Baugher (2015) argues that in such cases hospice volunteers are able to draw upon those experiences of bereavement to discover and develop their caring capacities. Interestingly**,** Duguid et al (2006) note that studies seldom report learning as a possible primary motivation for volunteering. Their findings suggested that motivations were both personal and altruistic and whilst some volunteers did not identify learning as being a primary motivation for their volunteering some did see this as an important aspect of their volunteering experience. This again raises the important distinction between primary motivation and motivations which can develop through the process of volunteering. Furthermore, motivations and the strength of those motivations can change over time (Rochester et al 2012).

The review indicated scope within this thesis to investigate further the various motivations which underpin hospice volunteering and consider how they impact on the experience of the volunteers. Furthermore, such investigation related to research question RQ1 since consideration of the volunteers' motivations, both primary and ongoing, shed light on the experiences of the volunteers themselves and the culture and organisational factors which were shaping those motivations.

Staff and Volunteers: Boundaries: real and imaginary lines in the sand

The literature as discussed above indicates that hospice volunteers make a unique contribution, but the relationship between volunteers and those with whom they work remains somewhat of a mystery (Guirguis-Younger et al. 2005). Morris et al. (2013) note that while generally good working relationships between volunteers and staff are reported, some concerns over professional boundaries have been found (Payne 2002; Towers et al. 2003; Claxton-Oldfield et al. 2011). Furthermore, studies suggest that volunteers do not always feel part of the multidisciplinary team (Claxton-Oldfield and Claxton-Oldfield 2012; Help the Hospices 2012), that power differentials are enforced (Payne 2002) and such power relationships merit further research (Burbeck et al 2014). There is a need for clarity regarding the boundaries between professional and volunteer roles and sensitivities around job substitution, real or perceived, need to be handled carefully (Naylor et al. 2013; Thompson and Russell 2017). Whilst there may be well founded concerns relating to volunteer roles being used to substitute those of paid staff (Help the Hospices 2012), a review of qualitative literature by Burbeck et al (2014) concluded that volunteers were themselves keen to avoid any such substitution. In a small-scale interpretive study, Field-Richards and Arthur (2012) explored the nurse–volunteer relationship in a day hospice; they found an increasing formality which sometimes challenged smooth working relationships. They concluded that volunteers see their role as becoming increasingly formalized partly as a response to increasing administrative demands on hospice nurses. That said, whilst recognising a distinction between volunteers and paid staff, Burbeck et al (2014) also found examples of volunteers themselves adopting a quasi-professional role, so they were taken more seriously and so their role was recognised by both staff and patients. It should be noted their study explored volunteers whose work involved direct care of patients and in both in-patient and home-care settings.

Tensions involved in negotiating the boundary spaces that volunteers inhabit, informality, and regulation, merit further research (Morris et al. 2013), and making such issues open and explicit within the hospice would support the further understanding and development of the role of volunteers in the hospice. Scott and Kumar (2014) raise some important issues relating to hospice volunteers working alongside paid staff in palliative care. They suggest that staff may make assumptions and underestimate the skills and professionalism of volunteers because they give their time without financial reward. Furthermore, volunteers and their views might not be valued to the same extent as paid members of the team and they note the paradox whereby in UK hospices the overall governance, responsibility and strategic management rests with trustees all of whom are volunteers, yet in some hospices there is a reluctance to involve volunteers in the delivery of care to patients. It was important

to address this in this study as UK hospices, including the one in this study, look to extend their services into the community which could see volunteers more involved with direct patient care. As explained in Chapter 5 discussions with staff, in particular one of the Lego focus groups, showed that some staff did have some reservations about such developments. Interestingly, some of the participants concluded that their views were based upon perceived risk as opposed to any actual risk of utilising volunteers alongside paid staff in this way. This realisation not only raised an important point of discussion but also highlighted to the participating staff the potential that the Lego technique offers in generating and sharing ideas. The data in the study more broadly showed variation and inconsistencies at Fernbank about the boundary position of volunteers and paid staff in different departments within the hospice. This impacted upon the role of volunteers within those departments and the extent to which they were utilised. In some cases, especially in clinical areas involving direct patient care, volunteer involvement was limited as a consequence of increasing professional regulation and governance, sometimes it was as a result of how practice had evolved over time and in some cases, it was determined by individual members of staff and their experience of working with volunteers.

Guirguis-Younger and Grafanaki (2008) recognise the importance of the 'natural helping model' in which volunteers do what is needed in an informal way and argue that it is particularly relevant in palliative care. However, they acknowledge that negotiation may be required in some settings in order that this approach can co-exist within a structured inter-disciplinary care delivery model (2008:21). Whilst the primary focus of this study was the volunteers, the multi-layered methodological approach and the stated research questions were designed to better understand how volunteers and staff co-exist in the hospice. This is discussed in detail in Chapter 4 but in summary was achieved by both listening to and observing volunteers and staff, in order to expose the perceptions of each, in addition to those of my own as the researcher.

Professionalisation of hospice volunteering

Paine et al (2010) discuss the increasing trend towards the professionalisation and with it more formal approaches to volunteering within TSOs. These moves have included employment of paid volunteer managers and the development of National Occupational Standards for the Management of Volunteers. Within such organisations, the dominant management model typically includes 'a volunteer co-ordinator; a written volunteer policy; task descriptions for individual volunteer roles; a recruitment, written application and interview procedure; an induction programme for new volunteers; training; supervision; recognition; and increasingly, evaluation' (2010:99). They go on to point out that the

appropriate application of these in practice is what will determine the degree of formalisation. It is important to note that this literature relates to TSOs in general and not specifically to hospices. Within the thesis and in responding to the research questions as stated in Chapter 1, it was important to establish both the existence and application of any such policies and procedures in the hospice and any impact they had on the volunteers and their work. Regarding managers of volunteers in hospices, Doyle (2002) makes the point that despite the complexity of their role and the large numbers of volunteers involved, these managers are neither members of the senior management team nor is their work fully understood and appreciated by management and trustees (2002:ix). This also raises important issues about the relative standing of volunteers within the organisation and the understanding of their work within the hospice, areas which are encompassed within the aims and research questions which the thesis seeks to address. Rochester et al (2012) discuss the trend towards formal management of volunteers, adopting a workplace model which is hierarchical involving paid volunteer managers. Whilst they acknowledge the potential benefits of such an approach to both the institution and the volunteers, especially where volunteers are working in large, bureaucratic organisations such as the NHS, they do consider an alternative model which is more egalitarian with a minimum application of rules and procedures. It should be noted that Help the Hospice (2012:11) reported an underinvestment in volunteer management and that 60% of UK hospices cited time, and 40% funding, as 'very important' barriers to effective volunteer management. This is likely to be an important consideration for TSOs, including hospices where funding may be limited or uncertain. The hospice in this study has over the last ten years moved to employ one Volunteer Coordinator and paid managers in the charity's shops whose primary role is management of volunteers. The study involved spending time with volunteers, staff and trustees, some of whom have been involved with the hospice over a considerable time period, providing them with a lived experience of the hospice's development through their hospice work. The study was designed to identify any shifts towards professionalisation and formalisation of volunteering, and the impact of any such change.

Hospices in the UK are examples of 'hybrid organisations' (Billis 2010:3). With their roots and ethos firmly in the charitable 'third' sector, increasing complexity, changes to funding and with a greater emphasis on accountability and management have seen a blurring of boundaries and more influence from both the public and private sectors with regards to such things as funding, regulation and governance. Paine et al (2010) explore changes in TSOs and noted that standardisation and formality are replacing more 'homegrown', less bureaucratic approaches. However, they argue that despite an overwhelming drive towards professionalisation and formalisation, some organisations have succeeded in keeping the

spirit of volunteering alive and central to its ethos. However, in the case of hospice volunteers, Watts (2012a) argues that their work has become increasingly formalised. There are tensions between professionalised managerial approaches and a more traditional volunteering ethos (Morrison 2000). Smith (1996) exposes these opposing views regarding management cultures for volunteers where on the one hand such approaches: 'can lead to a more efficient use of volunteers and greater satisfaction for the volunteers themselves', as opposed to those who would argue that such approaches 'may be at odds with the spirit and values of volunteering, threatening to bring an over-formalised and stylised structure to an activity for which informality and flexibility is its very lifeblood' (Smith 1996:187-188).

Most hospices in UK have always included a volunteer workforce and indeed some were founded by groups of volunteers. Over time however, as Morris et al (2017) make clear, 'hospices provide an example of volunteering caught between the informality of their roots and the increasing formalisation of the current climate' (2017:1710). The move to professionalise and standardise the volunteer could compromise the unique contribution which volunteers bring to a professional workplace, such as a hospice. Again, it is arguably a matter of 'balancing the good intention of the willing citizen with the developing professionalism of the world of volunteering' (Doyle 2002:16).

Opinion and approaches with regards to training of volunteers is divided. Some hospices take the view that the value of a volunteer workforce can be adversely affected with professional socialisation that can come with formal training, and if training is too extensive it can undermine the added value the volunteer brings ((Help the Hospices 2012; Scott 2018). The volunteers themselves may have individual and varying expectations with regards to the need for and / or entitlement to training which may be dependent upon different factors including their previous training and qualifications, professional experience and motivations for volunteering (Doyle 2002). There is a huge reservoir of tacit, even subversive, knowledge embodied within the practice of volunteers, which needs to be protected (Guirguis-Younger et al. 2005). The move to professionalise and standardise the volunteer could compromise the unique contribution which volunteers bring to a professional workplace, such as a hospice. Conversely, good training can avoid inappropriate professionalisation and can help the volunteer manage the boundary between the professional approaches to care and their contribution to the team (Help the Hospices 2012). Currently there is little research into the content and quality of volunteers' training (Scott 2018) and furthermore, investment in volunteers and their training is resource dependent (Watts 2012a), which can prove challenging for hospices where available funds are precarious and insecure. Issues relating to these important aspects of hospice volunteering have been addressed within the thesis

and in line with the research question, the study has sought to better understand the ways in which hospice volunteers experience training specifically and learning more broadly, together with the opportunities and challenges afforded to both the volunteers and the organisation,

All UK hospices are subject to legislation and regulation by the Charity Commission and the Healthcare Commission (Turner and Payne 2009). With the evolution of the hospice movement, over time there has been increasing professionalisation in that, hospices are now recognised as centres of highly specialised practice and expertise and at the same time are increasingly subjected to the same regulatory and inspection processes as NHS and other providers of health and care. Since the early inception of the modern hospice movement, hospices have become increasingly bureaucratized (James and Field 1992) and in order to meet the expectations of inspection and commissioning bodies, explicit policies and procedures are put in place, often mirroring those of public and private sector organisations. This could also be as a result of the staff and managers and indeed volunteers themselves having previously been employed in those other sectors coming to work and volunteer in hospices, bringing with them their working practices and ethos characteristic of their previous area of employment. That would include clinical and non-clinical staff previously employed in the NHS and managers and trustees, who are themselves volunteers, drawn from both the public and private sectors. Billis (2010) warns that with the increasing influence of adjacent sectors there is a danger of the potential loss of independence and possible mission creep, where voluntary organisations 'lose their soul' (Billis 2010:10). Scott et al (2018) raise the issue of increasing professionalisation of hospice volunteers noting the challenge in balancing the needs and aspirations of both the organisation and the volunteers, especially where the volunteers are subjected to traditional models of management in which they are formally managed by paid staff through hierarchical structures. Smith (1996) also recognized the development of increasingly formal systems for managing volunteers, largely based on those used for paid staff, and reflected in the language of interviews, references, and job descriptions becoming a common part of the vocabulary of volunteering (Smith 1996:187). There is now an increasing pressure on organisations for governance, regulation and accountability and hospices are no exception. Indeed, within clinical aspects of hospice care in particular, the requirements for ongoing registration, insurance, regulation and ongoing professional development of individuals working in those fields, can preclude some qualified professionals such as doctors, nurses and social workers from offering their services in a voluntary capacity within some settings, and this was evidenced in this research.

The work which hospices do and the services they offer, together with additional demands on those services mean that volunteers play an essential part both in economic terms and in terms of the roles and expertise they undertake in many facets of hospice care. Scott et al (2018) argue that volunteers can add to the quality of services; improve the patient and family experience; and personalise and demedicalise the care environment (Scott 2015). This would seem to align well with the underlying hospice care ethos and the original intentions of its founders described in Chapter 1. On a similar theme, Guirguis-Younger et al (2005) argue that with the shift towards a more medical model of care, volunteers have an important role to play in bridging the gap between patients and the clinical team. Furthermore, hospice volunteers play a role both in bringing the community into the hospice and taking the hospice out into the community, albeit usually in an ad hoc way providing an informal and symbolic link through their roles in the hospice and communicating knowledge of the work of hospices to the wider community (Scott 2015; Morris et al 2017).

Palliative EOLC has now developed into a complex medical specialism in its own right. With that development over time, there is a certain irony in that whilst hospices started as disruptive innovators, challenging the medicalisation of death, critics warn they are in danger of becoming incorporated as 'niche providers of specialist services within the system they set out to change' (Howarth 2007 cited in Leadbeater and Garber 2010:53). This development has implications for hospice volunteers which this thesis seeks to address.

Watts (2012a) explored the trend towards professionalisation of volunteering in hospices. She found that hospice volunteering is rewarding, but often emotionally challenging and is now highly routinised and closely monitored in ways paralleling practices in the paid labour market. This research looked for examples of that shift, by drawing particularly upon the experiences of long-serving volunteers who may have witnessed such changes over their time at the hospice. By immersing myself in the hospice culture, the ethnography aimed to identify any such cultural shift and establish the impact on volunteers and ways in which they were deployed and managed within the organisation.

Emotional aspects of hospice volunteering

The nature of hospice work is by definition emotionally laden given that palliative care centres upon people in the end stages of life. Depending upon their role, some volunteers are more likely to come into direct contact with patients and their families. As mentioned above, in some countries and more rural or isolated areas in the UK, volunteers are involved with patients and their families being cared for at home. Others may be volunteering within a hospice building, whilst others still may be involved in retail or fundraising activities which

take place within the community. It could be argued that only volunteers involved in direct care of patients would be exposed to the emotional aspects of palliative care. However, volunteers, including those who work in the community in charity shops and fundraising, also come into direct contact with people who are experiencing EOLC or have been bereaved. As such, these individuals are not detached from emotional aspects of volunteering. Claxton-Oldfield and Claxton Oldfield (2007) in a small study looking at the impact of volunteering in palliative care highlighted the lack of existing research into how 'being around death and dying changes someone and influences their outlook on life' (2007:259). However, a study by Guirguis-Younger and Grafanaki (2008) found volunteers who talked about their personal and professional growth and learning which had occurred through their exposure and interaction with patients in palliative care and the development of their emotional resilience which extended into their lives outside of the hospice in a positive way. This suggests that the volunteers are engaged in emotional work and learning and in the data analysis chapters this is discussed in detail in order to better understand this aspect of hospice volunteering.

Increasingly many hospices provide support services and strategies for staff and their volunteers and Help the Hospices (2012) recommend that hospices provide 'support and mandatory supervision to help volunteers manage the inevitable emotional workload that comes with sustained closeness to death and dying' (2012:9). However, a review by Claxton-Oldfield and Claxton-Oldfield (2008) found that most volunteers did not perceive their work as stressful although new or inexperienced volunteers were more susceptible to stressors and challenges. Furthermore, there was a counterbalance for the more seasoned volunteers provided by the rewards of their work. Examples of such counterbalance was evident in this study and are discussed in later chapters.

In a study of hospice volunteers in eight European countries, Scott et al (2020) looked beyond the tasks and practical activities which volunteers are involved with and focused upon the contribution they make to palliative care through 'giving attention, being with and offering compassion' to patients and their families (2020:7). This notion of 'being there' has already been addressed earlier in this chapter and exposes the emotional component which is inherent in some volunteer activities. This underlines the importance of understanding the depth and detail of hospice volunteering: practical tasks and activities together with those aspects of a volunteer's work and learning which are more difficult to quantify. The ethnographic approach in this study was designed to address this by not only listening to the volunteers' accounts of their experience but also, where possible, by watching them and being alongside them in the course of their work. The practicalities and rationale for this are

discussed in detail in Chapter 4 with examples and analysis arising from the data in Chapters 5-8.

Summary

The review of the available literature and published research into hospice volunteering indicated there was considerable scope for ongoing research. Existing research is wide ranging and multidisciplinary in nature, spanning different areas of academic and professional specialisms including: medical; nursing; healthcare; the voluntary sector; and social sciences.

As stated at the outset of this chapter, whilst there are studies which focus on hospice volunteering in UK, much of the research is located in US, Canada and other countries across the globe. The research in other countries throws up differences in the ways in which volunteers are deployed and cultural differences based on the different ways in which hospice care have evolved in those countries. Unlike UK, many of these studies focus on hospice volunteers working in their local communities, often with significant levels of involvement with direct patient care. This is different to the approach typically seen in UK and in the hospice in this study, where volunteers are not widely involved in care in the community and if they are involved in direct patient care it is generally within a specified hospice building working with and alongside paid staff. These differences are important when considering hospice volunteering and whilst much can be learned from culture and practice in other countries, there is scope for ongoing research in UK hospices, which this thesis seeks to address.

It is clear from the literature that volunteers are considered pivotal to the palliative care provision in UK and are central to the original values and ethos of hospice care. To ensure that none of this is taken for granted and with the ongoing change and development of both hospice care and volunteering, it is important to continue to examine hospice volunteering and the role and impact of volunteers for sustainability of the service in the future.

The particular areas which have emerged for further study are those less tangible and less visible aspects of volunteering which contribute to its complexity and ‘haziness’. Notably the emotional and social aspects of a volunteer’s work and the concept of ‘being there’ which have been seen to be inherent within the tasks which volunteers undertake. This unique position of volunteering, characterised by ‘liminality,’ lends itself to further exploration and occupies a central part within the thesis.

An additional gap in the literature which this review has uncovered is the role of the researcher in carrying out the research. Typically, the research was carried out by academics or health workers, often using traditional data collection methods including surveys, questionnaires and interviews. There appears to be an emerging consensus in the literature which acknowledges the complexities of volunteering and the methodological approach in this study was designed to address this. Spending time both talking to, listening to and observing volunteers and staff enabled a data collection of considerable depth and detail. Coupled with that is my own position as researcher but also a hospice volunteer, a trustee and an academic, carrying out the research in the hospice with which I have such a close association. Whilst all of these factors throw up their own challenges, which will be explored elsewhere in the thesis, they nonetheless offer an original approach not seen elsewhere in the literature.

Furthermore, Morris et al (2013:431) in their narrative review of literature into volunteers in EOLC make the point that studies into hospice volunteers tend to group all sampled volunteers together, not taking account of the range of individuals including professionally qualified people who offer their services for free, such as counsellors, therapists and trustees. This study does acknowledge that diversity within the volunteer cohort and includes specific consideration of trustees and professionals working as volunteers.

Finally, the published literature tends to focus largely on practice; theoretical engagement and application of theoretical frameworks is less evident. There is only limited scholarly consideration of social and emotional aspects of the volunteers' workplace experience and also the extent to which the original aims of hospice care, straddling the medicalisation of hospitals and the home setting are influenced by the presence of volunteers in the hospice setting. In responding to RQ 3, this study used sociological theoretical concepts to better understand the experiences of volunteers and volunteering in a hospice setting. Moreover, engaging with the volunteers and staff in a hospice through an ethnographic approach provided a micro level perspective which enabled a better understanding of the wider aspects of hospice volunteering.

Chapter 3 Theoretical and conceptual frameworks

Introduction

The purpose of this chapter is to introduce the theoretical concepts which have been used to abstract the data in the thesis. The theories are those pertaining to liminality; situated learning and specifically the application of communities of practice; invisible work; and emotional labour. The chapter includes an explanation of the role of theory in research and its place within ethnographic methodology, followed by a detailed consideration of the theoretical lenses which have been applied within the thesis. The theoretical concepts which I finally settled upon, emerged as the ethnography developed and I became satisfied they were of particular relevance to my final research questions and the methodology. It is my contention that these theories, when considered in conjunction with one another, and informed by the data afford an understanding of: the complexities, nuances and unique character of hospice volunteering; the ways in which volunteers work and learn in the workplace; and the social and emotional components of the hospice volunteer role.

Why Theory?

In the previous chapter, the review of the literature concluded that in the published research into UK hospice volunteering there were only limited examples in which theoretical frameworks and concepts have been applied to research in that area. Collins and Stockton (2018) in their discussion of the place of theory in qualitative research make an important point which explains how theory can elevate the data and extend the reach of the research findings beyond the immediate site of the research:

> Rich and thick descriptions are at the cornerstone of qualitative work, but in a highly contextualized case, if there is not a strong framework, the details may devolve into a story that is difficult to transfer to other settings.
>
> Collins and Stockton (2018:6)

This assertion has a particular resonance with this study: a piece of ethnographic research in which the data emanated from detailed accounts from participants and meticulous observations within a specific research site, as well as an intention that the outcomes of the thesis will contribute to the understanding of hospice volunteering more broadly. It resonates with the position of Willis and Trondman (2000), who promote ‘theoretical informed-ness’ in ethnography where the use of theory with ethnographic data can have ‘aha-effects’ which ‘fuse old experiences with new ones, thus opening the reader’s minds toward new horizons’ (Willis and Trondman 2000:12). The methods used in an ethnographic study do not stand apart from the theory but rather are ‘conditioned by the theoretical approaches through which the knowledge they produced is made meaningful’ (Tutt and Pink 2019:476).

At this point, I offer some personal reflection which I believe is important to include in the written account of my doctoral thesis, firstly because with the benefit of time and experience, I no longer believe the insecurities which I originally had with regard to the use of theory to be unique to me amongst researchers and secondly, because I want to encourage others to look to develop their own confidence and immerse themselves in what can feel at first like a rather elitist world of theory. Only then can you start to use theory to explain practice and so better understand it, but much more importantly be prepared to look for the cracks, and challenge where existing and accepted theoretical concepts do not quite match up to real life research. Throughout the journey of my doctoral studies, the use of theory, be it theoretical concepts, frameworks or classical theories have been at best a niggle and at worst a near overwhelming struggle for me. I have had to come to terms with acute attacks of imposter syndrome, stemming I suspect from my background and training not being in the social sciences, and my knowledge of such theories having been acquired, in a somewhat ad-hoc way, during my professional career as a teacher educator. The acquisition of theoretical knowledge was largely by means of scholarly activity, attending conferences and sharing ideas with colleagues, the latter of which arose when making sense of the practice of teaching and education more broadly. Looking back, which theories I was exposed to seems to have been largely a matter of chance and fashion. Theories seem to come and go, rather like pop music. There are seven-day wonders which 'reach number one' but rapidly disappear from memory and one's playlist, whilst others become memorable classics, revered by their fans, and their composer and performers in some cases (eg The Beatles, David Bowie), being seen as 'National Treasures'. At the same time, music can polarise and whilst there may be ardent fans there will also be those for whom that particular music offers little attraction. So it seemed to be with theory as I was first exposed to it. Certain theories appeared with great regularity at academic conferences, going in and out of fashion, with just a few seeming to survive unscathed as theoretical pillars in certain quarters. Indeed, those theories which became established in some cases were almost cult-like in the sense one feels obliged to sign up to them to be part of the circle, use their language and look for ways to apply them, in some cases with little if any critique. The concern I had, and still have to an extent, is the way in which theory can sometimes be used in research: theory can be included in an attempt to elevate the status of one's work, but as Ashwin (2009:133) suggests 'the outcomes of the research are simply a tautological restatement of the theory'; it can be over-simplified; or it is over-complicated, often because of the way it is articulated. Tummons (2018), a strong advocate of the use of theory in research, stresses the importance of giving careful consideration to the relevance of a particular theory and its applicability when using it in a study, and is critical of the ways in which theory can be badly used and written about in research, when: ''theory is treated as a veneer, a layer of

sometimes needlessly complex language, sometimes dropped into an empirical study' (2018:8). I would share these concerns and argue that when theory is used in this way, one of the results could be that it can obfuscate and make ideas inaccessible to certain groups or individuals. This latter point is of particular importance to me given that it is my hope that the findings of my work can contribute in some small way, not just to an academic niche but to the hospice community more broadly. For reasons noted in Chapter 1, the research culture in most hospices is quite limited, and I would like to think that over time that can be addressed. One of the stated aims of this thesis was to, at a very local level, contribute to building the research capacity at the hospice where the research was carried out, through example and through encouraging volunteers and staff where possible to be involved with and take an interest in the research as it developed. For this to happen, I would argue that research needs to be seen to be more accessible and inclusive, rather than something done by 'others'. I am certainly not advocating a dumbing down of research nor an avoidance of theory or challenging ideas. However, I do want at least in my own work, to make the more theoretical aspects accessible and something which draws in an audience, rather than becoming a barrier. I hope to do this in the way I express my ideas, but also by providing tools in the form of photographs as a means of understanding through visual metaphor. Rather like theory, for some people those photographs will provide a clear connection with a theoretical concept or argument whilst accepting that for others those connections may be tenuous and less convincing. A more detailed consideration of the use of visual metaphor will follow in Chapter 4.

Therein was my dilemma with regards to the way in which I should use theory within my doctorate. There are the obvious reasons for including theory, not least of which is that it is a prerequisite of both the PhD and one's supervisor. That said, for me it needed to be more than that. I am confident that the theoretical aspects of my thesis are now embedded and underpin it, rather than being a bolt on. Moreover, perseverance with this approach has helped me to develop the thesis from what could be seen as a story, to something with depth and meaning, it informed the methodological approach and enabled me to respond to the research questions to which I set out to find answers. Mills and Morton (2013 :150) argue that the aim of a good ethnography is: 'to combine theoretical exploration with engaging description, respecting the integrity of both' and It has been my intention to strike a delicate balance whereby the theory informs but does not hijack the narrative of the thesis. This links with Trondman et al (2018) who discuss what they term the 'four elementary forms of ethnography' which in this study would be the 'lived experiences' of the hospice volunteers based on their 'cultural understanding' which leads to 'social criticism' and 'theorization' on the part of the ethnographer, where existing practices are examined and

other alternatives considered in the light of those experiences with the capacity of seeing things differently (2018:55). In some ways, I have to admit that in selecting the theories to try out and play with, it has felt like buying items of clothing which were ordered online: they sometimes fit in all the right places and you are delighted with them, they sometimes turn out to be completely the wrong choice and are rejected, or more often, they are a pretty good fit but there is always room for improvement. Continuing the analogy, one is usually drawn to an item because you have had something like it before, it has been recommended, or you see it by chance and decide to throw caution to the wind and try it. Whatever the reason, there will be items of clothing (and theories), which others may know of, but I am unaware of, and which may have turned out to be more suitable. But I have realised over time that I need to be confident in my choice and my own ability to be critical and selective.

And so to my use of theory in the thesis. I have not found a grand overarching theoretical approach which I believe captures the complexity of my study. Rather, I have opted to draw upon a number of different theoretical concepts, each of which provided a lens by which I could go beyond the data obtained in the research field, in order to better understand aspects of hospice volunteering and contribute in some small way to new knowledge in that field. Pink and Morgan (2013:357) argue that ethnographic research evolves in dialogue with theory, and such has been my experience. Indeed, it was only as the fieldwork progressed that I felt in a position to review and refine the data collection in conjunction with a theoretical perspective and rather than one taking precedence over the other, each informed the other. This is a common feature in ethnography and Willis and Trondman (2000:12) reinforce this symbiotic relationship suggesting a two-way process in an ethnographic study whereby theory can surprise data and data may surprise theory.

A number of theoretical concepts and frameworks resonate with the themes which have emerged from the study and without doubt, each in their own way have been important tools in providing answers to the research questions and provide a better understanding of the complexities of hospice volunteering. Some degree of filtration has inevitably been applied in order to select specific theoretical ideas from the available options; in doing so, often reluctantly, others have had to be discarded.

Liminal spaces

Throughout the thesis, the concept of liminality has provided a useful lens through which to explore some of the emerging themes. It has been used as a theoretical concept together with the data from the study to provide new ways to conceptualise and articulate the unique nature of volunteering in the context of EOLC. The notion of liminality has also been used as

a means of understanding aspects of the ethnographic research process and the role of the researcher and this is laid out in more detail in Chapter 4. What follows here is an overview of the concept of liminality, examples of its application in published literature and its relevance to this particular ethnography. Liminality is discussed further within the data analysis chapters.

When discussing the data and emerging themes, the notion of 'liminal space' is used as both a metaphor and as an overarching theoretical concept. Liminality is derived from the Latin word limen, meaning threshold. The French anthropologist Van Gennep (1908), introduced the concept of liminality in discussing transitional phases involved in social rites of passage. His work was developed further by Turner (1969) in his study of African tribal practices and the initiation rituals describing individuals and groups that are 'neither here nor there' or 'betwixt and between' (Breier et al 2019). More recently, the concept of liminality has been explored in studies of organisations and across contexts and disciplines. Some studies focus upon the physical aspect of a liminal space. Shortt (2015), in a study of hairdressers, considered physical spaces within a workplace which were used by workers for privacy, to escape from the public and as a break from the emotional aspects of their role when interacting with clients. Similarly, Pearce, (2003) used the notion of liminality and physical space to show how hospital corridors were sites of everyday communications and interactions, offering a transitory space for conversations without organisational conventions. Others adopt a more theoretical, conceptual stance (Daly et al 2015; Breier et al 2019) and this is the way in which it is applied in the context of this study where aspects of hospice volunteering are interrogated. Liminality is usually considered to be temporary or part of a transition from one thing to another, but alternatively may be a more permanent state (Concannon and Nordberg 2018). Ybema et al (2011: 28) conclude that: 'transitional liminality generates a sense of being *not-X-anymore-and-not-Y-yet*, permanent liminality creates a more permanent sense of being *neither-X-nor-Y* or *both-X-and-Y*' and the ambiguity that can be characteristic of liminality is explored by Bindley et al (2018) in the context of bereaved carers' experiences of palliative care. In this study, liminality is shown to represent a more permanent state for the volunteers and helps to characterise their unique sense of, for example, neither a member of paid staff or a member of the general public.

Volunteers and liminality

The concept of liminal space has previously been used by Vanderstichelen et al (2020) in their study of volunteers involved in direct patient care in the home and community care settings in Belgium. They used the concept to explain 'the space between and overlapping the professional and family domains' (2020:8) and argue 'that space, conceptually, fits the volunteer position, from which they provide complementary care according to continuously changing needs of the patient, relatives, professionals and situations' (2020:9). They

acknowledge that their study focused specifically on volunteering involving direct patient care. In this thesis, I undertook the ethnography within a hospice, where the volunteers were involved in a range of different roles and activities with only some of them engaging in direct patient care. As mentioned previously in the thesis, community volunteering involving direct patient care is not the usual model of hospice volunteering currently seen in the UK, and volunteers are more likely to be involved indirectly in patient care for example in this study in the day hospice or the reception area, or in volunteering roles which have no direct contact with patients such as volunteers who work in the finance offices, in fundraising or as trustees. As such, the research for this thesis builds upon the work of Vanderstichelen et al (2020) and extends the application of the concept of liminal space to explain the nature of hospice volunteering more broadly.

The data in this study shines a light on the liminality of volunteers and the nature of the space they inhabit. When enacting out their role as hospice volunteer, it could be said they are 'neither here nor there' or 'betwixt and between' (Breier et al 2019); they are not a paid employee of the hospice, nor, when they are volunteering, are they a member of the general public. For example, volunteers are subject to some but not all of the hospice policies and procedures, yet have access to areas and information which are not available to the general public; they may be involved in some but not all of the training and support available to paid members of staff. The thesis argues that acknowledging the significance and nature of the liminal space which hospice volunteers populate and understanding the unique position they hold can help to validate the position of volunteers in hospice care and mitigate concerns of 'losing the soul' (Billis 2010:10) of a TSO. Key findings from the study relate to the contribution volunteers make to the hospice culture and the unique liminal space they occupy. As discussed in Chapter 1, modern hospices in the UK were established to provide an alternative to hospital care for patients in the final stages of life, offering an environment which might be said to be more closely aligned to homecare, whilst at the same time providing expert and specialist clinical care as might be associated with hospital. Indeed, in those terms, it could be argued the hospice and its vision and ethos occupy its own liminal space of care. Findings from this study also show that volunteers play a vital role in enabling and maintaining that vision and ethos and sustaining those important links between institutionalised care and the community. Furthermore, it is that liminal space and the volunteers who occupy that space which help to give a hospice its unique character and ethos and can enable volunteers to exercise agency in fulfilling their role, examples of which are discussed in more detail later in the thesis. However, the liminality can give rise to limits being placed on the volunteer either by themselves or others, and generalisations applied to volunteers because they inhabit that unique space. Examples of such limitations include: particular roles being unavailable to someone who volunteers; participation in

decision making within the organisation; or accessing support and training opportunities. The concept of liminality is used in conjunction with the data from the study to examine the unique position of the hospice volunteers and the implication of liminality for hospice volunteering and as this thesis demonstrates, the 'in-betweenness of volunteering' being a distinctive characteristic of hospice care.

Extending the metaphorical analogy, a beach could be described as a liminal space (Shields 1991): the beach is the landscape which lies between and connects the land and the sea. Although distinctive in its character and makeup, a beach landscape is not static and its boundaries between land and sea are porous, albeit with varying degrees of rigidity. Beaches can provide a space for people in that place to adopt informal, relaxed and on occasions unconventional social practices and behaviours, away from the participants' social norms. This can be seen in those who visit a beach in, for example: the games they play, the activities they engage in, the food that they eat and the clothes that they wear (or don't). In the context of hospice volunteering, this could relate to those volunteers who are no longer in paid work in their life outside the hospice, to adopt, whilst in the space modified workplace behaviours which they miss in their everyday lives, without having to take on those practices of their previous working lives which they are not sorry to have left behind. Whilst on a beach it is usually possible to move into the spaces which abut that space (ie land and sea), albeit with varying degrees of ease and associated peril. For those who cannot swim or in colder climates, for example, passage into the sea would carry with it inherent risk and may indeed not be possible. In a warm climate however, when the sea is calm, movement from the liminal space to the sea would be inviting and for many be a very attractive and practically achievable proposition. Some of the volunteers in the study were using their volunteering as a way of 'dipping their toes' into a particular aspect of paid work, which they were not yet sufficiently knowledgeable about or qualified in. Occupying a position on the edges enabled them to learn more about it, gain experience and subsequently make more informed choices about transitions in the future. For other volunteers, experiencing from the boundaries a place where people were in the final stages of their lives provided a space for learning about dealing with death and dying in their own lives outside of the hospice. Movement is usually possible from a beach to the land; whilst barriers may present themselves, it is usually possible to negotiate the boundary to the land bordering the beach, although undoubtedly some routes may be easier than others. In this study I have used the notion of liminal space and a coastal landscape as a visual metaphor to characterise volunteering. I argue that the beach represents the liminality of volunteering whilst the land away from the beach could be the community or wider public. The sea is the place inhabited by paid staff of the hospice or aspects of EOLC in which volunteers are rarely involved. As described above, a beach has many distinguishing features, but it is not a static landscape. The amount of beach which is accessible can be determined by the tide and therefore the extent to which the water covers or exposes the

beach area. In some cases, there is a very limited expanse of beach and the water which could put one in mind of areas of the hospice where use of volunteers is limited as compared with areas of beach which are widely exposed and could be said to be representative of freedom of volunteering or alternatively volunteering with only distant connection and communication with paid staff. Some areas of a beach can be in very close proximity to the sea, just as some volunteering roles are very closely aligned to those of the paid staff. The entry and exit points to and from the beach can be clearly defined or difficult to navigate. An entry point may be a gentle, sandy slope, with signs at the boundary which might provide information, maps or warnings as might be exemplified by a volunteer who finds an easy transition to becoming a volunteer and clear guidelines and support for working safely within the space. Conversely, the entry points to a beach may be difficult to access which could say something about accessibility to volunteering from the general public for certain groups or individuals, giving rise to questions of diversity and equality. Alternatively, over time, entry points can disappear due to coastal erosion which could be representative of reducing recruitment of volunteers either deliberately or otherwise within a hospice. The latter could be insidious and happen very gradually, hardly being noticed until the outcome is irreversible. These are but some of the examples of where the metaphor of a beach in conjunction with liminality can be used in the context of hospice volunteering. Further examples are included later in the thesis, together with the photographs to support the concept as a visual metaphor, as explained previously.

Hidden aspects of Volunteers' Work and Learning: Work as described versus Work as practised

Hospice work is by its very nature, challenging, demanding and emotionally laden. Volunteers undertake a variety of roles within and outside the hospice. Many of these roles such as reception duties, providing refreshments, gardening, driving, may be deemed in the 'real' world of work to be low skilled and therefore low paid. However, positioning such roles within a hospice setting serves to highlight the hidden complexities of ostensibly low status roles in the workplace when one overlays the emotional component inherent in care. Benozzo and Colley (2012) refer to the reproduction of the Cartesian split within the academy, described as a de-emotionalized workplace in which 'head work' comes before the 'heart work' and emotion comes after knowledge. This split could arguably be extended to professional and lay knowledge, paid staff and volunteers. In a study of volunteers providing hospice bereavement support, Payne (2002) refers to the distinction between 'professional knowledge' as being global, generalized across situations and based on broad principles, as opposed to 'lay knowledge' which he argues is situationally and temporally contextualized, local and specific, with a tendency to privilege the former over the latter. The power and prestige associated with different forms of knowledge is important to consider in a workplace where paid professional staff work closely with and alongside volunteers. Such a

dichotomy could underpin the perceptions, relationships and boundaries of paid staff and volunteers and this has been considered in this research. In Western society, work has come to be associated with class and status, however there is a case for re-examining current attitudes to work, the changing nature of paid and unpaid work in capitalist societies and the different types of learning activities (Livingstone 2003). Interviews with volunteers in this study suggested that most consider the work they do in the hospice as being different from work they have done or continue to do outside the hospice and that it also differs from the work of paid staff. Apart from the trustees, most of the volunteers in the study self-identify primarily as 'volunteers' and then by their role, and in applying to the hospice many volunteers apply to the hospice to 'be a volunteer' with the specific role they undertake being agreed, and in some cases evolving over a period of time once accepted. Paid staff however all self-identify by their role eg Consultant; Fundraising Manager; Housekeeper; Clinical Services Manager, and in applying to the hospice for work did so in relation to a very specific role or position. In the discussions within this thesis, work is considered in a broad sense similar to Livingstone (2003) who adopted the stance where work includes unpaid housework and community volunteer work, as well as paid employment, a view shared by Harris and Chisholm (2009) who advocate a wider definition of work-based learning.

The concept of Invisible Work is addressed in the literature, and the term was first used by Arlene Kaplan Daniels (1987) when she was researching women's unpaid labour, including housework and volunteer work. It has since been used to examine work in other settings, including within the context of health and care (Allen, 2014; McCormack, 2014; Hatton 2017). Allen (2014) argues that nursing has many features that make visibility problematic and this study explored the extent to which the same can be said for aspects of the volunteers' activities within the hospice. As with informal learning, as discussed below, this was an important reason for spending time as a participant observer in the field, so that those aspects of volunteering which volunteers or staff may be unaware of or take for granted, might be noticed and made visible through those observations.

The hidden complexities of everyday work are addressed by Brown and Duguid (1991) when they discuss the differences between the way job roles are described and how they are enacted in practice. They distinguish between 'canonical practice' which is work as described within a job description and 'non-canonical practice' which are the actual practices that employees engage in and learn through to get the work done. Descriptions based on canonical practice can be an over-simplification which fail to recognise the learning, knowledge and skills which employees actually engage within the course of their work (Fuller and Unwin 2017). This view is reinforced by Allen (2000) who argues that some

nursing tasks which are actually highly complex appear simple because of the expertise of the nurses. Using the data from this study I compared the job roles of volunteers as described in the hospice website and information available for volunteers, with the roles in practice as described by the participants in the study and my own participant observation in the ethnography. Distinguishing between the canonical and non-canonical practices of the volunteers was important in gaining a better understanding of their role in the hospice.

Wrzesniewski and Dutton (2001) offer the term 'job crafting' which they define as: 'the physical and cognitive changes individuals make in the task or relational boundaries of their work.' They argue that in doing so, workers actively change and adapt their job and these changes can be visible or invisible. They are also able to exert control over their work and 'job crafters make the job their own.' They provide an example in which hospital cleaners in addition to fulfilling prescribed work tasks integrate patient care functions giving added meaning and value to their work: 'work as healer instead of cleaner' (Wrzesniewski and Dutton 2001:183). A further critical factor which impacts on the work and learning of the hospice volunteers relates to the work of Hodkinson et al (2004) who discuss the significance of the biography of an individual which predates their participation in a particular workplace, and the impact this has upon their workplace learning. This theme was also explored by Fuller and Unwin (2005) who found evidence of the way individuals' biographies, values and dispositions shape their decisions about how they will engage in work practices, both as individuals and relationally with colleagues. By discussing their work with the hospice volunteers and observing them in action, the ethnographic approach used in this study has been instrumental in 'deconstructing volunteering', getting underneath the explicitly stated volunteer role and looking for evidence of canonical and non-canonical practice, job crafting, invisible work and the influence of a volunteer's biography. In Chapter 7, I bring these important aspects of work and learning together, and I use the term 'workplace responsiveness' which I contend is helpful in explaining some of the more complex aspects of work as practised by hospice volunteers. Supported by examples from the data, I will also argue that workplace responsiveness carries with it both inherent benefits as well as demands and consequences and these are important considerations in the context of hospice volunteering.

Volcanic eruptions and Communities of Practice: how best to characterize the work and learning of hospice volunteers?

The notion of workplace learning is contested in the literature (Billet 2004; Eraut 2004; Rainbird et al 2004; Fuller et al 2005). Learning within a workplace is not limited to formal training but is also situated and often based on naturally occurring or unexpected events

arising out of everyday work and interactions with others (Billett 2004; Snoeren et al 2015). Extensive literature exists which explores the concept of workplace learning including formal, informal and emotional aspects of learning (Billet 2004; Eraut 2004; Rainbird et al 2004; Fuller et al 2005; Benozzo and Colley 2012; Duguid et al 2013). Learning includes informal training and non-taught learning, as well as organized formal schooling and further adult education (Livingstone, 2010). Billett (2004) critically discusses the artificial dichotomy of formal and informal learning and that informal or non-formal learning is considered less important than formal learning. There are some unhelpful binaries that frequently dominate discussions and explanations surrounding workplace learning, including informal versus formal learning (Cairns and Malloch 2011) and whilst literature exists about formal, informal (or non-formal) and emotional aspects of workbased learning, they are often explored as distinct and different concepts, and the literature which addresses these concepts together is limited (Benozzo and Colley 2012).

Wenger (1998:8) in considering people's concept of what learning is suggests that: 'the events of learning we can point to are perhaps more like volcanic eruptions whose fiery bursts reveal for one dramatic moment the ongoing labour of earth', and this might help to explain why, in the absence of prompting, most of the volunteers in this study had difficulty articulating their own experience of learning in the workplace, apart from relaying examples of their own 'volcanic eruptions' which in the main related to formal training they had availed themselves of, or very memorable events which had happened in the course of their volunteering activities. The ethnography was designed in part to address this; by observing the volunteers as well as listening carefully to them and talking to staff about their experiences of working with the volunteers helped to make visible some aspects of work and learning which might otherwise remain invisible.

Informal learning is often not acknowledged within organisations as learning, or such learning is rendered invisible and regarded as part of the job. However, there is value in rendering learning visible so that it can be consciously deployed in enhancing work and the quality of life (Boud and Middleton 2003). Guriguis-Younger and Grafanaki (2008) identified volunteers who described their work as: 'a learning experience of self-exploration and human connection' (2008:22). There is some published research into the work of volunteers (Livingstone 2010, Schugurensky et al 2010) and their informal learning (Morris, et al 2013). In a study of older adult volunteers, Narushima (2005: 577-8) concluded that volunteers experience a sense of on-going learning and personal growth through their volunteering activities and their learning was characterised as trial-and error, informal, interactive and problem solving. That said, empirical research into the connection between volunteer work

and informal learning is limited (Duguid et al 2006). This may be because despite the contributions of volunteer work to the economy and societal well-being, only paid work tends to be considered real work. Other contributing factors may be methodological difficulties in uncovering informal learning together with the marginal status of volunteer work (Schugurensky et al 2010). The ethnographic approach in this study was designed to address some of these difficulties; by spending time as a researcher observing volunteers and staff in the setting, as well as talking with and listening to participants helped to raise the profile of volunteers' work and expose some of those hidden aspects.

Referring back to my personal reflection at the beginning of this chapter, I mentioned theories which during my professional career had been influential, assumed notable importance and featured prominently in academic writing and discussion. Communities of practice, as first proposed by Lave and Wenger (1991), is one such example. There has since been a proliferation of research studies where communities of practice has been the theory of choice to explore an eclectic mix of groups and how they learn in the workplace and beyond. In the early stages of this research, I questioned myself as to the relevance of volunteer learning and whether it was really of central importance to the study. Indeed, at times I wondered if including it was an attempt to placate my supervisors by giving the thesis some direct connection with my role as a lecturer in teacher education. Despite having an understanding of workplace learning, I now realise I was subconsciously defaulting to notions of learning taking place in sites of formal education or supervised work placements and assuming that learning would not be an important aspect of hospice volunteering or the main priority for most hospice volunteers. This thinking was reinforced in those early stages of the study by the volunteers who for the most part when asked about their learning when volunteering would speak of induction and other forms of organized training they had accessed. Developing Lave and Wenger's (1991) ideas of situated learning and communities of practice, Delamont et al (2010:8) discuss the notion of 'fighting familiarity' and the potential beneficial outcomes of studying learning and teaching in non-educational settings. Applying the concepts of communities of practice and legitimate peripheral participation provided a theoretical lens by which to examine the situated work and learning of volunteers and in doing so consider teaching and learning in a particular setting which arguably would not be considered a formal site for learning. Furthermore, whilst the learners might not be seen as 'apprentices' in the sense that Lave and Wenger (1991) used in their discussion of communities of practice and legitimate peripheral participation, this study considered the extent to which these concepts can explicate learning in such a setting involving a very diverse range of individuals with their attendant biographies and life experience.

Wenger et al (2002) provide a comprehensive definition of Communities of Practice:

> Groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis. These people don't necessarily work together every day, but they meet because they find value in their interactions. As they spend time together, they typically share information, insight, and advice. They help each other solve problems. They discuss their situations, their aspirations, and their needs. They may create tools, standards, generic designs, manuals, and other documents or they may simply develop a tacit understanding that they share. However, they accumulate knowledge, they become informally bound by the value that they find in learning together. This value is not merely instrumental for their work. It also accrues in the personal satisfaction of knowing colleagues who understand each other's perspectives and of belonging to an interesting group of people. Over time, they develop a unique perspective on their topic as well as a body of common knowledge, practices, and approaches. They also develop personal relationships and established ways of interacting. They may even develop a common sense of identity. They become a community of practice.
>
> (Wenger et al 2002: 4-5)

On first reading, I would argue that this presents a rather benign, comfortable and unproblematic picture of how people work and learn together, creating new knowledge and understanding. However, the word 'community' is often used in the literature associated with hospices and hospice volunteering (Claxton-Oldfield and Claxton-Oldfield 2007; Guirguis-Younger and Grafanaki 2008; Morris et al 2017). Volunteers are typically drawn from a local community; they provide a link between the community and the hospice; and hospices generally serve a local community as well as being heavily dependent upon that community for funding and support. This was one of the reasons I was initially drawn to the notion of communities of practice (Lave and Wenger 1991), as a concept since, on the face of it, it seemed to resonate with a hospice setting and the ways in which the volunteers in that setting might experience work and learning. The theory explores situated learning in the workplace, focusing on the relationship between learning and the social situation, and for learning to take place requires a degree of active social participation. On the one hand the concept provided a means of addressing the research questions, and specifically, RQ3, but it was also my intention to scrutinise the definition specifically and the theory more broadly in order to determine the extent to which it explicates the data and where there were shortfalls or contradictions when the principles of the theory and the volunteers' experiences in a workplace are aligned.

In determining whether or not a group of people does constitute a community of practice, it was important to establish the extent to which the three defining characteristics as described by Wenger (1998) applied in the case of the hospice volunteers. Those characteristics are:

i. Mutual engagement; ii. Joint enterprise; and iii. Shared repertoire (Wenger 1998:73).

Mutual engagement: relates to the ways in which people interact together in the course of their work. This engagement can be face to face or through interactions on the telephone, email or social media and is based around that exist within interpersonal relationships within the community. Wenger makes clear that the community does not constitute a homogenous group but can be diverse in its makeup. This was an important consideration in this piece of research where the volunteers are a diverse set of individuals in terms of for example: age, experience, qualifications and job role within the hospice. Wenger also makes the point that building the community and keeping it going can be a consequence of less visible and possibly undervalued contributions, providing an example of an individual: 'helping daily work more bearable for everyone by providing an endless supply of snacks' (1998:75). The ethnographic approach allowed me to be alert to examples of mutual engagement and the success or otherwise of volunteers' mutual engagement within the hospice and beyond and I was reassured that, contrary to my first impressions, there was not a requirement for passive, benign and compliant interrelationships since there was evidence in this study where mutual engagement was characterised by both support and some tensions. These are explored in detail with examples from the data in Chapter 8.

Joint enterprise: refers to the shared work or common endeavour of the community of practice (Tummons 2018:5) and is characterised by negotiated practical action, common accountability and mutual engagement (Jewson 2007:70). It is an evolving process within the community and 'pushes the practice forward as much as it keeps it in check … an enterprise is part of practice in the same way the rhythm is part of music' (Wenger 1998:82). Here it was important to look for examples in the study where volunteers work with each other and others, and uncover to what extent they work with, outside or around, official rules and procedures, or as a community adapt their ways of doing things. Moreover, there was the potential for connections to be made with Brown and Duguid's (1991:41) concept of canonical and non-canonical practice, as referred to above. These connections are identified and discussed in the data analysis chapters.

Shared repertoire: refers to the of 'routines, words, tools, ways of doing things, gestures, symbols, actions or concepts' (Wenger 1998:83), which the community adopts and develops over time as part of its practice. It was interesting in speaking with and observing volunteers to find examples of shared repertoire enacted in practice and the impact of these within communities of practice as shown in Chapter 8. There were many examples of volunteers who had developed ways of working together, one such example being the 'blue folder'

created and used by the volunteer receptionists. Details of this, together with further discussion and analysis of the ways in which volunteers work and learn in this way are considered in the data analysis chapters.

In critiquing this theorisation of situated learning it is important to consider the process of becoming a participant in a community of practice and the model as described by Lave and Wenger (1991) involving the transition from novice or 'newcomer' to 'old timer'. In explaining this learning process, they drew upon ethnographic studies of apprenticeships including midwives, tailors and butchers. However, this single inward, linear trajectory of novice to expert is criticised by Fuller and Unwin (2004), along with the concept of novice, arguing that not all novices are the same, and some may be experts and more skilled in certain areas than their older and more experienced colleagues. Fuller et al (2005) go further in highlighting the importance of researching the background and disposition of individuals and what they bring with them to that community. These arguments resonate strongly with the hospice volunteers in this study. Even volunteers who are new to the hospice, not to mention those who have been there some time, are actively engaged in situational learning but they bring with them a diverse range of skills, prior knowledge and experience from their life and work outside of the hospice. Indeed, some are recruited because of particular knowledge and expertise they are able to contribute. Therefore, whist not rejecting the theoretical concept of communities of practice out of hand the thesis argues that when looking at the volunteers' membership of communities of practice, the learning trajectories associated with that membership and the relationships within those communities is not a simple or linear trajectory for all volunteers and is influenced by a range of factors including the biography of the individual volunteers and their personal disposition and preferences. A further important consideration is the connection between the liminal space of volunteering and the extent to which this can support or limit learning in communities of practice. The liminality can also help to explain how some volunteers may be members of multiple CoPs some comprising only volunteers in its membership whilst others are a combination of volunteers and staff.

Conceptualising Emotion in the work of Hospice Volunteering

In the early stages of this research, whilst being very conscious that there was likely to be a significant emotional component involved in hospice volunteering it almost seemed too obvious to merit detailed study. Indeed, following my mid-doctoral viva, it was suggested by one of the examiners that the concept of emotional labour, which I had only briefly alluded to in my work up to that point, would be a useful theoretical concept to develop further in the thesis. At that stage, and with only what I now acknowledge was a very limited understanding of emotional labour, I initially decided against this as I understood the concept

carried with it rather negative connotations and on the face of it did not chime with my investigations up to that point. However, I later returned to the suggestion and having examined the relevant literature much more fully and applied some critique, I am now of the opinion that emotional labour, together with other theoretical considerations of emotion in the context of work are indeed helpful tools with which to make sense of aspects of hospice volunteering and the work of hospice volunteers.

A body of work exists within the literature which explores the sociology of emotion and of particular relevance to this thesis, in health and care settings (Phillips 1996; Kelly et al 2000; Henderson 2001; Gray 2009a; Sawbridge and Hewison 2013; Riley and Weiss 2016). The concept of emotion is inextricably linked to the notion of care and has some bearing to a greater or lesser extent on the work and practices of all health and social care practitioners. John Fox (2006) discusses the concept of 'detached concern' which medical students and other professionals working with the dying learn to protect themselves from emotion-laden experiences. He contrasts that with the concern which volunteers are able to show in their role; a role that in his view does not require the same detachment. The emotional demands placed on those who witness grief and support the bereaved require skill, knowledge and sensitivity (Payne 2002). However, concerns are expressed in the literature that emotional labour can be invisible (James 1989) and the emotional component of nurses and care workers may go unrecognized, unacknowledged and unsupported (Henderson 2001; Badolamenti et al 2017; Sawbridge and Hewison 2013). It was important therefore to determine the extent to which these concepts and arguments applied to the hospice volunteers in this study.

Dr Arlie Hochschild's (1983) in her book, 'The Managed Heart: Commercialization of Human Feeling', examined the work of flight attendants and debt collectors and proffered the terms 'emotional work', 'emotional labour' and 'gift exchange' to explain how the workers used and managed their emotions. These concepts have since become pivotal in a wide body of research into emotion and work. She defined emotion labour as: 'the management of feeling to create a publicly observable facial and bodily display' and this is in the context of a workplace involving payment. Those same acts in a private setting such as home or family she referred to as 'emotion work' (1983:7). She argued that as well as the physical and cognitive components of work, emotion is a third important aspect whereby emotions are managed by inducing or inhibiting feelings so as to render them "appropriate" to a situation (Hochschild 1983). The emotions which the worker displays might not necessarily be the same as those which they are feeling and are a response to the situation in which they find themselves and the emotions of others. To describe the process whereby the worker

manages their emotions to display the emotion which they feel should be required of a particular situation, Hochschild introduces the terms ‘surface acting’ and ‘deep acting’ in which a worker respectively either fakes or induces the emotion which they feel is required.

She suggests that jobs which involve some degree of emotional labour have three characteristics:

1. Face-to-face or voice-to-voice contact with the public.
2. The worker produces an emotional state in another person – gratitude or fear, for example.
3. The employer exercises a degree of control, through training and supervision, over the emotional activities of employees.

(Hochschild 2012:147)

Emotion work is skilled and demanding and requires time and emotional energy (Reay 2004; James 1992) and occurs when a person ‘induces or suppresses feeling in order to sustain the outward countenance that produces the proper state of mind in others’ (Hochschild 2012:7). Emotion work /management/ labour intervene to shape our actions when there is a gap between what we actually feel and what we think we should feel (Smith 2012:12) and these responses are socially and culturally determined by what Hochschild (2012) calls ‘feeling rules’. Hochschild’s perspective suggests there may be managed coercion of emotions and feelings on the part of management with largely negative connotations, whereby emotional labour becomes another commodity. In other words, there is an expectation that workers align their inner emotions with the emotion they display outwardly in line with the ‘organisational feeling rules’ (Hochschild 1983). This suggests a negative view of emotion and emotional management in the workplace. Colley (2006) exposed such negative aspects alongside issues of gender associated with emotional labour in the work of nursery nurses, concluding that emotional labour carries a cost for the worker because ‘her emotional labour power is controlled and exploited for profit by employers.’ The literature reveals the gender implications of emotional labour and it can reinforce gender stereotypes in the workplace (Noon et al 2013). Of specific relevance to health and care settings, Kelly et al (2000: 957) discussed the professionalisation of emotions in order to present an impersonal approach of medicine to staff, patients and wider society. Such an approach would be in conflict with the vision that hospices seek to avoid the medicalisation of EOLC as discussed in Chapter 1. It has been evident in this study that the opinion of some of the volunteers prior to coming to the hospice was that it was a sad place but upon entering they found it by contrast to be often a happy environment and often full of laughter. Indeed, my own observations often confirmed that view. However, there were also occasions when

there were incidents of sadness or distress to which volunteers were exposed or were directly part of. The extent to which this range of emotions is managed by both individual volunteers and the organisation is considered more fully in the data analysis.

However, other studies interrogating emotional labour in a variety of occupational settings have found positive aspects of emotional labour (Humphrey et al 2015) where workers are able to manage their own emotional responses and use their emotional skills with a degree of autonomy. Gray (2009a) argues that emotional labour brings added value and sustains a caring environment between nurses and their patients. Riley and Weiss (2016) in reviewing the literature of emotional labour in health and social care settings noted authors who recognise a reciprocal aspect of emotional labour in which both the patients and the workers derive satisfaction from offering emotional labour (Bolton 2000, Rodriquez 2011). Indeed, in later work, Hochschild (2013) herself asks the question 'Can Emotional Labour be fun?' and discusses care workers specifically, whose work involves a high degree of emotional labour but from which they derive great satisfaction and gratification. She argues the importance of recognising the extraordinary emotional labour required in maintaining a thriving care setting and warns against a 'broken care system…. in which care is devalued', concluding that given the right conditions, jobs requiring emotional labour could still be tough, but they would be meaningful - and even fun (2013:35). The satisfaction which can be gained through engaging in emotional labour was characteristic of the experience of many of the hospice volunteers and indeed was a significant motivating factor in sustaining their volunteering.

The other concept Hochschild uses in her analysis of emotional labour is that of emotion work as a 'gift exchange' which Bolton (2000) uses to explain aspects of emotion work in the context of the nursing process. She argues that nurses escape from the organisational 'feeling rules' and go above and beyond the job description, offering 'additional gestures of caring which they believe are an essential part of their identities as professional carers…… a personal gift given freely, sometimes unconsciously, without counting the costs' (Bolton 2000:581-2). That said, the idea of a gift has many different facets in terms of the gift itself and the process of giving and receiving of that gift. These include: unwanted gifts; duplicate gifts; gifts which derive personal satisfaction for the giver; gifts which are given in the expectation of getting something in return. The concept of emotion work as a gift is particularly relevant to hospice volunteers and merited further consideration in the light of the data.

In examining the literature on emotional labour in health care settings in addition to considering the work of doctors and nurses, it is important to also consider its relevance to

other workers who work in such settings. In this study, whilst there are examples of hospice volunteers who are doctors and nurses, more commonly their work within the hospice involves ancillary roles such as receptionists, hospitality, administration and in the case of the trustees, management, with varying degrees of work being on the 'front line.' Ward and McMurray (2011) carried out an ethnographic study of receptionists in General Practice in UK which exposed the complexity and 'emotional rollercoaster' that can be associated with their work. In studying the practice of the receptionists, they found examples of an emotional labour technique which they term 'emotional neutrality' and they used it to describe 'apparently dispassionate emotional displays intended to evoke a sense of calm or acceptance in others' (Ward and McMurray 2011:1585). They also recognised their ability to manage their emotions when dealing with unknown and unexpected events such as might occur in the course of their work. They coined the phrase 'emotion switching' defined as 'the process of sequentially managing and performing antithetic emotions with a view to matching and managing the emotions of others' (Ward and McMurray 2011:1586). Given that many of the hospice volunteers in this study are engaged in similar ancillary roles these concepts will be discussed further in the data analysis chapters to consider their relevance to the research data.

Reay (2004), develops Bourdieu's (1986) concepts of social and cultural capital to examine what she refers to as 'the murky waters of emotion', with a particular focus on education and family. In her writing, she draws upon the notion of 'emotional capital' as described by Nowotny (1981), and other feminist writers who argue that emotions are regarded as resources which can be used along with other forms of capital, within a particular field that allows those resources to count (Colley 2006: 25). It is suggested that emotional capital is shaped in the family and may be influenced by issues of gender, social class and other dimensions of inequality (Allatt 1993; Reay 2004; Andrew, 2015). However, Cottingham (2016) examines the concept of 'emotional capital' and uses it to explore the working practices of male nurses in the US. He defines emotional capital as comprising: 'emotion-based knowledge, management skills, and capacities to feel that links self-processes and resources to group membership and social location' (Cottingham 2016:452). He supports the notion of emotional capital as a type of embodied cultural capital whilst at the same time challenging cultural stereotypes about men and emotion and the argument that emotional capital is exclusively feminine. He also examines the situational use of emotional capital: the ways in which it is activated and used as practice in nursing and the extent to which emotional capital may be: 'both a set of innate qualities brought to the profession and skills, capacities and knowledge developed over time.' In other words, whilst they may have had emotional capital when they joined the nursing profession, their experiences in nursing

helped them develop it further. His study found that whilst men see their capacity for compassion as similar to women there may be differences in the way they activate that capital.

Baugher (2015) suggests hospice volunteers who have come to volunteering following bereavement acquire emotional capital through the grieving process and are able to find meaning in situations that many consider 'negative and stressful' and seek to avoid'. In caring for others, he argues they have already developed emotional competencies required for the volunteer role. A defining characteristic of emotional capital is 'it is all about investment in others rather than self – the one capital that is used up in interaction with others and is for the benefit of those others' (Reay 2004:71). A number of the volunteers in this study had come to hospice volunteering as a consequence of death and bereavement, in some cases having had direct experience of hospice care for a family member or close friend. It is hospice policy that in most cases it is advisable to allow a period of twelve months following a bereavement before taking up a role as a hospice volunteer. It was common to hear of volunteers who derived great pleasure and satisfaction from giving of themselves and some were able to draw upon their experience of loss in carrying out their role at the hospice.

Lopez (2006:137) offers an alternative and more positive vision making a distinction between emotional labour and what he calls 'organised emotional care'. He suggests this offers an option whereby organisations can: 'support emotional authenticity instead of attempting to manufacture it'. He suggests this is achieved through 'self-conscious organisational interventions that encourage relationship building and emotional honesty' (2006:137). As such, 'compassionate caregiving is built into the structure of the organisation rather than imposed as a set of rules about how to feel'. This option he argues is particularly relevant to care work settings than other kinds of service work such as those described by Hochschild (2012). Data from this study provided many examples where such: 'compassionate care giving' was integral to the hospice and evident in the ways in which there was a symbiosis between many of the volunteers and staff. This symbiosis appeared to be authentic and natural based on a mutual intention to care for another individual, rather than something which was imposed. Emotion work in healthcare settings has been defined as the act or skill involved in the caring role and recognising the emotions of others (Smith 2012). Lopez (2006) emphasises that meaningful relationships are central to organised emotional care and the importance of spending times with residents and building relationships. Worryingly, in one nursing home he studied he observed care as defined by the physical tasks of looking after a resident and 'sitting and conversing with residents was

not viewed as part of good care but as a dereliction of duty.' This raises the difficulty of the relative invisibility associated with emotion work as compared with the other two elements of physical and cognitive skills, a concern recognised by Colley (2006). Gray (2009a) situates his concerns in a nursing context, arguing that emotions are made invisible in nursing and remain largely implicit in practice, despite emotional labour being vital to both practitioners and patients, informing interpersonal relationships and sustaining quality care. The role of many of the hospice volunteers is characterised by emotion work interweaved with the more easily defined physical and cognitive tasks and as will be discussed later in the thesis, this has a bearing on the work and learning of the volunteers and more specifically the disparity between the canonical and non-canonical description of their working role.

Hochschild's original use of the concept of emotional labour was in relation to paid work, rather than unpaid or voluntary work, where the employee produces and manages particular emotions and feelings considered appropriate for that role. Pervading themes in the literature of emotional labour are the gendered aspects and links with cultural practices within domestic life and traditional family units. James (1992) provides a comparison between women's domestic care work and the work of hospice nurses and notes the invisibility and ambivalent status of emotional labour in each. This is important given the original intention of hospices to shift away from a medicalised model and replicate where possible care at home, as explained in Chapter 1. Therefore, accepting the premise that hospice volunteers occupy a state of liminality between home and work, between paid and unpaid and between clinical and ancillary workers in a health care setting, I would argue that it was reasonable in reviewing the data to apply these theoretical concepts of emotional work and labour to better understand the experiences of the volunteers in this study.

Summary

This chapter has introduced the theoretical concepts which are used within the thesis to critically examine hospice volunteering. The particular theories are those pertaining to liminality; situated learning and communities of practice; invisible work; and emotional labour. Their selection was determined by their relevance to the stated research questions and the methodology. The theories are used where appropriate to interpret the data but also there is acknowledgement where shortfalls and limitations arise in the theory when applying it to hospice volunteering. As such I show the extent to which the selected theories illuminate the more nuanced aspects of work and learning focusing particularly on those emotional and social aspects of work and situated learning as they pertain to hospice volunteers and, where possible, suggest ways in which such theories can be extended or developed. The data for the study is representative of a particular moment in time; the use of theory allows

for abstraction of the data which then opens up the possibility of wider application and a degree of generalization.

Chapter 4 Methodology

Introduction

This chapter provides a comprehensive and critical account of the methodological approach in this study. The ethnography has been a complex undertaking and the length of the chapter reflects that complexity. The ethnography adopted a multi-layered approach so each of the methods which was employed in the study merited detailed consideration within this chapter. Furthermore, one of the methods included was a relatively unconventional approach involving the use of metaphorical modelling as a data collection tool. Given that it is a method which may be less familiar than other more traditional methods used in ethnography, it was important to include considerable descriptive detail in addition to the expected justification and critique. Moreover, in the context of this particular study, the nature of the setting for the research, combined with the positionality of the researcher, presented some specific, and in some cases unique challenges and opportunities within the ethnography, all of which were important to convey in this written account. Finally, to complement the reflexive approach which has underpinned the methodological approach in the study, I have explored the use of photographs and visual reflection. This technique has shown itself to be important in relation to the progress and development of the thesis and also, in conjunction with selected theoretical lenses, has been a valuable tool for abstracting data. Again, it was important to detail this within the chapter, not least because it has a direct connection with the methodology and arguably makes a small but unique contribution to the way in which research can be developed and presented.

The chapter opens with a critical account of the methodology, including a detailed rationale for adopting a qualitative ethnographic approach, together with a critical account of its application in practice. As importantly, there will be a recognition of any short falls or limitations inherent in the process and the extent to which these have impacted on the study and the outcomes of the research. The challenges and opportunities afforded by the chosen methodology in the context of this research are clearly explained, and ways in which such an approach has enabled a greater understanding of hospice volunteering. The multi-method ethnography combined participant observation with interviews, specialist focus groups using the principles of LEGO® Serious Play® (LEGO® Open-source), and secondary data collection from hospice artefacts. The rationale for the use of these different methods, together with a reflective critique of their implementation in the study are included within this chapter. In short, these approaches provided rich data with which to illuminate and understand the culture and practice of a workplace where volunteers and paid staff co-exist. Detail of the setting and access to the research site is explained. The context of a hospice

setting, together with the nature of the work of hospice volunteers posed particular methodological challenges over and above what might be seen as standard research protocols, most notably some of the ethical and moral decisions which transpired, together with the emotional aspect of the research process and its impact on the researcher and the researched. These are discussed in detail within this chapter together with critical consideration of positionality and my own role as the researcher in the ethnography.

Qualitative approach

Historically, there has been a debate as to the relative value of quantitative and qualitative research where the former was considered as relatively superior by virtue of its positivist basis. However, Aspers and Corte (2019:143) warns against what they refer to as 'methodological tribalism' which they contend is often based upon misguided debate. In the context of this thesis, more important than any such debate is the consideration of the approach being suitable and appropriate for what the researcher was trying to find out.

An agreed definition of qualitative research in the literature can be somewhat illusive. However, Martyn Hammersley (2013) having acknowledged the difficulty offers a definition which he suggests incorporates defining features which can characterise qualitative research and it captures the essence of the approach used in this study:

> A form of social inquiry that tends to adopt a flexible and data-driven research design, to use relatively unstructured data, to emphasize the essential role of subjectivity in the research process, to study a small number of naturally occurring cases in detail, and to use verbal rather than statistical forms of analysis.
> (Hammersley 2013: 12)

The aim of this study was to find out about the lived experiences of hospice volunteers and the social and cultural factors which shaped those experiences. Far from finding an homogenous group with a shared experience amongst the volunteers, the study uncovered individual experiences and diversity within the cohort as well as themes and common threads which helped to determine the direction of travel of the research process. Qualitative researchers embrace outliers and actively seek diverse points of view from participants to enrich data (DeChesnay and Abrums 2015:xx). They study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them (Denzin and Lincoln 2005:2). I wanted to understand how hospice volunteers enacted their role and contributed to the hospice and in order to do that I opted to use 'qualitative methods and personal involvement ….. and research which was flexible, relatively unstructured and based upon detailed descriptions rather than statistics of what is seen and heard' (Henn et al 2006:16).

Ethnography

The ethnography took place in a hospice in the north of England over a period of four years. In their study of qualitative nursing research, DeChesnay and Abrums (2015:9), introduced the term ‘focused ethnography’ which they describe as being characterised by intense but not necessarily continuous periods of data collection and they suggest is particularly useful for understanding organisational culture. In this study, rather than spending the time continuously at the research site, I visited the hospice frequently to carry out data collection using a range of different methods, and the research questions and data collection focused particularly on volunteering in the hospice, rather than an ethnography designed to examine wider aspects of the hospice culture. The principle of engagement by the ethnographic researcher contains two elements: human connection with the participants and an investment of time (Walford 2008: 9). The time required to carry out conventional ethnographic studies is considerable and Hammersley (2018) argues that the pressures academics and postgraduate students in universities are currently working under pose a significant threat to ethnographic work and a shift towards ‘more efficient means of collecting data’ (2018:3). Pink and Morgan (2013) offer an alternative approach, debating the use of what they term ‘short term ethnography’ which they argue is ‘characterized by forms of intensity that lead to deep and valid ways of knowing’ (2013:351). Whilst it may be seen by some to have been an inefficient or even extravagant use of my time, in terms of ethnographic practice and specifically in the context of this study I would suggest that the considerable time invested at the start of the research was important for what was to follow. Due to time constraints and the competing demands of a part-time PhD, full time employment and a busy family life there were however some limits as to how this study constitutes conventional ethnography where long periods, traditionally years at a time, are spent in the research field. Jeffrey and Troman (2004) discuss the challenges ethnography presents in terms of the time required to devote to the research. They identify three different modes of ethnographic research time, each with specific features: 'compressed', 'selective intermittent' and 'recurrent' modes. Of the three modes, the ‘selective-intermittent’ most closely describes my approach. This type of research specifies the specific area for investigation, and the researcher would be continually selective about the place and the people with whom they spent time. It allowed for more flexibility and pragmatically it fit more realistically with the demands of other aspects of my life at the time. It also enabled me to focus on the volunteer activity within the hospice and to an extent filter out unrelated aspects of the hospice which whilst inherently interesting were deemed not directly pertinent to the particular focus of this research. Apart from the initial period of broad familiarization, specific rich contexts were selected for examination and interpretation. There is less 'hanging

around' as the research develops than there might be in a compressed approach where a continuous length of time in the field is stipulated.

The main focus of this ethnography comprised participant observations at the research site which were supported by field notes, together with scheduled observations of individual volunteers, shadowing them during their working shifts. Other methods included informal conversations; interviews with individual volunteers and members of staff and specialist focus groups applying the principles of a technique known as LEGO® Serious Play® (LSP). The fieldwork commenced on 3/06/2014 with the final documented visit taking place on 6/11/2018. During that time, I completed 81 hours of scheduled events such as: arranged observations of individual volunteers; interviews; meetings; and training events (see Appendix 3). In addition to these organised events, I visited the site in my role as trustee at least once every two weeks and on each occasion built in time either before or after the trustee business to 'hang around' various areas of the hospice to carry out participant observation, with the focus on naturally occurring hospice activity and particularly that which related to hospice volunteering. In other words, having 'a 'magpie' attitude to information picking up anything that looks interesting' (Walford 2008:9).

Historically, ethnography has been most closely associated with anthropology and qualitative sociology (Madden, 2010). Ethnographic accounts were produced, often by travellers and missionaries, who having spent long periods of time living in unfamiliar places, went on to describe cultures and communities who were usually located outside the West. In sociological fields, in 1920s-1950s, the University of Chicago used ethnographic case studies of urban life. Over time, ethnography spread to different disciplines including psychology and human geography. Ethnography does not then have a standard, well-defined meaning having been redefined and reinterpreted across multi-disciplines to deal with particular circumstances (Hammersley 2018). Ethnography is growing in popularity as a method of choice for nursing research and it is considered to be particularly effective for researching health and social care provision in the context in which it occurs (Allen 2004).

> Ethnography usually involves the researcher participating, overtly or covertly, in people's daily lives for an extended period of time, watching what happens, listening to what is said, and/or asking questions through informal and formal interviews, collecting documents and artefacts – in fact gathering whatever data are available to throw light on the issues that are emerging focus of inquiry.
>
> (Hammersley and Atkinson 2007:3)

This definition captures very well the essence of the approach I adopted in this study to find out more about hospice volunteering through, in this case, adopting an overt presence in a

particular hospice, using a variety of methods to generate data and above all spending extended periods of time within the research setting and amongst the research participants.

Ethnographers study the lived experiences, daily activities, and social/political context of everyday life from the perspectives of those being studied and typically the researcher immerses [herself] in the natural setting for long periods of time to gain a deeper understanding of people's lives (Buch and Staller 2013). The essence of ethnography is the tension between trying to understand people's perspectives from the inside, while also viewing them and their behaviour more distantly, in ways that may be alien (and perhaps even objectionable) to them (Hammersley 2006). In my study, for reasons which are discussed within this chapter, I did not want to limit myself to gathering participants' perspectives through conversations with them. I wanted to balance those verbal exchanges with observation of what took place in the setting by watching individuals and groups within the hospice, attending meetings and events and sometimes just by being present in a particular area of the hospice. Karen O'Reilly (2012) discusses the issue of validity in ethnographic research and argues that the research is 'valid, plausible and credible when it involves direct and sustained contact with human agents, and is collaborative, flexible, iterative and inductive' (2012:227). In this study that was achieved by going backwards and forwards over things; revisiting and questioning that which I was told or observed; checking data by looking for different perspectives, confirmations and contradictions, all of which took time, engaging with many individuals and situations within the hospice setting. This approach to data collection endeavoured to provide some degree of validity. Some observations confirmed what had been said in interviews and focus groups; sometimes issues emerged which I was then able to review at a later date with participants to clarify what I had observed. On other occasions things had been observed which were contradictory or it was clear that participants had not been aware of particular aspects of their work. Sometimes this was because the participants had thought something at the time too obvious or inconsequential to merit sharing with me in interviews but there were other examples of which they were unaware. Examples are considered in more detail in the data analysis chapters of the thesis. I was interested not only to find out about individual volunteers' experiences, but from that to gain a better understanding of factors which shaped those experiences and hospice volunteering more broadly. As Geoffrey Walford (2008) explains, 'ethnography balances attention on the sometimes minute everyday detail of individuals lives with wider social structures (2008:7). O'Reilly (2012) identifies defining features of ethnography as a practice which:

> Evolves in design as the study progresses, involving direct and sustained contact with human beings, in the context of their daily lives, over a prolonged period of time. It examines social life as it unfolds, including looking at how people feel, in the context of their communities, and with some analysis of wider structures, over time… examining reflexively, one's own role in the construction of social life as ethnography unfolds.
>
> (O'Reilly 2012:3)

I have included this because of the reference to reflexivity and the researcher's own role within the ethnography. This is an important aspect of ethnography which is not always mentioned in definitions but has proved to be of significance for me in carrying out this study. As a 'novice' ethnographer, I would admit to having been quite naïve at the outset, but nevertheless I have encountered important ethical and emotional aspects of the research process which having experienced them I would argue have wider implications for researchers and supervisors involved in ethnography and research more broadly. Further consideration of this are picked up on later in this chapter.

These definitions therefore broadly mirror the approach used in this research. Specifically, I spent extended periods of time with the volunteers and staff in a particular hospice. The selection of the site, participants and how time periods were chosen are discussed later in this chapter. The ethnography shone a light on examples of the work and learning of volunteers and staff at first hand, affording the opportunity to see and hear about the work people do and the stories they tell within the hospice.

The research site

The hospice chosen for the fieldwork for this ethnography is situated in the north of England. When the hospice, Fernbank, first opened in 1981 it was originally located in a detached Victorian house which had been donated to the founders of the charity by the widow of a local businessman. The house is set within extensive garden areas which over the years have been cultivated and cared for and become a valued part of the hospice facilities. They provide a peaceful setting for the use of everyone at the hospice and the patients in the inpatient unit are able to look out on the gardens and views of the local area. At that time, in the upstairs of the original building there were four bedrooms adapted for patient use and one office shared by doctors and other clinical staff. Downstairs was the kitchen, two lounges (one available for smokers), a dining room and a chapel and mortuary. The attic space was used for changing rooms and storage. The medical input was provided by two general practitioners who gave their time freely, a salaried matron and nursing staff, supported by other nurses who came and volunteered outside of their paid work at the local hospitals. There were two individuals who dealt with all the administration for the organisation and these were each volunteers and on the original Board of trustees at the

hospice. The patients who came to the hospice at that time would have had cancer as their primary diagnosis and be in the final stages of life. From the beginning there were also volunteers who helped out in a variety of roles throughout the hospice and in the local community. I myself was a volunteer at that time, helping out in the kitchen and making drinks and refreshments for patients and their visitors. Since that time Fernbank has expanded significantly both in terms of physical resources and the range of care and services it provides with plans for further development in the future. On the original site, the house is still part of the functioning hospice building but it has been extended and there is now a purpose built 12 bed inpatient unit and a day hospice which provides a range of facilities for patients who are living at home. For the majority of patients, cancer is their primary diagnosis, but the admissions policy now is more wide reaching and offers services to a range of other patients with life limiting illnesses.

As explained in Chapter 2 the funding and running costs of hospices in the UK are only part funded by the state and a greater proportion of finance is through charitable giving. This relies on significant fundraising efforts for the hospice to continue its work. This is led by a small team of paid fundraisers but augmented by volunteers who offer support in a variety of ways. There are also hospice shops which have paid shop managers but are otherwise entirely staffed by volunteers. All aspects of the work done by the hospice is now achieved by combining the work of paid staff and volunteers. The hospice provides a range of highly specialised EOLC and offers support and advice to other clinicians, health practitioners, care providers and members of the public. There are currently over 700 volunteers registered with the hospice with a ratio of approximately 7:1 volunteers to full-time equivalent paid members of staff; the longest serving hospice volunteer at the time of this research having been with the hospice for 31 years. Detail of the Volunteer Demographic Statistics as recorded by the hospice can be seen in Appendix 2

The ethos and values underpinning this methodology resonate with my personal approach to research practice: it was an attempt to make the research process more collaborative, providing an opportunity for shared participation between myself the researcher, and participants. The impact of this research aimed for active involvement by key members of hospice staff and volunteers in the research study in order to support the embryonic research culture at the hospice, enhance the research skills and experience of individuals, and be of direct benefit in terms of developing volunteer strategy and practice. The research was designed to enable people within the organisation to feel valued enough so their voices are heard and debated (Hockley et al 2012) and to actively encourage volunteers and staff to share in the research process creating a ‘communicative space’ (Kemmis 2001) across

the organisation. Hospices are not by and large centres for research or prolific in their research output (Payne et al 2013). One of the aims of this study has been to promote the value of research within the hospice by establishing good professional relationships with participants; being open and transparent and, where possible, keeping volunteers and staff involved with the process and outcomes. This hospice had no significant history of formal research, and whilst there was enthusiasm amongst individual staff and trustees, to date research and education is embryonic within the institution. This is not unusual in hospices and resonates with research by Payne et al (2013) who looked in detail at research capacity in hospices, identifying substantial barriers such as: hospices being small, independent institutions having no research culture, a lack of infrastructure, expertise and resources, and most do not benefit from research partnerships with the NHS or university sectors. Despite these barriers they concluded that it was essential that hospices do contribute to research in the future. Regulation of health care provision and commissioning of services are increasingly combined with the requirement that providers demonstrate evidence- based practice. Hospices also need to understand and question what they do in order to disseminate that knowledge and expertise more widely amongst other providers of EOLC. This study involved research in which the participants were actively involved in shaping the direction and focus and involved with me, the researcher, in a joint process of knowledge-production (Bergold and Thomas 2012). From the outset I discussed my research with staff at the hospice, seeking out their ideas as to key issues they considered should be included within the research. These conversations informed my research and helped me to frame and re-frame my research questions. In that sense, the ethnography, far from being fixed would better be described as fluid and dynamic, developing over time with 'fits and starts' and changes of direction along the way. Some staff and volunteers were instrumental in suggesting potential participants and enabling me to establish contacts with those volunteers. By sharing some of the findings and areas of interest as they emerged, individuals would say words to the effect of, 'Oh you ought to speak to so and so about that,' and thus extended my network and reach within the field. By actively involving the hospice staff and volunteers I aimed to use a model of research described by Henn et al (2006), in which the role of the academic is transformed from the expert and professional methodologist who designs and runs the research in their own terms, to a skilled enabler of research. In so doing the approach attempted to democratise the research process and flatten some of the traditional hierarchies. Without exception, the volunteers and staff when approached were very positive and keen to contribute to the research. It was apparent that they were keen to share their ideas and opinions and were very accommodating and generous in giving their time and support. They were also interested in the research as it was progressing, suggesting people and things I might be interested to look at and observe

and sending me follow up emails with afterthoughts which had occurred to them after an interview or shadowing event. Similarly, there has been an openness amongst the staff who were keen to be involved and were generous with their time, and welcoming when I was observing or asking questions. The original decision to undertake the ethnography in this hospice setting was a deliberate choice and not one based on convenience. I believe that decision has been vindicated in that it provided rich and valuable data and the participation in the research process was beneficial to the participants and to the organisation more broadly. Indeed, in keeping with Baugher (2015) as a hospice volunteer myself, I found that the research 'created spaces for volunteers to speak openly about experiences they rarely, if ever, had the opportunity to do so elsewhere in their lives' (2015:310).

A hospice provides a valuable research site to explore the nature of volunteers' work in a professional workplace and the learning associated with a volunteer role. The research design enabled me to study the volunteers' experiences in its authentic context. Arguably this approach is limited in terms of its generalizability although the importance of formal generalization can be overvalued (Flyvbjerg 2006). This approach offered the benefits of obtaining 'thick description', a term first used in the context of ethnography by Geertz (1973) and later expanded upon by Denzin (1989).

> A thick description ... does more than record what a person is doing. It goes beyond mere fact and surface appearances. It presents detail, context, emotion, and the webs of social relationships that join persons to one another. Thick description evokes emotionality and self-feelings. It inserts history into experience. It establishes the significance of an experience, or the sequence of events, for the person or persons in question. In thick description, the voices, feelings, actions, and meanings of interacting individuals are heard.
>
> (Denzin1989: 83)

Such rich and detailed data from one institution led to findings which are particularistic and even unique to the hospice (Henn et al 2006:66), and this is valuable in itself. However, I would suggest that there are also findings which while not being directly transferrable or replicated elsewhere will nonetheless be relatable and contribute to knowledge and understanding of hospice volunteering more broadly, 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. With regard to the choice of research site, it would have been an option to undertake the research in another hospice, rather than one with which I had a personal connection. Indeed, Walford (2008) suggests it can sometimes be a mistake to opt for a site

where one already has connections and access is assured. This is an example of the researcher's positionality and the impact it has on a research study. This important issue is discussed further later in this chapter. I took the decision to carry out my research at the hospice with which I had those existing connections on the basis that some of the findings would be unique to that setting, which was important for me and I was keen to better understand volunteering in the hospice where I had significant responsibilities in my role as a trustee. However, although I would make no claims that the outcomes of the study are widely generalisable, I do consider that there are findings which may be applicable to other settings and contexts in the wider world. As Lisa Russell (2013) asserts, 'no two ethnographies are the same. Each one has its own individual fingerprint' (2013: 46). However, while ethnographic research may not be statistically representative, it can still have relevance for a wider population through the transfer of understandings to similar settings, through theoretical explanations that can have wider application, or through overt and modest generalisation (O'Reilly 2012).

Gaining access to the site and establishing relationships

Hospices are independent organisations which are not part of the National Health Service and as such the research study did not require ethical review by an NHS ethics committee. However written permission was obtained from the Hospice Board of Trustees who were the formal gatekeepers for accessing the field. As a trustee of the hospice, I had completed an enhanced Disclosure and Barring Service (DBS) clearance, details of which were held by the hospice. I had an established professional relationship with the Board members, the Chief Executive and other members of the Senior Management Team (SMT). I was able to present a verbal proposal to the Board at one of their regular board meetings to support the written request and this afforded the opportunity for trustees and members of SMT to ask questions about the proposed research. Given my existing relationship with the Board members I considered it important to follow procedure and my request and the Board's approval was formally recorded in the minutes of that meeting.

I have made clear the importance of establishing relationships from the outset and being explicit about the intended approach, encouraging a degree of active input and involvement of volunteers and staff. O'Reilly (2012) suggests that trust and rapport can be easier (and quicker) to build where the ethnographer is already an insider. Whilst I would concur with that view to a point, I would argue that insider/outsider roles are not always clearly defined or polarised and, in my circumstances, this was such an example. Without question I was an insider within the hospice in that I was familiar with the setting and known to many of the actors within that setting in my trustee role. However, because of that trustee role and my

intention to spend time observing and talking with volunteers and staff, I needed to not assume that trust and rapport was a given, and indeed I needed to spend time reinforcing my existing relationships. There were also volunteers and staff who were not known to me, nor me to them, so as far as they were concerned, until I had the opportunity to introduce myself and explain the reason for me being at the hospice, I was to them, an outsider. Above all, throughout the research, I sought to constantly reassure participants of my intentions and rationale for the research: it was not to 'check up' on their performance, as might be assumed to be the case (rightly or wrongly), when people in senior positions within an organisation carry out observations, but rather the research was a genuine attempt to better understand the role of volunteers in the hospice and to inform future developments. MacMillan and Scott (2003) discuss researcher identity: how an individual might choose to describe themselves on different occasions within a research setting, and as they describe it 'we find ourselves wearing different hats' (2003:103). Such choices they argue, whereby a researcher for whatever reason decides to emphasise or downplay a particular aspect of their identity, can impact on the dynamic. In my own case, I found that when introducing myself to individual participants or to groups of volunteers and staff at meetings I attended, I did not consciously downplay aspects of my identity, but tried to present an open picture of who I was and why I was setting out to do the research. I did not find any need to downplay any particular role and was keen to avoid any perception of 'hidden agendas'. Consequently, my introduction included my role as a trustee, undertaking a doctorate, the University I worked at, the nature of my 'day job' and my historical links with the hospice. Without exception I was met with a positive response and the introduction generated interest and further questions about who I was and the research study itself, which I was happy to answer. It was an important and valuable exercise in building trust and openness with the people with whom I would be coming into contact during the research process. These ongoing relationships and reassurances were established and further developed through regular conversations with groups and individuals, letters and email correspondence and posters displayed within the hospice. In the context of this study, although initial access to the site was a formal process of obtaining the requisite permissions from the gatekeepers of the hospice, access was actually an ongoing process, 'a moment-by-moment process of negotiation and trust that can be rescinded at any time' (Walford 2008:16). Each time I wanted to spend time with the volunteers, I was in effect asking them for permission to access their 'liminal space of volunteering' and be alongside them in their work.

Having gained access to the site, the staff and senior managers in the hospice were very co-operative in providing me with access to relevant paperwork and documentation pertinent to the hospice and the volunteers. I cannot stress enough the importance of establishing

effective relationships in this sort of research, especially given the sensitivities inherent in a hospice setting, and because of my dual role as trustee and researcher. The staff and possibly also the volunteers might see me as some sort of representation of management and this was something I was keen to avoid, not least because I do not see myself in those terms even as a trustee. I needed to establish relationships with volunteers and staff such that they did not perceive my role to be in any way managerial or intrusive and associated with any top-down supervision of their role or performance. I endeavoured to make this explicit in my conversations with participants and where possible operating on the participant's terms. I was courteous and appreciative towards volunteers and staff, being aware that I was a 'visitor' within their working area, particularly when observing or shadowing. This would be an important consideration for any research in a workplace but is particularly significant for an ethnographer. As discussed earlier, the knowledge and experience I have of the hospice and its staff could be seen to carry a threat to the validity and reliability of the study. Conversely however, that relationship was beneficial in terms of establishing a degree of trust, confidence and credibility between myself, the staff and volunteers from the outset and sustaining that throughout the course of the study.

In his analysis of ethnographic methodology, Hammersley (2006) makes the important point that the essence of ethnography is the tension between trying to understand people's perspectives from the inside while also viewing them and their behaviour more distantly, in ways that may be alien (and perhaps even objectionable) to them. Indeed, this could present a challenge for the researcher in terms of relationships they establish with participants. Allen (2014) maintains that:

> The hallmark of good ethnographic field relations is the successful management of a marginal status … the importance of developing an affinity with participants while retaining the necessary intellectual distance for the research.
>
> (Allen 2014:15)

It would have been easy to become fixated on the narratives and opinions of the participants in the study and I needed to be able to take a step back and explore these more fully in relation to the organisational context and relevant theoretical frameworks. Furthermore, in recognising the importance of ensuring ongoing trusting relationships in an ethnography, it was important to be honest on the occasions when I provided summaries of findings and emerging issues to interested parties at the hospice (including participants). Some of the findings and issues inevitably met with some degree of surprise, discussion and challenge rather than painting a rosy picture of complacency. There is a delicate balance regarding the researcher's relationship with participants: gaining the trust of people can reduce the dangers of behavioural adaptation and feelings of being checked up on or judged but on the

other hand, becoming too close to those being observed can compromise the study and threaten validity by the researcher over-identifying with participants and 'going native' (Henn et al 2006:197).

Because I was already known to many people in the hospice and they were aware and interested in the research I was undertaking, staff and volunteers did chat informally to me on occasions, and issues relating to volunteers were often the subject of discussion at meetings I attended. Inevitably these conversations, observations and discussions become part of the data collection for the ethnography, not least my own reflexive thinking. However, it did throw up some ethical issues about my relationships with participants and informed consent. Whilst I could not 'airbrush out' these aspects of the data, I did attempt to follow up such comments in the more formal data collections such as the shadowing events and recorded interviews.

One of the reasons for needing to spend time in the field at the start of a new ethnographic study is that as the researcher one may will feel strange and obtrusive and you will have an effect on those you are spending time with (O'Reilly 2012). I needed time to settle in and blend in with the surroundings and often that meant I was doing little other than sitting around in the reception area or chatting to people around the hospice. At the start of the research, I devoted days to visiting the hospice and spending time 'hanging around' in order to orientate and familiarise myself with the setting. As noted earlier in this chapter, an important aspect of this research was the need to establish and maintain relationships with volunteers and paid staff in the hospice and be open and informative about the research I am doing. Those early visits to the setting were crucial in starting to make those connections. When I first visited the hospice, despite being in a building with which I was familiar and being known to some of the staff and volunteers, I still felt a degree of nervous anxiety as if I was there for the first time.

It felt funny in reception today when I arrived. I wasn't quite sure how to introduce myself to the volunteer on reception. Signing in I normally sign in the staff book when I am going to a trustees' meeting but I didn't think that was appropriate today and used the Visitors' Book instead. I was there to observe and just get a feel of the place before my first shadowing session next week. Where to sit? I settled myself down on the couch opposite the reception desk, but after a while that didn't feel quite right. People kept asking me if I was OK as they went past. Was I waiting for someone? Did I need help?..... I had planned to sit here next week but I've realised I won't be able to see and hear the volunteer properly. It's going to be better sitting with her behind the desk. The notebook has to go too. It felt too formal and it

could be off-putting for people if they see me scribbling. I'm going to have to rely on memory. (Field notes 20/6/2014)

Following those early visits, I went on to spend time in other areas of the hospice, sometimes adopting a relatively passive position in that I was not overtly involved in hospice activity but rather spectating what was going on around me. During those times it was about using all my senses and having a heightened awareness of the place I was in (Pink 2012; Pink and Morgan 2013). At other times I was invited to attend meetings within the hospice and on those occasions, I was sometimes there to observe and other times to have a more explicitly active role. When I was with individual volunteers, again the level of active involvement varied from observing in close proximity, to actively undertaking some of the activities of the volunteer with whom I was spending time. The level of activity and involvement was determined at the time either in conjunction with the volunteer or in response to events as they unfolded.

My visits to the hospice and my timetable were often dictated by the activities and availability of the volunteers who were already giving time to the hospice and I had no wish to encroach excessively upon that. Most of the volunteers were happy to extend the time on the days they were at the hospice for volunteering to meet with me before or after for interviews and generally they were less likely to meet me outside of those days when they attended. I also tried to build in time between observations and shadowing for reflexive writing in the form of field notes and review of the ongoing data collection. Long bursts of observation, uninterrupted by periods of reflexive recording tend to result in data of poor quality (Hammersley and Atkinson 2007). Using the metaphor of Jeffrey and Troman (2004:542), 'just as a cinematographer gradually zooms closer and closer on to their preferred subject, in this mode', over time I was able to 'pursue particular interests with gusto and to discard those avenues that seemed less relevant or interesting'. The approach availed me the opportunity to leave the site and reflect on events and experiences before returning to the site to hone in on a specific area of interest or adjust the focus of my 'gaze'. Although I had a notebook with me when doing observations, I found that in practice, the recording of written notes during observations was minimal. Where I did make notes, they were highly abbreviated and acted as prompts for more expansive notes which were completed as soon as possible after the event, often in the car park at the end of a visit to the setting. Notes are first and foremost a response to mental triggers and events as they happen. In particular I noted points which were relevant to the key research questions and some filtering had to be applied to maintain some focus in the complexity of an observed event. That said, sometimes notes were made which had at the time no obvious relevance to the research

themes but had made sufficient impact on me that I wished to capture the event for later review and reflection. Indeed, as soon as the researcher puts pen to paper and constructs their field notes, it is an interpretation as opposed to a factual version of events and it is important to acknowledge that 'the writer-ethnographer is including and privileging his/her own meaning of events' (Beach 2005:3). However, the use of field notes did make an important contribution to my understanding of the setting and the interactions and activities I observed. Due to the sensitive nature of the hospice setting, audio or video recordings of volunteers and staff whilst carrying out their work at the hospice were not considered to be an appropriate data collection tool for this study.

Sampling

No setting will prove socially homogenous in all relevant respects, and the adequate representation of the people involved in a particular case will normally require some sampling (Hammersley and Atkinson 2007). Deciding who to spend time with, where to be, what to watch is not a one-off decision, but is part of the ongoing practice of ethnography (O'Reilly 2012). In this study, the hospice comprises an in-patient and a day care unit on site where volunteers are involved directly with staff and patients, undertaking a variety of roles. Volunteers also contribute to the hospice within the local community in charity shops and fundraising activities. For reasons of expediency this research focused specifically on volunteer activity within the hospice, although there were individual volunteers who contributed to the study who undertook roles both in and outside of the hospice building. In part this decision was taken because of limitations of resource, time and feasibility. With over 700 volunteers registered with the hospice, it was decided to limit the sample and to focus on the depth and detail of those volunteers' experiences who operate within the hospice itself, whilst at the same time acknowledging the importance of future research to include volunteers involved in the community, fundraising and retail activities of the hospice.

The research participants were selected in various ways. Sampling was ongoing in the study and not set in stone at the outset. This was in response to the data collection and themes and areas of interest which were emerging and merited follow up. The sample was based on volunteers and staff who wanted to contribute to the research. In some cases, participants were approached by myself and invited to participate. This purposive sampling was used to gain a representative sample (Gray 2009b) but also an attempt to ensure diversity and inclusion (O'Reilly 2012) and specifically was intentional on my part to ensure representation of gender, age and ethnicity within the sample. I also wanted to include volunteers from the different areas of the hospice eg reception, day hospice, in-patient, trustees and administration.

The shortness of much contemporary fieldwork can encourage a rather ahistorical perspective, one which neglects the local and wider history of the institution being studied (Hammersley 2006). To ameliorate this, I ensured that within the sample I included volunteers and staff who had been with the hospice for long periods of time, as well as more recent recruits. As mentioned previously I have my own longstanding connections with the hospice which means I have a personal historical narrative which I acknowledge influenced the data and its analysis. This was significant given that one of the emerging areas of interest within the research has been the changing nature of volunteering over time.

Snowball sampling relies on the researcher obtaining a strategically important contact who can recommend other possible participants (Henn et al 2006:183), and in the early stages of this study the volunteer coordinator was instrumental in helping me to establish some networks and contacts with individual volunteers. She acted as a gatekeeper in that her role ensured she had a working knowledge of the individual volunteers, their contact details, volunteering role and their length of service in the hospice, enabling her in some cases to approach volunteers in the first instance and with their permission, put them in direct contact with me. As the research progressed some of the volunteers suggested others who they thought might be interested in participating or who they felt had particular knowledge or experience which they felt might be useful for the study. Where individual volunteers were suggested by friends and colleagues, I did need to be careful to take into consideration the impact of this in that it might exclude individuals who might want to participate but were not part of those particular networks and friendship groups. To address this, I also went to volunteer meetings and used information sheets (Appendix 4), and posters (Appendix 5) in the hospice to promote and explain the research and as discussed below. Those meetings were particularly helpful in explaining the detail and nuances of the research, dealing face to face with questions and queries and establishing initial relationships with volunteers and staff. This led to individuals directly approaching me and offering to become involved in the study.

A total of 25 volunteers and 12 members of staff took part in scheduled observations, interviews and LSP sessions, and some of those individuals participated in multiple data collection events. In addition to those active participants, the ethnographic observations included numerous other volunteers and staff who were present at the time when observations were taking place and I would argue contributed to the ethnographic data as a consequence of their presence in that setting which influenced the context and therefore my observations and thinking as the researcher. In some cases, their presence in the observation area may only have been transitory, they may have been interacting with others or they may have been engaging in their

work role. This latter group did raise some ethical issues regarding consent which needed to be addressed and this is discussed later in this chapter. The hospice volunteer cohort includes amongst its number many individuals who volunteer in the community in retail and fundraising activities. The participant volunteers in this study were limited to those involved in volunteering activities directly associated with the main hospice site, although some did also do further volunteering for the hospice in the community and were able to draw upon those experiences to inform the data for the research. It became apparent that the demographic of the volunteers at the hospice was very different to that which one would typically find in a workplace and did not mirror the demographic of the paid staff. For example, the youngest of the participants in the study was 17 and the oldest was over 80 years old. That age demographic immediately suggested a defining characteristic of the liminality of hospice volunteering which sets it apart from the space occupied by paid staff at the hospice and others in paid employment in that it is open to accommodating individuals who might not be able to access the hospice and possibly many other workplaces in a paid capacity. When carrying out their volunteering role, individuals are stepping into a unique liminal space; they are neither X nor Y, they are 'neither here nor there' or 'betwixt and between' (Breier, et al 2019): they are neither a paid member of staff, nor a member of the general public. The concept of liminality was introduced in Chapter 3, and specifically the way in which a beach landscape provides a visual metaphor in this study. Further examples of this unique position will be exemplified in other chapters. The use of photography as a tool for reflective thinking is also explained later in this chapter and how I have used that technique to connect my thinking, especially relating to liminality, and represent ideas within this thesis. Therefore, within this chapter, some of those photographs have been included in order to illustrate ideas in relation to the themes under discussion, although it should be noted, that these images are not data in themselves but rather have helped me to conceptualise the data and emerging themes and to illuminate the narrative.

Research methods

Qualitative research may involve more than one research method or technique, and often follows an iterative process (Henn et al 2006:178). As mentioned above, the methodological approach was a multi-method ethnography in which participant observation was combined with interviews, informal conversations as well as attending a wide range of meetings which took place within the hospice. I also used a technique known as Metaphorical Modelling, in which groups involving volunteers and paid staff represented and share their ideas by building and discussing visual models based on the principles of LEGO® Serious Play® (LSP). Secondary data was obtained from hospice artefacts and documentation including hospice publicity materials, minutes from meetings, training materials and information sheets. Secondary data already held by the hospice also provided information about the

scope of the volunteer role and the demographic detail of the volunteer cohort working within and outside the confines of the hospice itself.

Through the nature and range of methods it can adopt, ethnography can provide a nuanced understanding of an organisation and allow comparison between what people say and what they do (Savage 2000). The purposes of opening up different modes of communication is not necessarily to reach a single neat answer as 'triangulation' might suggest but to reveal the complexities of lived experience (Clark and Moss 2011). The combination of all these methods were instrumental in bringing to the surface some of the complexities of the volunteers' activities and their learning when carrying out their roles. As Sarah Pink makes clear, 'research findings that are based solely on participants' verbally reported practices cannot facilitate an analysis of their actual practices' (2012:41), so it was important for me to have different tools at my disposal in order to tease out those more nuanced aspects of volunteer activity which can be otherwise taken for granted or hidden. For example, a combination of sitting alongside a volunteer receptionist and watching her engaged in her everyday activities followed by an interview with the volunteer after the event was extremely helpful in clarifying and in some cases uncovering things of which the volunteer had been unaware. A summary of the research purpose of each of the data sets in the study is shown in the table below.

Data Collection Method	Description and purpose	Data collected
Participant observation: 'hanging around the setting'.	Time spent in different areas and departments in the hospice. Orientate and familiarise myself within the setting To see hospice activity in 'real time'. Establish relationships. Observe more volunteers.	Data relating to volunteers working and interacting with staff, other volunteers, patients and members of the public. Data relating to work of volunteers in practice. Data relating to volunteers working with paid staff.
Participant observation: Shadowing individual volunteers	Spending time with an individual volunteer whilst they carry out their role in the hospice. Establish and maintaining relationships with participants. Compare narrative accounts obtained in interviews with actual practice.	Data relating to specific volunteer roles. Data relating to work of volunteers in practice. Data relating to volunteers working with paid staff.
Participant observation: Attending Board and Subcommittee meetings	Being present at meetings involving trustees, members of staff and SMT. Opportunity to observe trustees and staff working together. Exploration of policy and management relating to volunteers.	Data relating to strategic discussion and decisions relating to volunteers. Data relating to work of trustees in practice. Data relating to trustees working with paid staff.
Participant observation: Attending volunteer meetings and training events	Being present at meetings involving volunteers and members of staff. Establish and maintaining relationships with participants. Explaining the purpose of the research study.	Data relating to volunteers working and interacting with staff and other volunteers. Data relating to specific volunteer roles. Data relating to volunteer support. Data relating to formal training of volunteers.
Interviews	Pre-arranged meetings with individual volunteers and paid members of staff. Establish and maintaining relationships with participants. Individual views and experiences of hospice volunteering. Opportunity to clarify issues relating to shadowing sessions.	Data relating to individual volunteers and paid staff perceptions of volunteers and volunteering. Data relating to specific volunteer roles. Data relating to management of volunteers.
Recorded conversations	Unplanned conversations during participant observation sessions. Opportunity to extend the number and range of participants contributing to the study. Clarification and explanations of observed practice.	Data relating to individual volunteers and paid staff perceptions of volunteers and volunteering. Data relating to specific volunteer roles. Data relating to volunteers working and interacting with staff, other volunteers, patients and members of the public.
LSP sessions	Sessions with small groups of paid staff and trustees using metaphorical modelling techniques. Expression of individual responses shared within a group.	Data relating to individual trustees and paid staff perceptions of volunteers and volunteering. Data relating to management of volunteers.
Hospice documentation and artefacts	Analysis of hospice documents including relevant social media relating to volunteering at the hospice. Evidence of historical change and development of volunteering at the hospice. How the volunteer role presented by the organisation. Comparison of policy and practice.	Data relating to policy and management of volunteers. Data relating to communication relating to volunteering at the hospice. Data relating to Induction and formal training of hospice volunteers.

Figure 4.1 A summary of the purpose of individual data sets in the ethnography

Participant observation: 'Being there' in the site: when, where and why?

Participant observation involves the researcher in becoming part of a group or situation that is being studied, although not necessarily as a member of that group (Henn et al 2006:198). Observation involves (at least mentally) standing back, noticing and noting things, and developing ongoing analyses. It is critical, purposeful and reflexive (O'Reilly 2012). The observations took place in different areas within the hospice, watching the comings and goings, the interactions and activities which took place at the time. Most notably these observations were in the reception area, the day hospice, and the administration, finance and fundraising offices. I also engaged in participant observation when I attended a range of different meetings. Some of those meetings I would have been present at anyway in my capacity as a trustee, but during the research period I also used these events as an opportunity to further the data collection for the study. Other meetings were regular events organised by volunteers and staff to which I was invited. In addition, I went to training events and a study day at the hospice which related to the volunteers.

The ethnographer initially discovers the insider's view of the world, the emic perspective, and in addition the researcher brings the etic perspective, to the field of study (Roper and Shapira 2000). An emic perspective reflects the participants' point of view, whereas the etic perspective echoes the researcher's point of view (Madden 2010). Participant observation takes time and time enables the strange to become familiar and the familiar strange. Participating, enables the strange to become familiar; observing, enables the familiar to appear strange (O'Reilly 2012). However, in this study I found the boundaries between participation and observation often overlapped and the boundaries were blurred. My reason for wanting to go beyond observing was in order to be alongside the volunteer and to an extent share their experience. On other occasions however I needed to adopt a more objective stance in that I was physically present but at the same time taking a step back to try and make sense of the observed behaviours and responses of actors in the field. The level of involvement of the researcher involved in participant observation can vary and may be determined by situations as they arise in the field (Roper and Shapira 2000). On occasions it involved me being 'present in the space' not only observing but adopting a sensory approach: noticing and collecting data of what I saw, heard and felt whilst being in the field. I may have been sitting in the hospice reception area or being amongst patients, volunteers and staff in the day hospice, being part of what was going on, but often blending in and not necessarily noticed by others.

Participant observation could be described as a continuum where the researcher is

observing or participating to a greater or lesser extent, depending on the circumstances. During the ethnography the role which the researcher adopts is not static and can easily swing along the continuum from low to high levels of participation (O'Reilly 2012:111). In this study there were occasions where my level of participation was comparatively low when I was sitting observing but that could change to a much higher level if, for example I joined in with the volunteer activity to respond directly to a visitor at reception for example or join in an activity with a group of patients in the day hospice.

One of the areas of the hospice where I spent significant periods of time engaged in participant observation was the main reception. The reception area is a large space through which, with the exception of patients who are being admitted to the in-patient unit and those attending the day hospice, all staff, volunteers and visitors access the main hospice building. Sitting in the reception area also provided a clear view of the entrance to the in-patient unit, several offices and the corridor leading to the kitchen, quiet room and lifts to the upper floors. The day hospice is located upstairs and access is gained from a different entrance on the other side of the building. The administration and fundraising offices are located on the first floor of the main building together with other staff offices and meeting rooms. The main meeting room is located on the second floor near to the changing rooms and storage facilities. Spending time in these different areas of the hospice, either extended periods or brief walk-throughs showed themselves to be rich sites of data providing insight into the different functioning parts of the hospice. Each area had its own defining characteristics and dynamic but at the same time there was a sense that each was interconnected by the people and a shared contribution to the life and work of the hospice. The observations and the data which ensues is similar in many respects to the practice of Urban Sketching (Campanario 2012), in that the observations helped to tell the story of the surroundings of the hospice and be a record of a particular place and time. Like urban sketchers, each observer will see something different in a particular landscape. Some might focus on specific detail whilst others might focus on the wider scene. The data obtained from my observations were in that regard subjective and of that moment in time, applying mental filters which helped to maintain a balance of focus without excluding what might be initially extraneous but subsequently significant data. On these occasions, I was not observing specific individuals but rather the situation, place and space in which I found myself. These observations were particularly helpful in the early stages of the research. In my role as trustee, I had always felt I was very familiar with the setting, given that I had visited the hospice regularly over a period of many years. However, on those occasions I usually passed through the reception area en route to specific meeting rooms, rather than spending significant periods of time there. Similarly, my trustee role rarely required me to spend time

in the administration offices or day hospice. As a researcher, within that same setting in the early stages, I felt quite nervous, almost as if visiting for the first time. Early observations or observations in parts of the hospice I did not usually frequent helped me to become orientated and more familiar with the research setting, more at ease with my role and as an increasingly regular visitor, start to blend into the surroundings so as to be more taken for granted by the volunteers and staff. Even reflexive ethnographers who consciously reflect on the effect on fieldwork of their presence want to reduce this effect where they can (O'Reilly 2012).

I was keen that my observation would focus on what might be seen as the everyday occurrences and not just the unusual or eye catching. It was important therefore to take advantage of opportunities as they arose, however brief and not only rely on consciously planned and pre-arranged observation sessions. Arriving early for scheduled appointments and sitting or standing around between interviews or afterwards were important times for watching what was going on. How people speak to one another; what is said; what it feels like when it is quiet; contrast this when things are busy; laughing; banter; demonstrating care and compassion; 'saying the wrong thing'; times of distress and sadness; giving information; answering questions; reassuring. Sarah Delamont (2008:43) makes the point that observation in ethnography is about using all the senses and these were just some of the things I saw, heard, felt whilst 'hanging around' which were then captured in highly abbreviated notes made at the time, and later reflected upon and reviewed.

Shadowing and detailed observation of hospice activity focused specifically on individual volunteers and paid staff within the hospice, or on specific events. This participant observation enabled me to directly observe actual behaviours and responses as they occurred in the field and compare them with the participants' accounts through conversations and interviews relating to those events. This links with my focus on less visible aspects of the volunteer role in using observation to uncover the invisible. Walford (2008) makes clear the opportunities such an approach can afford the researcher: 'by living through the process of getting to know the culture, an alert ethnographer can understand that which has become tacit knowledge to those who inhabit the culture'(2008:8).

Combining observation with invisibility might be considered counterintuitive or even contradictory but I would argue that invisibility can be a product of being taken for granted or seen as natural or instinctive and it requires a suspension or rejection of that stance so that the observer is able to bring such aspects of the role to the fore. I shadowed individual volunteers in different areas of the hospice such as the reception area, the day hospice,

fundraising and finance offices as the volunteers performed their roles. It required me to spend extended periods of time spent in those areas either directly alongside the volunteer or sometimes slightly more distant which allowed for more detached observation. When I was shadowing a volunteer, they agreed with me a suitable time slot and typically I would spend between 1 and 4 hours with each volunteer, depending upon the length of their shift that day. Allen (2000) discusses different roles of the ethnographer in the field as having three main elements: researcher as 'helper'; researcher as 'observer' and researcher as 'shadow' and this resonates with my own experience. At times the role was clear but on occasions events would dictate the role I adopted. For example, when shadowing receptionists I sometimes became 'helper', when enquiries were made at the desk and the volunteer was otherwise engaged; 'shadow' when I was with a volunteer in their workspace watching that volunteer in the course of their work and sometimes engaging in conversation with them or asking questions; 'observer' when I was in the field but not actively with the volunteers and typically more physically distant from them. I did not want to be 'in the way' of a volunteer, especially when they were interacting with other people in the course of their work. Above all I made intuitive decisions, to try to ensure my actions were in the best interests of the patients, family members, participants and the reputation of the hospice. The areas of volunteer involvement I focused on for the research included: reception duties in the hospice; volunteers driving patients to and from their homes to the day hospice; administrative roles in the hospice; trustees; and housekeeping duties within both the inpatient and day hospice areas. In some of these roles the volunteers worked with or alongside paid staff, in others they worked independently and, in many cases, had direct contact with patients and a range of visitors to the hospice. There have been some practical issues and decisions made in carrying out the ethnography which impacted on the data collected and these are discussed later in this chapter.

I observed volunteers carrying out their receptionist role, some of whom were new to the role and others who had many years' experience of volunteering at the hospice. Prior to the observations I ensured I had had a meeting with each of the individual volunteers to talk about how the observations would be conducted, answer any questions and complete the consent forms (Appendix 6). When spending time with the volunteer receptionists I needed to decide where to position myself in the available space. Sitting alongside the receptionists or sitting away from them, within the reception area would for example affect the participant and have an impact on data collected. Initially I had planned to sit facing the reception desk on a sofa and observe the activities from that position. I had thought I would be less obtrusive and distracting for the volunteer. However, it very quickly became apparent that the practicalities of this were not conducive in that it was difficult to hear the detail of

conversations or observe easily the reception desk area. Subsequently I sat with the volunteer behind the desk and without exception they were all happy for me to do this. Indeed, some of the volunteers were quite proprietorial in the way they took a pride in showing me the 'workings' behind the desk and area of their workspace. There were occasions when I was mistaken for a volunteer by members on the public, most notably when a receptionist had to leave the desk area for a short time or was speaking to someone either face to face or on the telephone when somebody else needed attention. This had the advantage of enabling me to experience, albeit for very short periods, 'being a volunteer receptionist'.

As mentioned above, the reception area is a hub for the hospice in that it is the main point where most people enter and leave the hospice. The reception area is staffed by a team of 25 volunteer receptionists who work either independently or in pairs on a rota basis. The reception desk is staffed from 9am-9pm, including weekends. There is a paid member of staff whose role includes the management of this group of volunteers. Directly behind the reception desk is an office where usually 2-4 members of paid staff are present at any one time and the door is left open so that those members of staff have sight of and easy access to the reception desk area, should it be required. All staff and visitors are required to sign in on entering and leaving the building and this is overseen by reception staff. It is also a focal point where people pass through en route to particular offices, wards or other areas of the hospice. It contains vending machines which staff, patients and visitors use, and food items can also be purchased from the reception staff. There is a section dedicated to retail items where people come to browse and purchase items which raise funds for the hospice. There are comfortable sofas and chairs where people often wait for appointments and which patients sometimes use when they want a chat and a break from the ward area. Family members and other visitors also use this area as a 'break out facility' for example when they need some time away from the inpatient unit. Sitting in the reception area at times felt like being on a bench in a village square. Sometimes, it is a busy and vibrant space, with lots of coming and goings, chat and laughter. Phones ringing, staff passing through, things being 'dropped off' at reception ranging from a donation from a member of the public to a delivery which requires the attention of a specific member of staff. Members of the public arriving and leaving, some obviously familiar with the routines and the people, whilst others may be there for the first time. Some in obvious distress, others cheerful and chatty as they pass through the space. At other times, particularly in the evenings and weekend it may be quiet and almost peaceful but even those periods were usually interspersed with someone arriving or leaving, hellos and goodbyes and pausing to sign in and out. Observing in this space, even for a short period, enabled me to watch, listen and 'be' in that aspect of hospice life.

The day hospice was another place I spent periods of time in to observe. The day hospice is available to patients as part of their end of life care where their needs can be met through the activities and facilities the day hospice provides, and who do not require in-patient care at that particular time. Some of the patients who attend day hospice subsequently become in-patients or have been discharged from the in-patent unit but continue to access the day care. Patients usually attend one day a week for a particular length of time, but their cases are reviewed on a regular basis. One day is allocated specifically for younger patients and towards the end of the research study the day hospice secured specific funding for a project working with groups of patients and their carers with chronic lung disease who attended one afternoon a week for a defined period for particular help and support with their condition. On the hospice website, the day hospice is described as follows:

It enhances quality of life for patients by helping maximise independence through engaging activities and therapies and provides personalised care in a relaxed environment. It also offers the opportunity for patients to meet other people who are going through a similar experience enabling them to share concerns in a supportive environment. The team offer a wide range of medical and nursing care alongside therapies and support from our Patient and Family Support team.

The day hospice is staffed by paid staff and volunteers and is open 5 days a week. The volunteers in this area are involved with the housekeeping duties and refreshments for the patients, they spend time doing craft activities and games and also work in specific areas such as art therapy, hairdressing and complementary therapies. Many of the volunteers in this area of the hospice also spend much of their time sitting with patents and talking with them, which as is shown in the data analysis chapters, is an important contribution in the care of those patients.

There is another group of volunteers who are linked to the day hospice and these are the drivers who transport individual patients to and from their homes to the hospice. The drivers use their own cars; some transport the same patient regularly over a period of time whilst others provide cover and as such will stand in when other regular drivers are unavailable. The drivers, like the receptionists, are a group entirely comprising volunteers. Some of the drivers having brought a patient to the day hospice, stay on for the session and are involved with other volunteering activities; others leave and return to collect the patient at a specified time.

Observing in the day hospice brought me in close proximity with patients, as well as volunteers and the day hospice staff. On the occasions I observed, once the patients had

arrived and settled the main rooms were vibrant and full of activity. There were some quiet areas which patients could access if they wanted a break from the main activity and also side rooms where medical consultations or therapies took place. The volunteers and staff in the day hospice were easily differentiated because the staff wore distinctive uniforms. This was a point of difference from the reception and administrative areas of the hospice where for the most part people were identified by a particular lanyard which defined them as a named member of staff or as 'volunteer'. In the day hospice, when I was engaged in participant observation, at times I positioned myself on the periphery, seated away from the main focus of activity but more often I would sit with the people there, talking to patients and volunteers and joining in some of the organised activities. When I sat with patients, I was always open with them about why I was there, and they were interested to know about the research. Without exception they spoke to me in glowing terms about the volunteers and what they did in the day hospice. Several of the patients were also quite happy to ask me to pass them a cup of tea or see if I knew the answer to a quiz question. As mentioned above, the volunteers do not wear uniform in the day hospice and so I did not feel that I stood out in the room, especially when I was sitting where activities were taking place. The patients and volunteers also appeared used to seeing new people coming into the space and although I was at first a stranger, I did not feel intrusive and all were open and welcoming in inviting me to be part of what was taking place.

The other part of the hospice where I shadowed individual volunteers whilst they were working was in the administration, finance and fundraising offices. These offices are located on the first floor of the original building and are quite small rooms, in close proximity to one another. In each room there were usually three or four members of staff working as well as individual volunteers. The rooms were all quite cluttered and it was not possible for me to be anything but obvious whilst I was in the room. Space was limited and a place had to be made for me to sit during the observation. The volunteers I observed in those rooms worked alongside members of paid staff and they were all known to one another. That said, the volunteers were able to work independently of them and appeared very familiar with what they were doing and the tasks they wanted to complete whilst there. There was a busyness about these areas of the hospice; individual volunteers were keen to provide me with a commentary as they worked and were also able and willing to answer questions and explain things as the session progressed. These observations were a useful opportunity to observe volunteers in close proximity to paid staff and see how they worked and interacted together. Data relating to these observations are considered in more detail later in the thesis.

An important opportunity for participant observation was by attending meetings at the

hospice. These included Board meetings and sub-committees arising out of my role as trustee and also meetings of staff and volunteers to which I was invited or asked to attend. I also attended training events for groups of volunteers. These events were useful sites of activity, I was able to watch and listen to the events as they unfolded, and consider such things as for example, the language and terminology used in the meetings, policy issues where they related to aspects of volunteering, who was the 'voice' of the volunteer at the various meetings and the focus and direction of any discussion which related to volunteering. Attending these meetings was important in the context of this study and these issues are discussed further in this chapter in relation to my positionality in the research.

Board meetings and sub-committee meetings included trustees, members of the SMT and representatives from Human Resources, Finance and the administration and fundraising teams. They often included matters on the agenda relating to aspects of volunteering. Meetings were invaluable in providing an insight into the organisational and cultural issues which influence volunteering either directly or indirectly. For example, when policy documents were presented to the Board this enabled me to see the strategic processes at work which could impact on volunteering. At these meetings, as noted above, I had an active dual role in that I would have attended the meetings anyway in my role as trustee, but I also used them in my role as a participant observer to gather data for the study.

The other meetings which I attended were more predominantly in my role as a researcher, as participant observer. Although my role as trustee was made clear as part of my introduction to the groups, I would not have been present at the meetings had it not been for my research activity. That said, it is important to stress once again that my role as trustee is firmly embedded within my role as researcher in this study. I was invited to some of the monthly meetings arranged by the volunteer receptionists to which staff who work closely with this group of volunteers are also invited. These meetings had a degree of formality in that they were regular, an agenda was provided, and minutes were taken and circulated. The invitations and outcomes of each meeting were sent out by email to all the volunteer receptionists, including those who did not attend the meeting. Whilst they followed some of the accepted protocols of a formal meeting, the atmosphere was very relaxed and friendly and there was a sense of shared hospitality between all the attendees, including generous provision of home-made cakes which it transpired were seen as an essential part of the meeting. As well as providing me with a different view of the volunteers in action, I was also able to use the meetings as an opportunity to introduce my research, participants offered their involvement as a result and others who did not get directly involved were able to hear about and ask questions about the research in progress.

Meetings involving volunteers which I attended also included those held in the day hospice. These were organised by the staff, but volunteers were encouraged to attend and provided an opportunity for those volunteers and staff to share ideas and ask questions with one another. The meetings had some sense of formality in that specific items were highlighted as intended areas for discussion and key points were noted during the session. The meetings took place in the evenings in the day hospice, which was a place this particular group of volunteers was very familiar with, and staff and volunteers sat in comfortable chairs arranged in a semi-circle. The meetings took the form of an informal conversation and again, I was invited to talk to the group about my research and the ways in which people might like to be involved. These visits generated participants as well as questions and comments about the study and gave me another place to observe a different aspect of hospice volunteering.

The training events I attended were the Induction sessions for new volunteers and a conference held for staff, volunteers and people from the community with links to EOLC. Whilst I did not speak about my research to the whole group at these sessions, I did have conversations about it with individuals who were attending the events.

Field notes relating to these meetings were an important component, and in this case my approach was to make very brief annotations during the meetings which were expanded upon after the event to more detailed, dated field notes which also included where relevant, some reflexive comments for my records. I had full access to minutes of meetings and training materials as well as web and paper publications relating to the hospice, all of which provided useful documentary evidence and a further layer of data with which to illuminate aspects of hospice volunteering. These meetings were important sites of participant observation, providing wider perspectives of hospice volunteering relating to the stated research questions, extending my contacts within the organisation and raising the profile of the research within the hospice. Detailed discussion and analysis of the data relating to these meetings follows later in the thesis.

Karen O'Reilly (2012) notes that participant observation could be seen to be an oxymoron and a contradiction in terms, requiring a delicate balance of involvement and distance but she concludes, 'it is what gives the approach its strength. Participating enables the strange to become familiar; observation enables the familiar to appear strange '(2012:106). However, it is worth acknowledging that it can be difficult to suspend one's preconceptions (Hammersley and Atkinson 2007: 81) and important to work to 'fight familiarity' (Delamont

2005:96). In this study there were occasions when over a period of time, things which had at first jumped out at me as unusual or particularly striking, I became used to. This shows how important those first observations in a particular place are when you notice for the first time such things as where people sit; how a room is laid out; where different doors lead to; what is displayed on the walls. I became less aware of such things once I became used to a particular part of the hospice and yet they were important points for me to note and reflect upon at the time. That said, I found that I could start to ask a different set of questions of myself and of others once I felt more settled and less nervous or intrusive having become much more familiar and started to understand the regular routines and practices. For the familiar to appear strange required ongoing questioning, curiosity and reflection on my part as the researcher, to avoid things being taken for granted or seen in a new or alternative light.

Interviews

A further important collection of data was by means of interviews. These included semi-structured, scheduled interviews and what Spradley (1979:58) refers to as 'friendly conversations' which were part of the participant observation. These interviews were with both volunteers and paid staff. Forsey (2008) argues that ethnographic interviewing is part of the process of participant observation and indeed in many cases in the context of this study the two things were inextricably linked. Interviews with individual volunteers were undertaken both before and after a period of me observing them at work. 'What people say they do is not always the same as what they do' (O'Reilly 2012 :14) and this was very apparent in this study, especially concerning less visible or taken-for-granted aspects of the volunteer's activities. Conversations prior to an observation were useful in that I asked the volunteer about their role and often what they told be alerted me to look out for certain routines or interactions, which I might have otherwise missed or not understood. For example, in advance of me observing her, one volunteer explained to me about a filing system which the receptionists had created for themselves as a shared resource, which they used in conjunction with post-it notes as a means of communication with each other. Having explained its purpose, I was then able to watch her and other receptionists using it in in practice. Conversations after an observation enabled me to talk to volunteers and staff about things which I had observed and also provided an opportunity for the participants to expand on things they had shared with me during the shadowing events. It often proved difficult or inappropriate for volunteers to talk in any detail whilst they are working, and I was struck by the way that without exception, volunteers prioritised their work over me. Both myself and the individual volunteers were anxious to avoid loss of concentration and focus, being prepared for interruptions and aware of the importance of not appearing to be

distracted (especially so for reception). These informal, 'on the spot' conversations, together with interviews arranged outside of the participants' work schedule ensured that points could be talked about in more detail than when the volunteer was working. The conversations I had whilst engaged in participant observation were often quite brief, involving a few questions in the setting. Where possible, and with the permission of the individual(s) concerned, conversations were recorded, but sometimes it was more appropriate to make brief notes on paper. The scheduled interviews took place in a quiet pre-booked room at the hospice or in the case of staff we met in their offices or in a side room close to their area of work. With volunteers, the time was determined by their availability and was usually arranged to take place either before or after one of their usual hospice shifts. I was anxious not to prevail excessively on the volunteers by asking them to make additional visits to the hospice. However, this did sometimes create problems for me in terms of pressures and commitments of my own work and is an aspect of the methodological approach which proved challenging in terms of management of time and efficiency.

All the interviews took place within the main hospice building. The 'quiet room' which I used for the scheduled interviews is normally used for conversations with staff and patients' families and carers. It is small, with no windows and furnishings included a sofa and easy chairs with a low coffee table. This provided a degree of informality and comfort, although it was quite warm in the summer months and with that in mind, I ensured we always had water available to drink during the sessions. Some of the interviews with members of staff were also held in this room, but others were in the individual member of staff's office. I noticed a different ambience here, due to the layout and furniture in the room. In the offices, due to lack of space, the interview was conducted with the member of staff sitting on one side of their desk and me on the other side. Also, in these instances the member of staff would either be already in the room when I arrived, or they would come to reception to meet me at a pre-arranged time and take me up to their room. Initially I noticed a sense of formality and hierarchy, which I had not been aware of when interviewing volunteers or staff in the quiet room. It was probably more evident because these were all senior members of staff, each with their own individual office space which they had invited me into. On reflection, the participants in the quiet room, despite the comfort of the room, probably also experienced feelings of formality and hierarchy, coming to a room for a scheduled interview with a researcher. It underlines the importance of the setting, the difficulty in assuring neutrality between participants and the researcher in an interview situation, and the importance of the researcher being alert to adverse effects they may be able to mitigate either prior to or during the event. It also made me realise that for the ethnographer, the interviews are part of the participant observation in that irrespective of any questions or conversations that take

place, I was alert to and noticing these different environments and settings and the impact of these both on myself and on the participants.

Each interview was recorded using a small audio recording device which was discreet and placed in a position where it was as unobtrusive as possible. I explained to participants that I would be recording the session, but I did not want them or me to be distracted by the device whilst we were speaking. I checked the battery level before each interview to ensure it was more than adequate for the session. Towards the end of each interview, I signalled the session was drawing to a close but allowed time before switching off the recorder to capture any final thoughts which occurred to participants. On one occasion, having switched off the recorder, a volunteer as they were getting up to leave remembered something else they thought might be of interest to me, so we actually resumed the interview and the recording to ensure her ideas were captured.

I took the decision not to take written notes during the scheduled interviews as I decided that this could have a detrimental effect on the flow of conversation, be distracting for the participant and affect my own focus and concentration on what the participant was saying to me (Forsey 2008). The audio recording provided me with a means of revisiting aspects of the conversation following the interview. I also asked participants to email me with any thoughts that occurred to them after the event which they felt would be relevant. My own experience of being interviewed has taught me that it is often such thoughts which are as significant as some which are discussed at the time. Participants did take advantage of this and provided me with additional data and suggestions from them for further consideration, thus enabling more participation in shaping the direction of aspects of the study.

In the case of volunteers, the purpose of the first interview was to meet and, in some cases, start to get to know the volunteer for the first time, as well as to explain the research on a one-to-one basis and obtain their formal consent. I designed the consent forms (Appendix 6) and discussed each section in detail with each participant before they signed the document. I countersigned the paperwork and every participant were provided with a copy for their own to take away with them. In designing the forms I was careful to be concise without losing the detail relating to the purpose of the research and how it might be used; the right to withdraw; and protecting the identity of individuals. I also provided the participants with a copy of a Participant Information Sheet (Appendix 4) if they had not previously received one which contained further detail of the research and their involvement in the process. In some cases, they had already been introduced to the research through their attendance at one of the meetings I went to where I explained the study to the group. However, I decided that it

was important to go over the detail again and also respond to any questions the volunteer had before they formalised their participation. These sessions were also used as an opportunity to find out about the individual volunteer's volunteering role and it was as a consequence of some of those exchanges that I took the decision not to do a shadowing of that particular role. When I obtained permission to access the site initially, I was given full access to the hospice and any individuals who wished to participate. However, access is not a one-off transaction, and, in an ethnography, it is a recurring process requiring negotiation and, in my circumstances, some personal reflection and decision making. In some studies, there will be places a researcher will never gain access because it is denied to them by the gate-keepers of the site, possibly for reasons of health and safety or liability; the researcher needs to always question themselves as to why they need access to a specific situation and not to assume they have an inalienable right (O'Reilly 2012:90). In this study, it became apparent from conversations with some of the volunteers, for reasons I discuss in detail later in the chapter, that it would be inappropriate for me to observe them by shadowing their work and the better course of action was an interview.

As noted above, interviews with staff were also undertaken as part of the study. I spoke with staff from all the main areas of the hospice covering clinical, administrative and housekeeping. These conversations were carried out on a one-to-one basis. The staff either worked directly with or were responsible for managing volunteers in the course of their work. Some were also involved in strategic management and decisions relating to the hospice volunteers and volunteering activity overall. This was an important adjunct to the participant observation and interviewing of volunteers, providing a different perspective and detail which was essential to addressing the stated research questions.

My intention was to use the interview to include but not be limited to asking some specific closed questions as well as others which were intentionally open-ended, in order to gather data relating to particular points I hoped to cover. These questions were laid out for my own reference on an interview sheet (Appendix 7). Some of the questions were asked of all participants during the course of the interview but the order in which they were discussed varied, depending upon individual responses and the direction and flow of the conversation. In that sense the interviews were semi-structured. However, I made it clear to all the participants that I was keen for them to talk with me about anything they thought might be pertinent to the study and I allowed time for this in planning the sessions and encouraged that flexibility as I conducted the interview. Some interviews were also tailored to the individual respondent, when I had shadowed a volunteer in their work or if a member of staff had a very particular role involving volunteers. Crucial to this study was not just hearing

about individual volunteers' stories but also working out how those stories relate to the wider organisational culture. 'The questions we ask in an ethnographic interview should allow us to locate the biography of the individual in the broader cultural domains in which they live' (Forsey 2008:59). in other words, I wanted to link the volunteers' experiences captured in the interviews to the broader issues contained within my research questions.

Visual research methods

As has been detailed in Chapter 3, most studies of hospice volunteers have used traditional data collection methods such as surveys, interviews, focus groups and questionnaires to collect qualitative data. A review of research methods commonly used in EOLC research, commissioned by the National Institute for Health Research (NIHR) and carried out by Goodman et al (2012), concluded that research in this field using creative, representational methods to enable self-expression is underdeveloped. In the context of this study, in addition to using conventional tools for data collection, I used a technique involving metaphorical modelling (Gauntlett 2007, 2011), based upon the principles of LEGO® Serious Play® (LEGO® Open-source). LSP was originally developed in 1996 by the Danish American business company 'The Lego Group' and used within the global organisations including Daimler Chrysler, Roche, Nokia and Orange (Blair and Rillo 2016) as a tool for business development and strategy and was designed 'to generate more engagement, imagination and playfulness in staff meetings' (James and Brookfield 2014:116). The methodology of LSP was then extended into corporate business environments and other training contexts but its use at that time was tightly controlled and restricted in that sessions had to be led by facilitators who were consultants trained and officially certified by the company (Kristiansen and Rasmussen 2014; Gauntlett 2007). In 2010 the LSP method and materials were officially put into the public domain and since then have become widely used in a range of settings and contexts including business, media, education and health (Peabody 2015; Blair and Rillo 2016; Hayes 2016; McCusker 2020). Metaphorical modelling involves participants coming together in groups for a structured session involving the building of a series of metaphorical models using the principles of LEGO® Serious Play® (LEGO® Open-source). The technique is predicated upon a process in which participants think and express themselves as they create using the medium of Lego to create representative models. It is a process of thinking with our hands and learning through making (Papert & Harel 1991; Gauntlett 2011; Nerantzi et al 2015).

Social research often requires participants when asked a question to produce instant responses providing verbal accounts of their views and opinions, and most people can't really provide accurate descriptions of why they do things as soon as you ask them

(Gauntlett and Holzwarth 2006). Having used the technique in other settings, I have found that the process of building and explaining a Lego model which represents a concept metaphorically, has enabled some participants more time and latitude to shape the conversation and talk about the subject in their own terms. I therefore decided that it might be a useful technique to include in this study where I was looking to elicit participants' views about potentially sensitive and complex areas such as their workplace relationships, learning, and emotions within their work with death and dying. It is argued that taking time to make something, using the hands, gives people the opportunity to clarify thoughts or feelings, and having an image or physical object enables them to communicate and connect with other people more directly (Gauntlett 2011:4) Furthermore, some researchers contend that the use of visual methods, including LSP, for data collection can potentially make the familiar strange and provide different ways of knowing and understanding (Mannay 2010; Gauntlett, 2007). However, I share David Buckingham's (2009) reservations when he challenges the premise that 'visual or creative methods in themselves somehow provide more accurate or authentic representations of individual beliefs or attitudes' (2009:648). The use of LSP in the context of this study was never intended to be the primary means of data collection, but rather an available option which I would call upon when it seemed appropriate. Some of the individuals who were involved in LSP sessions also participated in one-to-one interviews and observed sessions. Whilst not making any claim therefore that this technique is essentially preferable to other methods, in the context of this research it has shown itself to complement those other approaches and, in some cases, afforded some notable advantages which will be discussed in more detail below.

I extended the invitation to take part in the LSP sessions to volunteers and staff and at the start of the study I expected the novelty of the approach might turn out to be a factor in encouraging participation, stimulating curiosity and possibly being seen as a preferred alternative to some individuals who did not want to involve themselves in interviews or observation. In the event, whilst some volunteers did offer to take part, issues of availability was one of the factors which limited the number of volunteers who participated. Most volunteers have a regular time commitment for their volunteering at the hospice and getting together groups of volunteers outside of those times which accommodated individuals' availability proved difficult. Other volunteers, having listened to what was involved, were not sufficiently curious to get involved, opting instead for more the more traditional techniques of interview and observation. The exception to this were the trustees who in their volunteering, meet together at the hospice on a regular basis and are known to one another. These factors, together with their interest and curiosity in trying out the technique turned out to be

significant in them getting involved in the sessions. Similarly, the invitation to staff was well received and it was possible to arrange group sessions around their working shifts.

The models were used as a focus for conversation and discussion of ideas and to explore the nature of the role and relationships of volunteers and paid staff and the experiences of volunteers in carrying out their role. In the context of this study, the approach drew upon characteristics of feminist research where attempts were made to develop relationships with the participants in order to disrupt and reduce unequal power relationships between researcher and participants. I anticipated that this may present challenges given my role as a trustee at the hospice, but the methods chosen and the way in which they were applied were underpinned with this intent. That said, I would agree with Dawn Mannay (2013:136) in her argument 'that whilst the use of creative methods may displace the voice of the researcher, they are ill equipped to eradicate existing power relations.' The approach I adopted aimed for an informal and unstructured exchange of ideas as opposed to a highly structured and one-way extraction of information (Henn et al 2006:189) and feedback from participants and my own reflection suggested that the use of LSP was successful in this regard. However, I would concur with the view of Buckingham (2009) that while the use of such participatory or creative methods might well alter the power relationships between researcher and the researched, it can hardly be seen to abolish them completely. Furthermore, given that these were group sessions as opposed to one-to-one interviews, whilst I made an effort to limit where possible my own impact as the researcher, I was also mindful of the group dynamic and any pre-existing relationships which might have a detrimental effect on the data collection. These could include for example any pre-existing power relations stemming from management hierarchy or more confident or vocal individuals within the groups. In practice, those concerns turned out to be less of a problem than might have been anticipated. The dynamic in the staff groups worked well and the feedback after the sessions included participants having really enjoyed the opportunity to talk and listen to one another in ways which they did not normally do in the course of their work. The building of models by each individual in the group as well as providing a metaphor for their ideas, acted as a prop by means of which individual participants could confidently share their thinking with others in the group. The model could be said to take the spotlight away from the individual and provided a focus when they were speaking which contributed to limiting what Mannay terms, 'the intrusive presence of others' which she argues can have the effect of restricting, dictating or influencing visual and narrative data collection (2013:141-143). Having experience of using these techniques prior to carrying out this ethnographic study in a range of other settings, I have found them to be valuable to both the researcher and participants in jointly exploring potentially complex ideas, avoiding 'top of the head'

responses, and combining the benefits of individual responses one would seek to achieve in an interview, with group interactions characteristic of focus groups. However, such methods cannot be seen simply as a means of enabling participants to 'express themselves' or 'tell their own stories – or indeed of enabling researchers to gain privileged access to what people really think or feel (Buckingham 2009). Furthermore, the researcher continues to play a 'steering role' (Pauwels 2004) and the success depends on the quality of the interaction between the facilitator and the participants, which I would suggest would also be true of other more traditional approaches such as interviews and focus groups.

When it came to explaining about the proposed Lego sessions, I had realised it might be difficult to explain this rather unusual approach to people who are unfamiliar with the technique. In a way it was a good thing because it made me think about the details myself and I think I have been less likely to make assumptions, as might be the case with interviews. In my experience, probably because interviews are such a widely used and recognised tool for gathering data, it is easy not to afford participants sufficient time to explain to them the detail and purpose of the interview process. To help with the explanation of the Lego sessions I took along some photos of events I had done previously in other contexts, including both examples of some of the Lego models and participants from those sessions. I chose the photos carefully trying to give a good representation, match some of the profile of the participants (for example, older adults and younger students) and try to convey the fun, informality and participatory nature of the sessions. Taking the pictures along proved very effective in generating interest and discussion within the group which was useful especially given it was an introductory meeting.

It was not a panacea for all, and some did find the activity challenging in the same way as people may be overawed and uncomfortable in an interview or focus group. I was aware that some participants did claim at the outset to be 'not very creative' and were initially constrained by the method. However, the preliminary activities and successful group dynamic which evolved enabled those individuals to gradually take a full part and make a valuable contribution to the session. Visual methods such as LSP are no guarantee of participation and do not negate issues of power and influence of the researcher (Buckingham 2009). The method did however afford the possibility of sharing of ideas within the groups as well as the expression of individual thoughts and opinions but unlike a focus group the key points were not determined by one or two individuals who could then influence the direction of the discussion. That said, the data was still influenced by the group dynamic and the decisions taken by the facilitator.

Description of the process

Given that use of LSP might not be considered to be one of the more conventional data collection methods used in research, and for the benefit of the reader who may not be familiar with the technique, this section provides a detailed description, with some illustrations, of how the LSP sessions were enacted in practice. Further detail is contained within an example of the planning notes which I prepared and used (Appendix 8) showing the broad outline of the preparation and sequence for the session.

The sessions were held in the hospice in an upstairs meeting room, away from the main activities and offices of the hospice staff. It was important to have an appropriate room where participants were away from their working area and also so that any noise from the activities would not disturb the normal function of the hospice. Participants were seated around a large table in the centre of the room. They each had sufficient working space for making their models but at the same time each person in the group could clearly see and hear all the other participants during the feedback sessions.

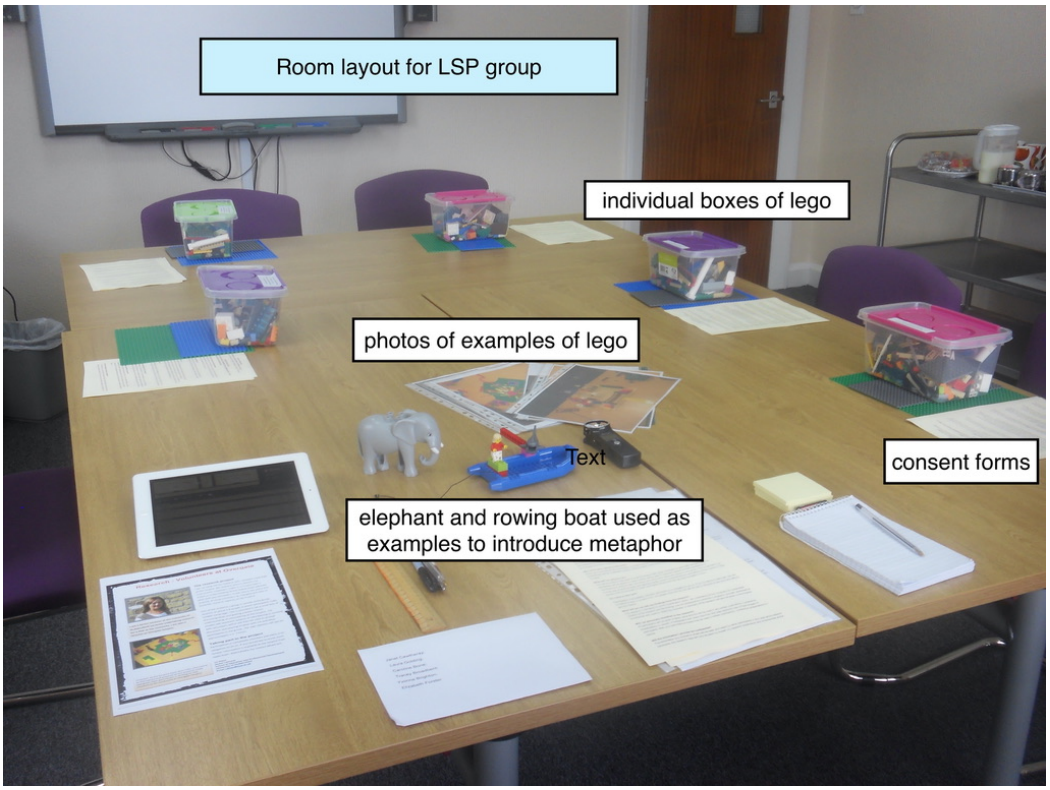


Figure 4.2 : Room Layout for an LSP Session

At the start of the session, each participant was provided with a box of Lego. Each box contained a similar but not identical selection of Lego pieces with which to work. Later in the

session the participants were given access to a much wider selection of Lego but experience of facilitating similar sessions in the past has shown me it is better to exercise those limitations at the beginning to avoid overwhelming some participants and to save time on some of the preliminary construction activities when access to a wide range of materials is not required. I provided the group with an overview of what the session would entail and how the time would be spent. It was important to share the plan and adhere to time scales as the participants had come away from other commitments, including work, to take part in the sessions. I reviewed the consent forms and ensured all the relevant documentation had been completed. The participants agreed for an audio recording to be made of the session to capture the verbal contributions. Photographs of the models were taken, and each participant was given set of post-its which was attached to each of their models for identification purposes. The post-its had two numbers: one which identified the number of the participant in the session, and the other denoting which build it was that individual had created. So, the illustration below indicates this is the second model produced by participant 3. This ensured on reviewing the session I would know which model belonged to which participant and also allowed for the photos to be used in the future in publication without disclosing the identity of the individual who created it.

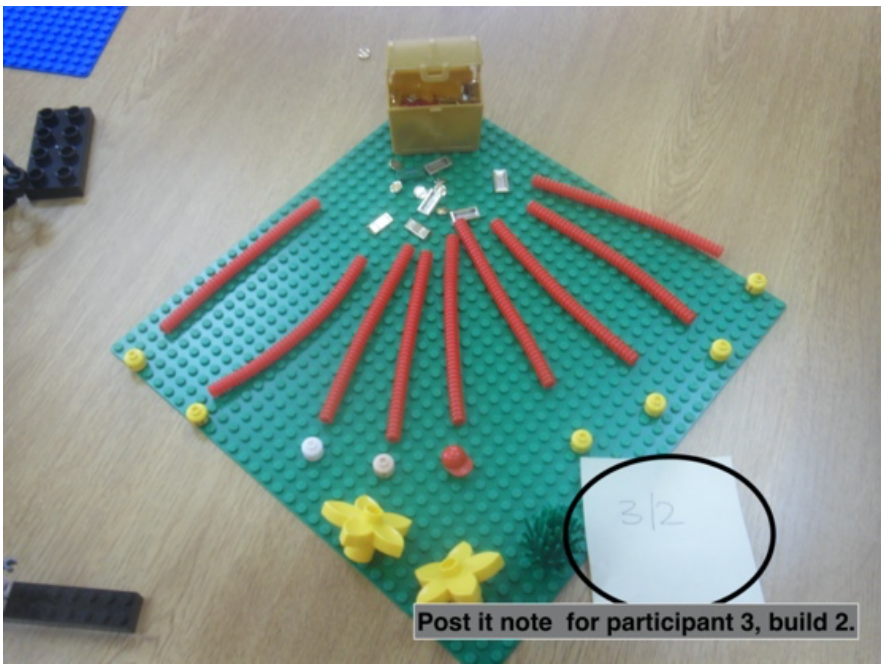


Figure 4.3: How individual models were labelled in LSP sessions

Although the LSP is predicated upon a 'playful approach', each session does have a structure and sequence which is planned and led by the facilitator. The sessions were planned to last no more than 90 minutes. Sessions which I have facilitated in the past have lasted several hours but in the context of this study, to allow for volunteers and staff to attend before, after or sometimes during their working time it was felt appropriate to limit the time and not to overrun. Each event involved a sequence of activities requiring individual participants to undertake a given building task followed by a feedback session in which each individual is given the opportunity to speak about their model and questions and discussion follows amongst the group. Time was spent on activities designed to gradually familiarise the participants with the medium of Lego and also to introduce the concept of metaphor. Metaphor refers to 'those analogic devices that lie beneath the surface of a person' s awareness and serve as a means for framing and defining experiences' (Mahlios et al 2010:49). In the context of LSP it means that participants use the Lego materials to create a representation of a given topic, rather than a precise model. The first task was intended to be a fun introductory activity which did not involve use of metaphor but rather allowed the group to play with and get used to the materials. Participants were asked to each build the highest self-supporting tower they could using only the contents in their allocated box. This was an important stage in the process as it allowed time to start to develop an effective group dynamic and to allow participants time to play with and become confident in handling the Lego. In the context of the hospice setting, it was also helpful to allow staff who had just come away from their working environments time to adjust and make that transition from their work.

The next stage in the process involved introducing participants to building a model which represents something in a more literal sense: in this case I asked them to each build a creature, name it and then introduce their creature to the rest of the group. Again, this was to help with establishing a rapport within the group, and make individuals feel more comfortable in speaking individually and expressing their thinking. The final introductory activities were designed to introduce the concept of metaphor and to distinguish between the literal and the metaphorical. First they were shown a Lego elephant and asked 'If this was a teacher, what words come to mind?' The group then suggested a range of metaphorical descriptors which they thought linked an elephant and a teacher. To complete the preliminary activities, they were asked to build 'A Friday Evening'. Having previously built their creature, it was possible to refer to that as a contrast between the literal and the metaphorical. The time required for this introductory phase is a matter of judgement on the part of the facilitator and varied for different groups but as well as understanding the process of LSP it was important in

establishing the group dynamic and for individuals to get to know me and others in the group.

Having completed these preliminary stages, the next phase involved individuals being asked to build a number of metaphorical models relating directly to the research study. For example: the volunteer role or the relationship between the volunteer and the paid staff. In the process of building, participants formulate their ideas and reframe their thinking helping them to think and express themselves as they create. Taking time to make something, using the hands, gives people the opportunity to clarify thoughts or feelings, and having an image or physical object enables them to communicate and connect with other people more directly (Gauntlett 2011:4). Participants are also given access to several large boxes of Lego to give them the option to use a wider variety of materials from which to construct their models.



Figure 4.4: Large selection of materials for use later in an LSP session

Using their model as a focal point or a point of reference, they then share that thinking with the researcher and the others in the group. It afforded opportunities for sharing of ideas within the group but unlike a focus group the key points were not determined by individuals who may then influence the direction of the discussion. That said, as discussed above, individual contributions will still have been influenced by the group dynamic and the presence of others to some extent. When an individual is explaining their model to the group, it is sometimes appropriate to ask the person to expand or clarify a particular aspect

of their model and the associated thinking. What is not appropriate is to ask someone to amend their build in any way and it is important the individual does not feel under any pressure to make changes or amendments unless they choose to do so. It is important to make clear at the outset to all participants that 'they are the architects and owners of their own meaning in relation to their model' (James and Brookfield 2014:118). Allowing an individual to speak to the group uninterrupted in this way 'positioned the speaker as the expert on that subject and could speak confidently without fear of reproach' (McCusker 2020:159). As the facilitator, once each participant had shared their thinking about a particular build, I did ask participants to consider how they might change their metaphorical model in some way to develop their thinking further eg 'if that represents *your* relationship with a volunteer / paid member of staff, what would an *ideal* relationship look like?' That then prompted conversations about professional relationships, the role of volunteers, the expectations of staff and the perceived boundaries which might exist. So for example, the first models created by some of the staff in their representation of volunteers included metaphors such as 'gems', 'gifts' 'backbone' and 'treasure'. However, when asked to consider more challenging aspects of the relationships between staff and volunteers, the models produced incorporated sharks, models with prickles and spikes, and weighing scales which led to reflection upon some difficult aspects and what was considered to be a fine balancing act when managing some individuals and groups of volunteers. Further examples of the models and themes arising out of the participants' verbal accounts at the Lego sessions are found in data analysis sections.

In the process of building the models the participants have 'private conversations' with themselves. However, an important part of the process is the collaboration which follows when they explain their models and start to put their thinking into words so making their private thoughts public, often leading to reflective conversations with other participants and the researcher. Moving from thoughts to words can be difficult, and 'stuttering interpretations' were common. Participants were reassured that their stuttering interpretations were valued and were an essential part of the process: their 'fledging thoughts' were as important as fully formed ideas and opinions.

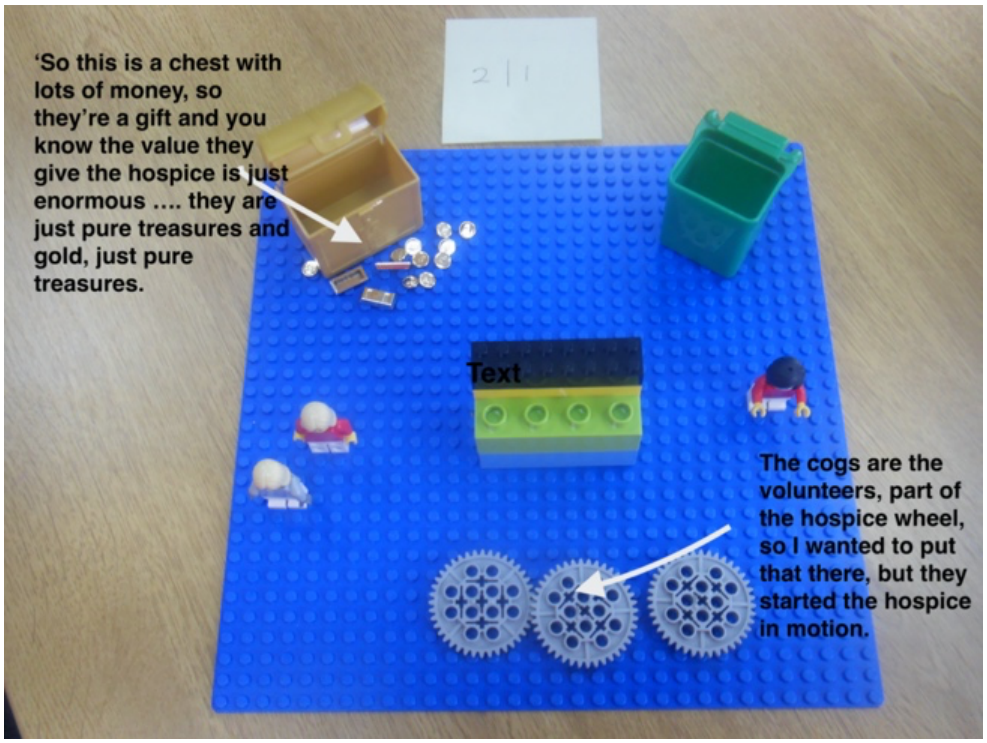


Figure 4.5: Example of a metaphorical build - 'A hospice volunteer'

Each individual completed up to four individual builds relating to the research questions. The final stage in the process was asking the participants to take part in a collaborative build, engaging in what I called some 'crystal ball gazing' and create a shared model to represent hospice volunteers and their role in ten years' time, ignoring any financial constraints.



Figure 4.6: Collaborative builds - The future role of hospice volunteers

These builds incorporated some of the individual models from the earlier parts of the session and also included some additions leading to some complex and detailed construction. The discussion generated by the joint builds exposed some valuable data relating to future development and sustainability of volunteering and the factors which could accelerate or

impede any advancements. Ideas which emerged from these joint builds are explored in more detail later in the thesis, but it was interesting to find that some of the staff who took part in the sessions took their photos of the joint build, enlarged them and displayed them in their offices, with the intention of using them as an aide-memoire for future reference and development. There were also comments afterwards from some of the senior management team that it was the first time they had really spent time exchanging ideas with some of the other members of the group who worked in different areas of the hospice. The feedback from all the participants was overwhelmingly positive saying they had found the sessions interesting, enjoyable and worthwhile.

There were limitations and points to consider when using LSP as a research tool. It would be naïve to claim that these methods allow some sort of privileged access to the participants 'inner self' (Buckingham 2009). Rather that for some participants the models acted as a prompt to aide recall or building of ideas, and in some cases provide a stimulus to aid discussion. There is a danger that 'style and the look' of the model may take precedence over content and meaning when participants build their models, and the concept of metaphor can sometimes be difficult to grasp. On occasions during the sessions, it was necessary to manage the emotional response of some participants arising from some of the issues discussed or conversations triggering memories of previous events or on-going issues associated with the participants' individual roles or workload. On one occasion this was not directly related to the research but rather was something the individual member of staff concerned had been dealing with during her working day. This emphasises the potential sensitivities of conducting research in a hospice setting. At the start of some of the sessions, some individuals stated they were 'not creative' and in the preliminary phases of the session appeared constrained by the method. This needed to be managed sensitively with a high degree of support and some humour; the group dynamic was important in this regard. Time was spent at those early stages in the session allowing participants time to play with the materials, getting used to the Lego, familiarising themselves with the materials in an attempt to mitigate any initial nerves and relax the participants by building models unrelated to the research. Some participants did find those early stages of the sessions challenging but I would argue that the same could be said for research participants in interviews or focus groups who can similarly be overawed and uncomfortable. In summary, most participants reported that had enjoyed the 'return to childhood' and the opportunity to 'play' with ideas, which was significant given the nature of the hospice workplace. An unexpected outcome of the Lego sessions was that enabling the staff to experience the sessions as part of the wider research process gave them ideas for future organisational

development where they said the technique might be used more widely as a method of communication and inquiry in the hospice.

I concluded that using this approach in the context of this study provided a communicative space, a playful space and a reflective space for participants and myself as researcher to explore aspects of hospice volunteering. However, it is important to note that LSP is a vehicle for expressing ideas and as such it is the verbal description provided by the participants which constitutes the data, rather than the models themselves, The visual data therefore is not data in and of itself but rather a tool to elicit further data (Barley and Russell 2019:237).That said, the combination of the model and each participant's verbal accounts 'contributed [in some cases] to a more nuanced understanding of participants' perspectives of hospice volunteering for both the researcher and the researched' (Mannay 2010:103;), in ways that other methods may not do (Barley and Russell 2019:239). Finally, as with other more conventional methods, it is ultimately the researcher who then exercises their agency in using the data to engage in a critical analysis of the emerging themes.

Ethics of the research study

This study has confirmed the unpredictable nature of ethnographic research in practice and some of the challenges it can present to the researcher in carrying out the research, not least with regards to ethical issues. Russell and Barley (2020) explore the ethical issues which can arise in the field when carrying out ethnographic research where there are competing demands, tensions and contradictions affecting participants, and sometimes the ethnographer herself. Against a backdrop of traditional ethical guidelines and regulation, they argue for a more malleable, nuanced approach, more applicable to ethnography, based on an ethics of care, acknowledging power differences and where the researcher is able to exercise professional autonomy. In this section I describe the steps I took to ensure I adhered to ethical principles in carrying out this study, but I have also tried to be open and transparent about the dilemmas and decisions which I was faced with as part of the research process and my rationale for the actions which I took as a consequence.

Consent

The gaining of Informed consent is presented as an essential part of ethical research and could be seen as a standard procedure which researchers ensure they undertake as part of the research process. In my experience gaining informed consent can be presented to novice researchers as an essential but relatively benign, procedural activity. In this study, I endeavoured to ensure that all the participants were informed of the nature, purpose and scope of the research and the data collection methods to be used. Whilst gaining informed

consent is generally regarded as central to ethical protocols and might appear straightforward in the first instance, in practice it can be problematic. In designing the information sheets and consent forms for this study, I realised that the language and level of detail must be well judged as it could potentially be off-putting and burdensome, especially in the context of a hospice setting. In some cases, volunteers, staff and in some cases patients, whilst potentially interested in the project often did not want to be embroiled with formal paperwork. Formal processes were adhered to in that voluntary, written informed consent was obtained from all the identified participants. I took time to explain the purpose and procedural aspects of the research in written format (Appendix 4) and through discussion. These participants were all told they had the right to withdraw at any point from the research and this was also made explicit in the written documentation presented. Each participant was also provided with their own signed copy of the consent form (Appendix 6) to retain for their records. However, consent is a dynamic, on-going collaboration, working out the details as they unfold in real time and real place, not a de-contextualised consent document that gets 'signed-off' (McKee et al 2010)

There are also challenges in ethnographic research with regards to anonymity of the site and the individual participants which Walford (2018) notes is exacerbated by the inter-connected world in which we live, social media and the affordances offered by a Google search. Discussing ethnographic research in particular, Walford (2008; 2018) argues that it is 'impossible to give complete anonymity to participants as they all know who the other participants are and (nearly always) know that the researcher is conducting research (2018:518). In this study, the site has not been named, nor the specific location divulged but it would not be difficult for anyone who wished to do so to do a relatively simple background search or have sufficient local or historical knowledge of the hospice to see beyond the vague, fictious backdrop. Similarly, the pseudonyms offer some superficial degree of anonymity to the participants but biographical details, individual role and job descriptions which are an important detail which may be included within the research account are likely to limit any guarantee of complete anonymity. Rather, I would support the position of Walford (2018) in acknowledging that 'it was never actually fully possible to offer anonymity in ethnography….. and researchers need to modify their research procedures such that the advantages of more openness in research are exploited' (2018:516). All participants were afforded respect and privacy and every effort was made to ensure confidentiality and anonymity was not breached. Pseudonyms were used throughout in presenting data from the research and where possible identifying features were withheld. However, it would be unrealistic to assume this can all be guaranteed in a qualitative study within a relatively small organisation, or where the position of participants in the hospice makes them identifiable.

MacMillan and Scott (2003) also highlight potential problems with ensuring anonymity when disseminating research. As they point out, the identity of a research setting and with it the individual participants, are unlikely to be recognised in broad academic circles. However, in what they term a 'small world' where the dissemination is to people with a shared specialist knowledge and interest in the research, there may be a need to be particularly careful in finding measures to protect the identities of research participants and it may prove impossible to completely disguise participants. This was relevant to this study if there was dissemination within the hospice itself. Moreover, hospices have a tradition of working closely together and individual staff and some of the volunteers may be known to one another across institutions. Consequently, dissemination within the 'hospice community' could put limits on any guarantee of anonymity, despite me using a fictional name for the hospice within the thesis. These issues were all discussed with the participants and made explicit in the paper consent form, whilst great care was taken in the writing up process to mitigate such limitations. Such dilemmas I would argue are an integral part of real-life research and as MacMillan and Scott (2003) recommend: 'it is preferable to understand the issues, recognise the dilemmas and look for compromise, rather than avoiding such research per se' (2003:104).

As indicated earlier in this chapter, some of the groups of volunteers had monthly meetings with paid staff with whom they worked, and these events proved to be a useful gateway to some of the volunteer cohort and an opportunity to publicise and explain the research. As the research progressed, some of the meetings provided me with data by observing the meetings, the discussions and the interactions between volunteers and paid staff. Crucially, in the first instance, they gave me the opportunity to explain the research and talk to the volunteers about the project much more fully than could be achieved in a written information sheet. I was able to answer questions and these exchanges resulted in individual volunteers offering to participate in interviews, shadowing and the LSP sessions. At the meetings I attended there were a few things which I made decisions about in terms of how to communicate with the group and how best to explain the research proposal to them. In effect I was selling my research and it was important I could highlight potential benefits the study might offer to participants and the hospice more broadly (Walford 2008). When I introduced myself, I explained the nature of my research and also my personal interest in it. As mentioned above, my interest emanated out of a very close personal connection with the hospice having been involved with it since before it was a functioning hospice and I have always been involved as a volunteer: tea trolley, kitchen, fund raising and then trustee. My own experience as a volunteer gave me added credibility with some of the volunteers and there was also interest shown in some of the historical aspects of the hospice which I was

able to share with them. I explained my working role at the University and how that connects with volunteers: trying to find out about things to do with learning in workplaces and an explanation of my 'day job' because of some of the references to 'learning' in the explanatory notes which provided to participants. I thought it was important that I gave them that background and also that I was a trustee at the hospice. I chose to share that 'dual role' because wherever possible I wanted my research at the hospice to be overt and transparent. I also reassured the volunteers that whilst I was hoping things might come out of the study which could inform policy at the hospice relating to volunteers and their development through my role as a trustee, any observation, shadowing and conversations were intended to find out more about volunteers rather than any sense of 'checking up' on them. I considered this to be an important distinction to make and as mentioned previously, it was crucial for me to establish and maintain the trust and confidence of volunteers and the staff at the hospice so that my dual role did not become problematic.

In order to observe the activities of the volunteers, the study involved examination and analysis of observations, interactions and conversations that take place within the hospice setting. Patients, family members and other visitors to the hospice were often present when observations are taking place and it was therefore particularly important that I was aware of the sensitivities of the participants and the data which was obtained, since as the researcher I have a responsibility to both active and passive subjects. I was confident that those volunteers and staff who agreed in advance to participate in the study were fully informed in relation to consent, but inevitably there are spontaneous or serendipitous events and interactions where standard approaches to obtaining consent were more problematic. The nature of the work of the hospice meant that bureaucratic approaches to publicising the research and requests for agreed consent would not always have been appropriate. So, for example, if individuals, especially patients and members of the public find themselves 'caught up in' an observation or shadowing 'episode', I took the decision as to when or if it would be appropriate to start explaining the research or obtaining explicit consent. Nevertheless, it is not possible to 'airbrush out' those conversations and interactions which were observed within a public space. To try to mitigate this issue I designed an A4 sized poster, (Appendix 5), copies of which I displayed in the hospice in the areas I was shadowing or observing. It included brief details of myself and the research study and a concise statement about participation in the research. I also inserted a photograph so people could identify me in the setting and contact details if they want to get in touch. This added to my credibility and ensured the research process was open and transparent. The size and placement of the poster were important: not too big or dominant in the setting but sufficiently prominent to be noticed. Information sheets were also available in close proximity to the

poster for those who wish to read more about the project. However, I recognise that in a setting where people are often entirely focused on much more personal and often distressing circumstances and events, some people are unlikely to read posters or be actively interested in the research project. I would argue this was not a problem unique to this particular study but rather touches upon a much wider debate about obtaining consent in public spaces and is something other ethnographers might need to address.

Ethical choices and the collection of data

The act of shadowing and participant observation more broadly in a workplace poses challenges for the ethnographer and this was particularly relevant in this study because of the nature of the setting and associated sensitivities. Decisions had to be made as to which situations were appropriate for observation and shadowing. As alluded to previously, this was particularly the case where the work which individual volunteers were involved with included the potentially sensitive exchanges with patients. For example, having spoken to some of the volunteer drivers about their work I took the decision not to travel with volunteers when they were transporting patients to and from the day hospice. I had initially intended to accept the invitation of some of the drivers to accompany them on some of those journeys as part of my participant observation. However, speaking to the drivers and reflecting on those conversations made me change my approach: I came to the decision that it would not be in the best interests of the volunteer, or perhaps more importantly the patient, for me to be present on those occasions as participant observer. The drivers each disclosed experiences they had when driving patients to or from the hospice which made me acutely aware that sometimes patients used that time with a volunteer to ask questions or discuss sensitive issues. These included conversations which were personal to the patient and on occasions they had waited until the journey home to broach particular things with the volunteer, rather than discuss them with staff they had been with at the hospice. Whilst these exchanges appeared to be an integral part of the role of these volunteer drivers and something I would have been interested to witness first hand as a researcher, I came to the conclusion that time is particularly precious for these patients and I did not want to run the risk of possibly compromising that moment a patient might have chosen to have a personal and potentially sensitive conversation with a driver which my presence could have compromised. Furthermore, for me to make use of such data in the study would, I suggest, have required the formal consent of the patient, which in these particular circumstances I did not feel was appropriate.

Similar decisions were taken in the light of volunteers whose role was on the inpatient unit doing housekeeping or nursing activities and those volunteers who were involved as hospice

biographers. Having spoken to these volunteers about their work, I decided it was ethically and morally correct for me to limit my data collection with these volunteers to interviewing and recorded conversations and avoid participant observation of their role in situ. That said, I would argue that such interactions between patients and volunteers could be an important area of research in the future with regards to the role of volunteers, but only on the proviso that careful thought and consideration in advance to ethical issues relating to consent and method, as well as the knowledge and expertise of the researcher.

Ethical ethnography involves awareness of your effects on the participants and on the data and conscientiously attempting to ensure that you cause as little pain or harm as possible (O'Reilly 2012). There have been challenges presented by virtue of the research approach, the nature of the setting and my own position as hospice volunteer, trustee and researcher. Savage (2000) asserts that ethnographic methods, and specifically participant observation in healthcare settings, raises challenging ethical questions. At the heart of my research was the wellbeing and respect for all involved either directly or indirectly; inevitably choices had to be made and decisions taken, which on occasions limited the data collected and put constraints on the research.

Data analysis

Analysis of the data was an ongoing, iterative process throughout the ethnography. It involved moving backwards and forwards through the data. The process of analysing data in this study supports the contention of O'Reilly (2012) who argues that in an ethnography 'analysis of data is so tangled up with every stage of the research process that it is difficult to talk of an analysis phase' (2012:180). Rather she suggests that ethnographic research is a practice in which data collection, analysis and writing up are not discrete phases, but inextricably linked (2012:180). Themes and questions emerged as the ethnography progressed, based on for example, what was observed in the field and things which transpired in interviews (Pole and Morrison 2003). This ongoing analysis of data feeds into research design and data collection (Hammersley and Atkinson 2007:158). Reverting back to an analogy I used earlier in this chapter, it was how I would imagine the work of a detective or forensic scientist conducting an investigation at or near the site of a crime – looking for clues, not discounting the ordinary or the extraordinary and looking for further evidence to corroborate or discount a line of enquiry. Close examination involving 'focused reading' (Gray 2009:496) and re-reading of field notes and transcriptions, and relevant literature, as well as listening often several times to individual recordings, was an ongoing process and helped in the identification of recurring themes with corroboration from various data sources. Themes related both to the research questions of my study and to the

selected theoretical concepts such as liminality and emotion work. A description of this iterative process which characterised my research approach is provided by Delamont (2008):

> The analytic themes and categories, arising from the data, from literature, from one's head, are constantly interacting with the data as they are collected: the ongoing research is led by, and leads, the theorising and vice versa as they are collected. (Delamont 2008:53)

However, there were also data which ran counter or did not fit neatly with a main theme, and are referred to by Brewer (2000:117) as 'negative cases'. Such data was nonetheless important to consider in the analysis and reflective of the complexity and nuanced nature which is a feature of hospice volunteering. It made me aware, for example, of issues relating particularly to volunteers working in a 'professional role' which became an important part of the thesis. In the research, I went on to consider the data as it related to different roles in hospice volunteering, including those involving qualified professionals who use their skills and expertise in a voluntary capacity, including trustees and volunteers in clinical roles. This was also prompted by the work of Morris et al (2013:431), referred to in the literature review, who argue that research into hospice volunteering does not take sufficient account of the range of individuals within the volunteer cohort and Turner and Payne (2009) who drew attention to the lack of research in the literature into hospice trustees. Within my own research I recognised that negative cases arising from the data analysis can become significant and indeed in this study this particular example became an important aspect of the thesis.

The process of what Brewer (2000:110) terms 'index coding' was helpful in ordering data into topics and maintaining focus, relevance and connections with the research questions and the selected theoretical concepts. This was particularly important given the volume of data generated from the ethnography. Thematic coding was helpful in showing the relationships (or lack of relationship) between various themes of importance within the data (Madden 2010:150). In reviewing and analysing the transcripts of interviews and field notes I took the decision not to make use of increasingly popular computer software programmes such as NVivo and Atlas ti but to rely instead on my own system of colour coding using a standard word processing package, as discussed by Forsey (2008). The initial themes were developed and refined as the research progressed. As Madden (2010:143) explains, initial coding of ethnographic data need not be overcomplicated and a series of generic themes

relating to the initial research questions was used in the early stages of the project as shown below.

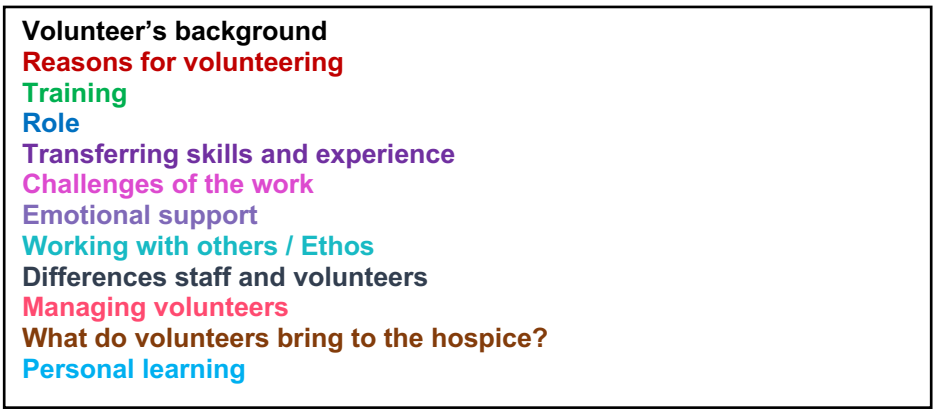


Figure 4.7: Example of initial themes and colour coding used in early stages of data analysis.

Where quotations are included in the thesis from the various data sets, these are intended to be illustrative of a particular point rather than necessarily representative of volunteers as a whole. However, as Forsey (2008:70) suggests, 'they are simultaneously idiosyncratic and reflective of the general patterns revealed through the research'. Some of the quotations included in the text were selected because of their pertinence to a particular theme arising from the research, whilst others were included as 'negative cases' (Brewer 2000:117) and judged to be important and a point of interest, despite not necessarily being typical. Where quotes are included, I distinguished between interview, recorded conversation or Lego group session extracts by labelling accordingly. I deliberately drew heavily upon illustrative examples from the data in the thesis as the participants' accounts were such a strong feature of the findings.

Positionality: where is 'me' in the research?

My pre-existing personal connections with the setting and acquired historical narrative provided both challenges and opportunities to the research. I am happy to acknowledge these and am keen that they become part of the research rather than attempt to ignore or side-line them. My own history and biography have been and continue to be central to this research. 'Ethnographers typically begin with an interest in some particular area of social life and while they usually have in mind 'foreshadowed problems', their orientation is an exploratory one' (Hammersley and Atkinson 2007:3). As explained in Chapter 1, my long association and involvement over time with the hospice led me to think that there were

fundamental differences between the volunteers and paid staff and that volunteers play a unique part within EOLC. Furthermore, I was of the opinion that as the hospice continued to change and develop, so too was hospice volunteering. As a trustee I was often involved in discussions and decisions of policy and strategy which impact on volunteers either directly or indirectly. I had a concern that at Board level, volunteers were usually referred to 'the volunteers' with little if any concern or acknowledgement of individual difference. 'Ethnographies are portraits of diversity in an increasingly homogenous world. They display the intricate ways individuals and groups understand, accommodate, and resist a presumably shared order '(Van Maanen 2011: xvii – xviii). Furthermore, there is now an increasing pressure on organisations for governance, regulation and accountability and hospices are no exception. I was interested to find out what impact these cultural shifts over time might be having on volunteers and the ways in which they are deployed in the organisation. Again, the gut feeling was that there was a rich depth of unexplored data which was waiting to be unearthed by getting in and amongst the world of volunteers and finding out more about their everyday lived experiences.

It is not possible to air-brush myself out of this research, and nor would I want to. At the risk of accusations of being self-indulgent, it has been important for me to reflect upon the likely origins of my value position and intentions in undertaking this piece of research. They are undoubtedly rooted in my life experience and choices made over time, which were in part determined by social and cultural factors of the time. As a young woman in the 1970s I undertook A levels at a Catholic grammar school with the ambition of becoming a doctor. Entry to medical school at that time required high levels of achievement in science A levels. A significant memory for me was my A level Physics classes where I was one of only two females in a group of about 15, taught by a male teacher. That teacher commonly took the boys to one side to demonstrate and discuss practical physics experiments with them. My female friend and I were told we could carry on with our written work as 'it would not really be of much interest to you girls'. At the time we accepted this without question, and it went unchallenged. Entry to medical schools was always at that time contingent upon an interview at the universities and at those which I attended I recall all the other interviewees being male; again, representative of the time when entry to the professions was largely a male preserve. I subsequently gained a place at medical school and the required A level grades however at the last minute took the decision not to follow this through. The reason I gave for my decision at the time was that I felt I would not be able to manage the demands of having a family with a career in medicine. I had grown up in a medical family and remember many doctors' wives being critical of female doctors for those very reasons and I suspect being exposed to those opinions possibly influenced my choice. I subsequently trained as a nurse

and staff at the school I attended expressed their disappointment that I had made that decision, reinforcing the place of nursing within a medical hierarchy where the subordination of nurses in healthcare was representative of wider social perceptions of gender and care (Carpenter 1995). Immediately following my initial training, nurse training was subject to major change and located over time within universities, leading to a graduate profession by 2013. As with other vocational professions this was arguably an attempt to gain higher status and financial recognition for the work they do through higher level qualifications awarded by academic institutions. Within the UK currently there is talk of a crisis of care in many hospitals, care homes and within the community. This at a time when what could be seen as 'basic care work' has become increasingly detached from other more specilialised and administrative nursing functions and undertaken by low paid, mainly female workers.
I subsequently became mother of three daughters and took the decision to leave paid work to focus on home and care 'duties'. I was always conscious of the subordination of that role despite my personal feeling that it was a demanding and hugely worthwhile undertaking. It also impacted on my professional career and my capacity to make any visible economic contribution. It was not unusual for people to ask: 'And what to you do?' to which I replied: 'Oh I don't work, I'm a housewife'. This chimes with a recurrent phrase I have heard said by some of the volunteers in this study: '*Oh, I'm only a volunteer'*. Fast forwarding the clock sees me grappling with another set of competing tensions and hierarchies within my personal and professional life, namely: teacher, researcher and carer, this time for extended family including grandchildren and an elderly parent. The overriding themes within this reflection as discussed in Chapter 3 include the absence of recognition for the value of emotional labour, and the reproduction of the Cartesian split, described as a de-emotionalized workplace in which 'head work' comes before the 'heart work' and emotion comes after knowledge (Benozzo and Colley 2012). Fraser (1994) suggested the idea of the 'universal caregiver' model which shifts the emphasis in society away from paid work and towards caring activities whilst at the same time warning against the commodification of care where care roles which are unwaged become waged and those roles are assumed by women and more recently migrant workers. Whilst not considering myself anti-male or an extreme feminist, nonetheless my life experiences have given me a sensitivity towards the impact of marginalisation and a certain aversion to hierarchy and patriarchy. Consequently, I believe in the importance of valuing those who find themselves marginalised or subjected to subordination by virtue of those powerful hierarchies. The work of hospice volunteers is positioned within the health care sector and as discussed in Chapter 2, the published literature indicates that they are involved in social and emotional activities inherent in care, but often such activities are hard to quantify and, in some cases, to recognise. Pink and Morgan (2013) describe their experience of ethnographic research as a journey in which

they learned about aspects of participants' work lives that they normally did not talk with anyone about (2013:356). Invisible work is often associated with family, domestic roles and care (DeVault 1994) and as this thesis demonstrates is an important component of the hospice volunteers' work. The ethnographic methodology enabled me to see examples of that invisible work at first hand, arguably helped by my life experience which has sensitised my awareness.

Role as researcher: insider, outsider, or a bit of both?

All ethnographers are to some extent outsiders and to some extent insiders and we cannot undertake ethnography without acknowledging the role of our own embodied, sensual, thinking, critical and positioned self (O'Reilly 2012). The historical and personal 'baggage' which I bring to the research without question influenced both the process and outcomes of the study. I believe it is important to be clear about this at the outset and recognise how such positionality has the potential to both contaminate but also illuminate research. Burns (2012) suggests that the positionality of the researcher and their organisational role are in constant conversation. I did find myself constantly reviewing and reflecting upon my position as a researcher and my role as trustee and where necessary making adjustments and decisions in the light of those 'personal conversations'. I wanted my research role to be overt, so that people in the hospice were aware of the purpose and nature of my work whether I was taking an active part in activities or adopting a more passive role when shadowing volunteers. It was important that people did not feel they were being 'spied on' or 'inspected' and from the outset I tried to be very clear as to the distinction between my role as a researcher and that of hospice trustee. Whilst I acknowledge it is not possible to entirely disaggregate the two roles and one is inevitably going to influence the other, the role of trustee is associated with management and in a hierarchical organisation, which to an extent is evident in the hospice, I was keen that my role as researcher was much more concerned with being alongside volunteers and staff and finding opportunities for them participate in and to influence the direction of travel of the research. This required investment and commitment on my part to develop professional relationships with volunteers and staff which were built upon trust, honesty and authenticity.

Having been involved with the hospice for over 30 years, I have acquired over that time a detailed working knowledge of its history, development and working practices. Along with that, Dewalt and Dewalt. (2011) identify "enculturation" as an element of participant observation. This refers to learning the tacit aspects of culture, which remain largely outside of one's awareness. The routines and practices might look so familiar that I would not see them as an outsider would (Goodwin et al 2003). Burns (2012) in his study of training and

development of Church of England clergy, notes that as someone who underwent that training himself some years previously, he became aware of his assumptions and expectations from the 'distant past' of that experience. Such criticism could be made in my case, but I believe the nature of the observation was such that, as mentioned earlier, I was spending time in places and situations in the hospice which would not normally be part of my trustee role. Every independent hospice is a charity, controlled by the Board of trustees who are responsible for the management and administration of the charity (Hospice UKd). Trustees are responsible for strategic management, major policy decisions and upholding the vision and ethos of the organization. The individual trustees are also themselves volunteers. The role requires trustees to have a degree of distance from the everyday running of the hospice; operational decisions rest with the SMT, all of whom are paid, and include both clinical and non-clinical professionals. Therefore, my own role as a hospice trustee is primarily a strategic one and as such I would not usually become actively involved in day-to day activity within the hospice. As a consequence, I am fortunate to have experience and familiarity of the field, whilst at the same time finding my curiosity and interest aroused by immersing myself in the detail and space of the day-to-day activity of the hospice which I usually view from a very different perspective. In so doing I could be said to be both an insider and outsider researcher (Allen 2004; Hammersley and Atkinson 2007). I would also argue that there is a value in managers, policy makers and those who have responsibility for strategic decisions spending time alongside those they manage in order to experience first-hand the work that they do, especially those aspects of work which might be less visible unless looked for. Ethnographers value the idea of 'walking a mile in the shoes' of others and attempt to gain insight by being in the same social space as the subjects of their research (Madden 2010). This research study provided me with that opportunity and as the research progressed, helped to shape my strategic thinking and consider the impact of decisions on the people they affect. Whilst some might question the validity of research carried out within one's own organisation I feel privileged to have spent time seeing and hearing about the work people do and the stories they tell within the hospice. It is perhaps something which others in managerial and strategic roles might usefully undertake in their organisations, to better understand individuals' roles and to give voice to subordinates within an institutional hierarchy.

My decision to undertake an ethnography within the institution saw me quite literally positioned in close proximity to staff and volunteers in a way that trustees would not normally be seen within a hospice. As a hospice trustee, I already have a pre-conceived notion of the work of volunteers based on my knowledge and experience in that role, but the ethnography enabled me to see things as those involved see things and 'to grasp the native's point of

view' (Denscombe 2007:63). In my work, I sought to emulate Walford (2008) in 'finding a balance between suspending preconceptions and the researcher using their present understandings and beliefs to enquire intelligently' (2008:10). However, O'Reilly (2012:55) explains that 'a realist philosophy of social science argues that what exists in the world is not only human beings' conceptualisations and interpretations of events, but also wider processes that the individual may not even be aware of.' This research, whilst seeking to find out about the everyday experiences of individual volunteers through an ethnographic approach, also sought to understand the institutional and cultural processes which shaped that experience. There were characteristics of Institutional Ethnography as described by Dorothy Smith (2006) in which the researcher seeks to take the standpoint of the people whose experience provides the starting point of the investigation, in this case the volunteers in the hospice, and then goes on to investigate the institutional processes that are shaping that experience.

Emotional aspects of the ethnography

The journey associated with the research for this study carried with it sensitive and emotive elements by virtue of the methodological approach (Widdowfield 2000; Humble 2012), the data collection process and the nature of the setting itself. 'Research which aims to explore the complexity of giving and receiving welfare must connect with context, ambiguity and, crucially, with emotionality' (Nicholson 2009:458). Also, personal pressures to complete the research, pressures from my working life as well as outside pressures and anxieties unrelated to the research at times competed with the emotional demands of the study (Roberts 2007; Humble 2012). As such, it was important that I considered my own emotional well-being as the researcher. Time spent observing in the hospice setting, along with detailed conversations with volunteers did lead to some unforeseen and unavoidable exposure to emotionally charged and challenging situations. The use of a reflexive diary together with the opportunity to discuss such events with my supervisor was important to my personal well-being. Ethnographic practice is more like feeling your way than following a recipe (O'Reilly 2012:45). Research is not emotionally detached, and the process could variously be described as: lonely, turbulent, with highs and lows, exciting and unpredictable. The research process can have an emotional effect on the participant. Experience has shown for example that a question asked of a participant, which might have been considered safe and innocuous, can prompt unanticipated emotional responses. Similarly, the researcher needs to deal with their own emotional responses. In this study, exposure to events during data collection in the field, revisiting data when reviewing transcriptions as well as writing up and sharing research experiences each, on occasions, prompted emotional, often unanticipated responses. Widdowfield (2000) discusses the place of emotions in

research and suggests potential benefits from recognising these emotions to both the researcher themselves and the academic community more widely. She argues that discussing emotions may fulfil a cathartic role. Furthermore, drawing attention to any emotional difficulties may be reassuring to other researchers who experience similar emotional demands (Widdowfield 2000:201). In my own situation I found it helpful to capture my own thoughts and critical incidents in field notes and written reminders. I also discussed some of the issues which arose out of my field work with my supervisor at formal supervision meetings. These discussions were important because they often provided a different perspective and support for me as a researcher, from someone who was not as immersed or connected with the field.

In the course of my research, I became very aware of the emotional impact of research on the researcher when spending time in the field, 'enmeshed within the emotional dynamics of the setting' (Humble 2012:83). Whilst sitting with a group of patients, volunteers and staff at the day hospice, completing a quiz about Hollywood films I was struck by the juxtaposition of banter, humour and laughter with talk of death and dying. A patient sitting next to me who, incidentally, had a portable oxygen supply in place and was sipping a small tot of whiskey said to me:

Did you get that one? I knew it was something to do with James Bond….' Almost in the same breath she began to tell me about her decision to come to the Day Hospice "… *they said why don't you try it? I thought that's somewhere you go if you're dying …. But then I thought to myself well I suppose I am …… Did she say it's a Walt Disney*?

(Field notes: 17/02/2015)

Her comments had a profound effect on me in appreciating the nature of conversations volunteers are likely to have with patients in the course of their work at the hospice. The experience is also illustrative of the emotional impact of ethnography on the researcher. Similarly, spending extended periods of time observing and shadowing individual volunteers as they went about their work, talking to them and asking questions also took its emotional toll, sometimes at the time and sometimes after the event. Pink and Morgan (2013) capture the essence of my experiences:

> Spending up to four or so hours with one person in a context where one is focused on trying to understand or imagine their embodied practices, sensations or emotions, asking them questions about this and reflecting on one's own affective responses is an exhausting experience.
>
> (Pink and Morgan 2013:256)

Other factors particular to this study was the nature of the site itself, when on occasions the work a volunteer might become engaged in may be explicitly emotive and their interactions with others necessitated me making fine judgements and decisions at the time to avoid me becoming intrusive.

Given the site of the research there was inevitably an emotional toll at times which I felt as a researcher. As a novice ethnographer I became aware that I had not perhaps prepared myself for this at the outset and undoubtedly, I have learned from the experience. I acknowledge that my experience was perhaps amplified because of the nature of the research setting. That said, I would argue that in teaching the principles of ethnographic research, it would be valuable to raise awareness of the potential emotional demands of such approaches and it would be a welcome addition to the formal teaching of research practice. Above all I would suggest that researchers, including those with considerable experience, especially when they are working alone, need access to informal support in addition to formal supervision which they can access, within reason, as and when required. A study which involves immersion in the field, by definition implies that the researcher will be exposed to unplanned events and incident and in the context of a hospice in particular, that exposure and vulnerability as a researcher should not be underestimated. Darryl Humble (2012) draws upon his own experience as an ethnographic researcher to discuss the 'emotional mess of research' highlighting the particular challenges of researching issues that either mean something personally to the researcher or are by their very nature sensitive and thus emotive topics (Humble 2012:82). Both of these resonate with my own study and as such I would argue that it is entirely appropriate that I should acknowledge the place of emotion in this research and the part it has played in shaping the research process.

A place for thinking: Metaphorical thinking in the research process using visual landscapes

An important aspect of ethnography pertinent to this study is the reflexivity which underpins my approach to the research process including, amongst other things the dilemmas and decisions associated with recording of data. Reflexivity involves reflection by the ethnographer on the social processes that impinge upon and influence data and the factors which influence the representation and legitimation of the data (Brewer 2000:127). Ethnographic research involves constantly moving forwards and backwards from our research questions to the data, and back to refine the research questions or line of inquiry in light of what participants share with us (O'Reilly 20012). For me, having completed this study I am increasingly aware of the messiness of the research process and reflexivity helped me

to slow down that process, reviewing it in slow motion and arguably made me a more thoughtful researcher. 'Even now, published work rarely explicates the myriad decisions, turn-arounds, heartaches and enlightened moments that constitute the ethnographer's daily fare'(O'Reilly 2012:12). Reflexivity then has been a crucial aspect of my methodological approach. A particular technique which I have used to support reflexivity has been the use of visual metaphors. When I first started my research, it had been my intention to apply the use of visual metaphor to my data collection methods using the principles of LSP. My rationale and execution of this has been discussed in detail earlier in this chapter. However, as the research process unfolded, I became aware of the extent to which my own thinking and ongoing analysis was being influenced by visual metaphors in ways I had not expected.

Mills and Morton (2013) consider the iterative nature of writing and thinking and suggest that: 'if ethnographers use writing to develop their thinking, then thinking also informs the writing and rewriting of fieldnotes' (2013:79). Moreover, Coles and Thompson (2016) explore the detail of that iterative writing process, coining the term 'inbetween writing' to describe the different kinds of writing ethnographers use to make sense of their experiences in the field. In my own case, that iterative process of writing, thinking and sense making has been punctuated by another activity involving the use of metaphors and visual landscapes. Whilst completing this thesis, I have been fortunate enough to spend increasing amounts of time in Northumberland and specifically the coastal areas. As a regular, very amateur runner who makes no claims to athletic prowess, in the interests of my own health and wellbeing I often go out running in the morning on the beach and dunes. I discovered that the running activity and the wonderful coastal environment seemed to enable an unlocking of my thinking about my research, be it making sense of the data or making sense of my emotional responses as a researcher. The ideas that occurred at those times were sometimes fleeting and sometimes confirmatory but always triggered by things I saw or noticed along my route that particular day. During my runs I became increasingly aware of how thoughts relating to my research would drift in and out of my consciousness. Sometimes those thoughts were fledgling ideas which had been niggling away at me for some time and on other occasions they were new ideas which popped into my head. The common factor seemed to be that these thoughts were triggered by things I noticed in the coastal landscape which provided a visual canvas for my thinking. The landscape and particular features of it became instrumental in connecting and anchoring my thinking; the visual and tangible anchored the cognitive and the theoretical. I captured the moments by taking photographs on my mobile phone which was a means of giving permanence to images and ideas which otherwise may have been lost or forgotten once the run was complete. The photographs were taken spontaneously and with no forward planning on my running routes, and all were taken within

a 3-4 mile radius. Of particular note and as can be seen in some of the photos included within the thesis, is how a picture taken in the same place but at a different time of day or in different weather conditions can provide such a different image. Indeed, it was impossible to replicate an image, once that moment had passed.

As a volunteer, when I am carrying out that role, I inhabit that liminal space so have a knowledge and experience of hospice volunteering. During the time I have been carrying out the ethnography however, I have discovered different aspects of volunteering and started to view things I considered familiar in new and different ways. In much the same way I have spent time running over familiar routes on the landscape of the beach and started to notice more detail, pausing to look and stopping to think. Indeed, the act of taking the pictures required me to stop, and in some cases, retrace my steps to capture a particular view or feature. The pictures, in conjunction with the data from the research, helped to disrupt my thinking about volunteering and were instrumental in considering different options and reinforcing emerging ideas. The photos have provided a means of anchoring thoughts and giving them a sense of permanence as well as providing a useful channel of communication.

The photographs were used in conjunction with notes made on my return from my run as a reflexive tool and also on occasions shared with my supervisor in an exchange of metaphorical analysis. During the last three years of the research project, I have compiled a photographic collection which I now consider to be integral to my doctoral thesis. The photographs have in effect become a reference library of visual images for me which I have revisited throughout the process of completing this thesis. Whilst the pictures are not in themselves data for the study, the collection provided a metaphorical representation of research findings and concepts; capturing the images enabled me to anchor ideas and concepts relating to the research data as they have emerged, in the same way as a theory might do. At certain times during the research study, the images also helped capture the emotional ebb and flow I have personally encountered as a researcher. The images have been particularly valuable to me in understanding the concept of liminality and how it relates to hospice volunteering and subsequently conveying those ideas to others. In making a contribution to the wider understanding of hospice volunteering, I would like to think that in the future some of the findings from the thesis would be of interest to a wider audience, including volunteers and others with an interest in hospices. As noted in the previous chapter, theoretical concepts are key to the abstraction of everyday experiences. However, it has been my experience that theoretical concepts can become a barrier to some, especially those who do not inhabit the world of academia and social science in particular. I would suggest that that the photographs have the potential, without ‘dumbing down’ to complement

and support understanding of those abstractions, so playing a valuable role in making new and possibly complex ideas more accessible to that wider audience.

In the first example, the pathways I noticed on one of my runs, captured in the photograph, prompted thoughts at the time of volunteers working and learning and linking this with the concept of ‘desire paths’ which I had come across in my reading. The term is used in landscape architecture to describe a path created by pedestrians which ignores a designated pathway or pavement and provides a shortcut or alternative route.



Figure 4.8: Desire Paths and Volunteers

‘Today I was running on Bunny Heaven 2. I’ve done this run so many times. Today it was near the end of my run so I was tiring and happy to be heading for the finish. Came to a fork where I’d to choose between two paths. Went down the wider better trodden one and after a little while realised it was the wrong one. Turned round and headed back to the other path. As I ran along the narrower route and one which should be very familiar I didn’t recognise it. It was overgrown and I couldn’t see very far ahead. Just for a moment I felt a sense of panic. Felt lost. My notorious poor sense of direction. The need to know where I’m going. It could only have been a few moment later I saw a battered fence which I instantly recognised. I’m

on the right path and nearly home. Sense of relief although short lived was palpable. I can relax on the last bit. The other path would have eventually have also got me back but by a longer route with hills! Discuss analogy with volunteers / desire paths.' (notes 28/08/2018)

In the next example, the scene which I encountered on one of my regular beach runs triggered thoughts at the time, which I captured shortly afterwards in notes, of volunteers reactions and responses when they are working but the same scene also gave rise to thoughts about myself as a researcher.



Figure 4.9: Confidence to navigate the unexpected

'Did the Ship run this am. Very familiar route. Calm; end of summer. Imagine my surprise when I rounded the corner having descended the dunes and found usual wide expanse of sand - my route home was completely submerged and a rocky path was the only option. It made me slow down. I had to think about my feet and not the environs as I had been doing. Made me think about confidence required to negotiate the unexpected, which volunteers are often required to do. Then got thinking about confidence required of a researcher. Confidence in your own research. Partly because of the masculinised culture often seen where language such as 'defend' and 'challenge' are the norm. But also the notion that you might actually have something important to share. I generally minimise my own work. What's so special? Surely it's obvious? But just sometimes I see examples where there are findings worth considering by others. ???' (notes 9/09/2017)

The selection of pictures below are examples of those I found helpful in conceptualising the liminality and hospice volunteering. The detail of these and other visual landscapes have informed the data analysis and been instrumental in developing my thesis.

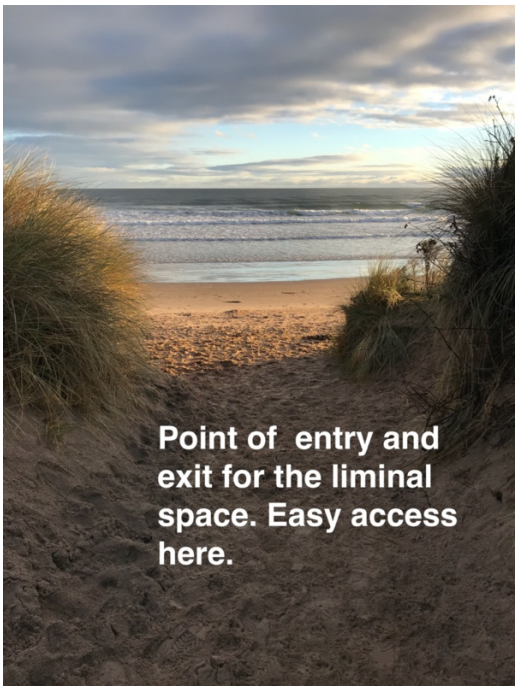
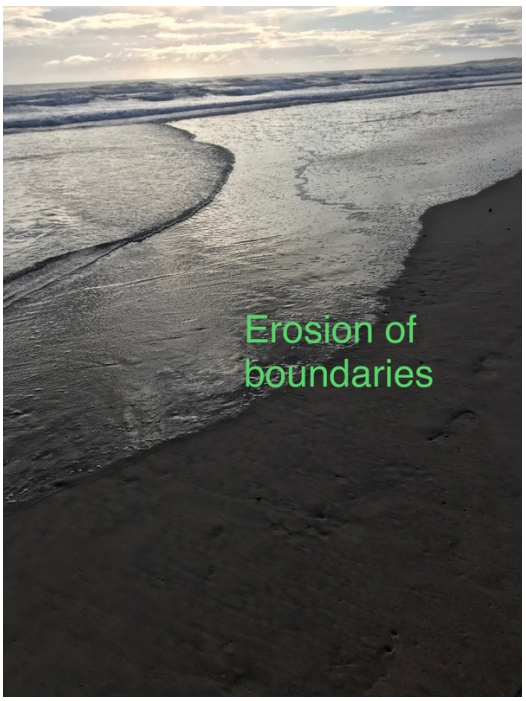
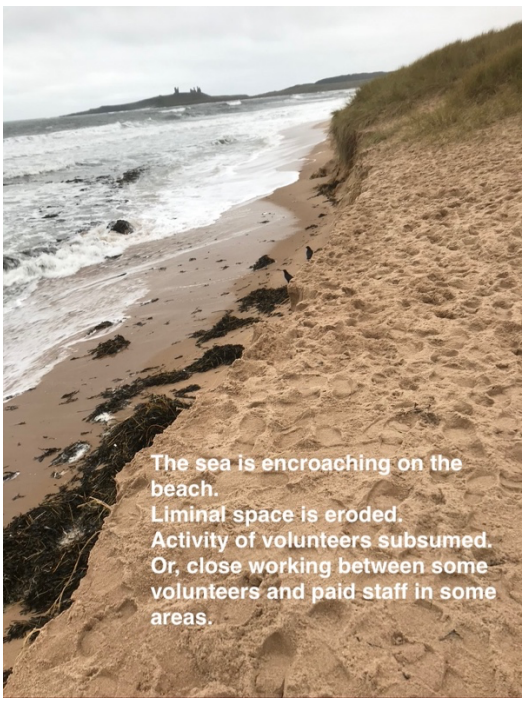






Figure 4.10: Different entry and exit points to the liminal space





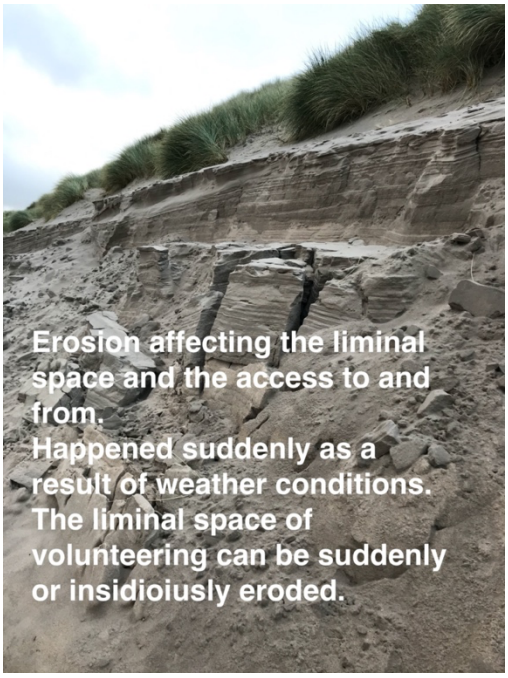


Figure 4.11: Erosion of the liminal Space

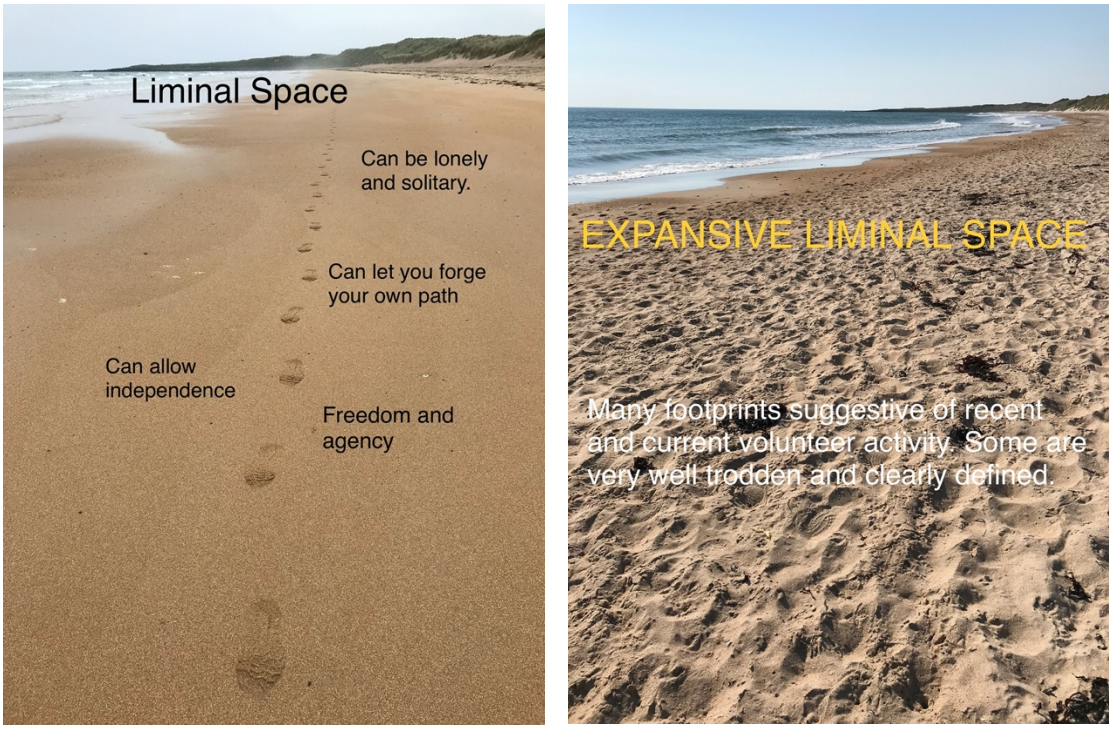


Figure 4.12: Volunteer activity within the liminal space

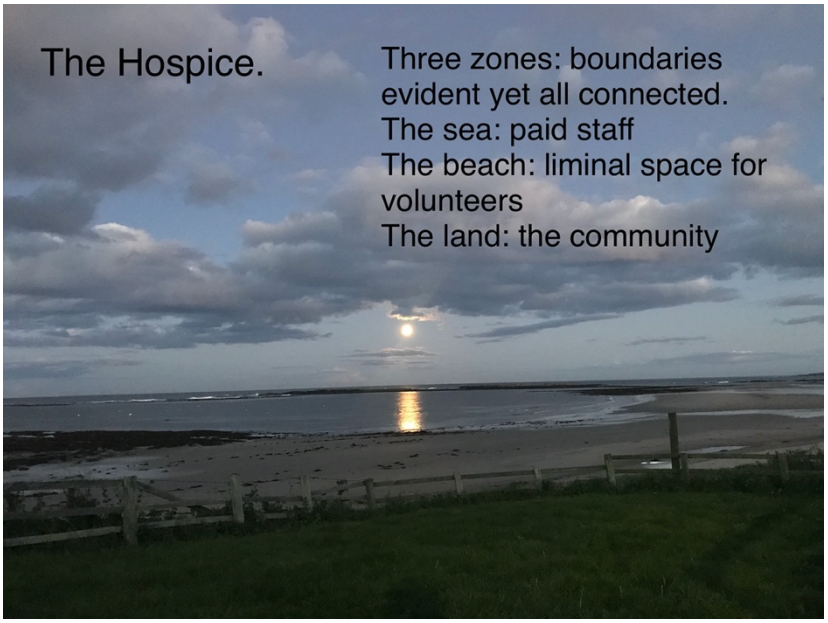
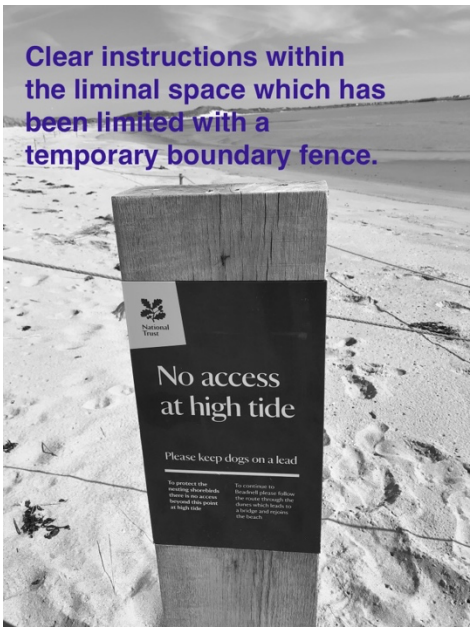


Figure 4.13: Liminal space within the hospice







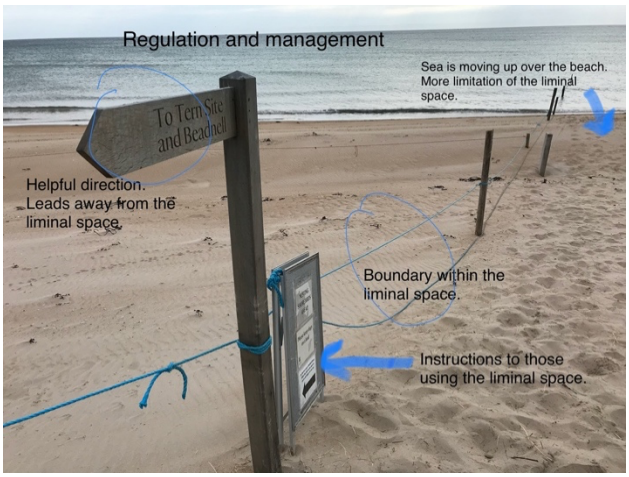


Figure 4.14: Regulation and management in the liminal space

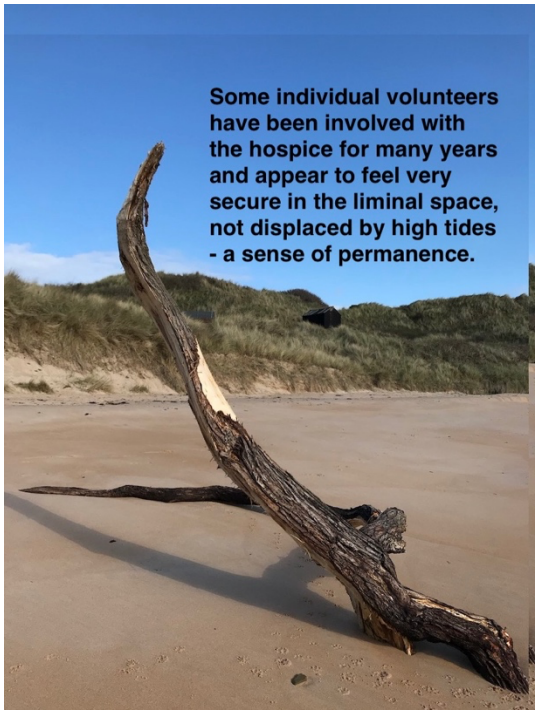


Figure 4.15: Liminal space - longstanding volunteers

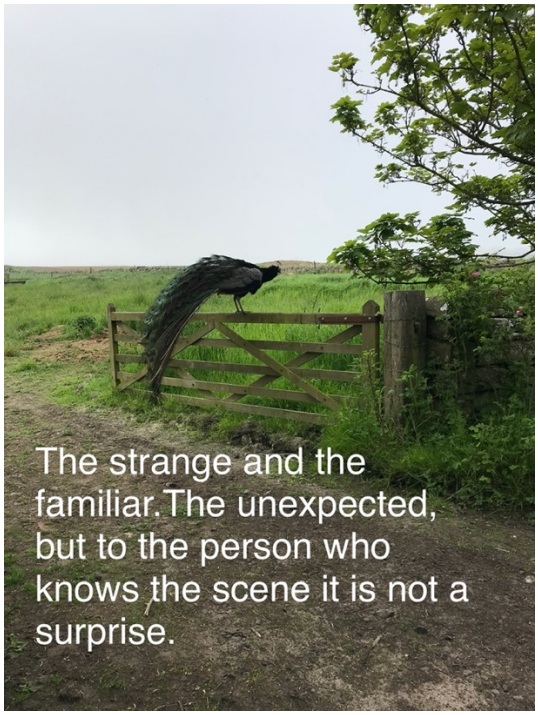


Figure 4.16: The strange and the familiar

The use of written field notes are central to ethnographic research and as has been explained within this chapter, have been used extensively in this study in conjunction with participant observation and the other data collection methods to capture in words what has been encountered in the research activities. However, the photography has also played an important part in that process: the pictures are not in and of themselves to be thought of as data, but rather they have been instrumental in capturing some of my otherwise fleeting thinking, giving it a permanence through which I was able to develop further my 'inbetween writing' (Coles and Thompson 2016).

Summary

Having decided that I wanted to better understand the experiences of hospice volunteers and how this was influenced by the culture and organisation within which they were working, the decision to carry out an ethnography seemed an obvious, if challenging choice for me at the start of my research. Choosing to adopt an ethnographic approach required me to spend time immersing myself in an organisation in order to better understand the experiences of the actors within the field as well as the culture which shape and impact on those experiences and it has enabled me to uncover some of the complexities of volunteering which are inherent in the everyday experiences of hospice volunteers and their work and learning. On a personal note, despite being a volunteer and a trustee for over thirty years, the ethnography enabled me to spend time in different areas of the hospice being with volunteers and staff and observing their work such that to some extent there was confirmation of things I already knew, but much more importantly I was able to start to understand hospice volunteering in new and different ways.

Chapter 5 The Liminal Space of Volunteering: What attracts volunteers to the space and what are the factors that keep them there?

Introduction

The next section of the thesis comprises four chapters, each of which offers a critical analysis of particular aspects of the data from the research study. The discussions focus on key findings of the study with reference to the data, relevant reviewed literature and theory and the main research questions of the thesis.

The main points raised in this chapter are particularly relevant in seeking answers to RQ1 which sets out to determine the benefits and challenges to individuals and the organisation of hospice volunteering. The discussions combine illustrative data and reference to relevant literature, to examine volunteers' initial motivations and factors which sustain their volunteering as well as particular benefits and challenges to individual volunteers and to the hospice organisation more broadly which hospice volunteering provides. It draws attention to the range of skills, knowledge and experience of the volunteer cohort and the extent to which these are utilised by the organisation. The analysis includes some comparison and discussion of the historical and current recruitment and management practices at the hospice with respect to volunteers. This is important since they affect the extent to which the expectations and motivations of some volunteers are met, and in some cases where there can be tension between the interests of the volunteer and those of the organisation.

Accessing the liminal space of volunteering

In examining the lived experiences of volunteers, one of the things which I looked to determine was why individuals decided to volunteer at Fernbank. Whilst it transpired that each individual had their own personal motivations and come to volunteering by different routes (Doyle 2002), I found some common themes emerged with regard to the motivations which had influenced their original decision for starting to volunteer at the hospice, together with other factors which assured their continuing involvement. Volunteers spoke to me about themselves, what brought them to volunteering at the hospice, and why they continue to volunteer. Sometimes this was in direct response to an interview question, but I also found opportunities to chat to volunteers when I was 'hanging around' in the hospice setting. I found individuals were happy to talk about this while I watched them working, or, in the case of trustees, opportunities often arose before or after meetings. By uncovering something of their biographies and the motivational factors of the volunteers it was possible to begin to understand the benefits which hospice volunteering affords to some of the individual volunteers. When talking to members of paid staff in the hospice, it became apparent that the factors which had been identified by volunteers as beneficial to them were in some

cases also of benefit to the organisation; however, there were examples where the benefits to the volunteer at the same time also presented challenges to the organisation. The Lego sessions with the staff and trustees exposed some of the more challenging aspects of having volunteers within the workplace.

When speaking with individual volunteers about their reasons for deciding to become a hospice volunteer, the responses varied, and in line with the other studies into volunteering and motivation (Claxton-Oldfield et al 2004; Phanalp and Trost 2009a), some common themes emerged. There were also some very personal and individual examples shared by a number of the participants, where their decision to volunteer coincided with them reaching a particular point in their lives such as retirement or following a bereavement (Morris et al 2013; Baugher 2015). The most common of these were amongst some of the older age volunteers when they reached the point when they were no longer in paid employment as a consequence of retirement, or because of significant chronic health conditions which had precluded them from continuing in their paid role. It was evident that for these individuals, volunteering provided them with some of the positive aspects they had previously gained through their working lives and subsequently missed in retirement. In these instances, their motivations for volunteering included the structure and routine it provided and a sense of purpose, all of which they said they missed having left paid employment. Freda, who volunteers in the day hospice, the inpatient unit and as a driver had previously worked before her retirement in a day care centre within the NHS. When I visited the day hospice, she told me her volunteering was important because it gave her a focus and a role outside from her home:

Well I know what I'd do if I stayed at home and there was nothing to do at home, I'd just sit in front of the telly, I know I would. (Observation: 17/02/ 2015)

For Sheila, volunteering had eased the transition from paid employment. She has volunteered at the hospice for eleven years after she was forced to take early retirement from her work with the Inland Revenue due to ill-health. When I was shadowing Sheila in her volunteering role, she told me what had first attracted her to volunteering:

I had to finish [work], unexpectedly and I think well I can't just not do anything, and I think this is what a lot of people think … yeah, I think people can find it really difficult to suddenly stop work, particularly if they've no hobbies or anything. (Observation: 3/09/ 2014)

Pam, who has multiple volunteer roles at the hospice told me she came to volunteering

following her retirement, and identified the benefits it brought her in terms of routine and structure, whilst at the same time allowing her the flexibility to do other things in her homelife:

I noticed from giving up full time work I was excited about the idea, but I wasn't able to fill my days in the way I really felt I wanted to. And, I had a lot of ideas, but I also like quite a bit of routine if I'm honest with you. And I like, the days of the week, you know, and things to do on certain days. That works best for me so, looking around and thinking about what else I'd like to do apart from my allotment and lots of other things, grandchildren. I would like to volunteer. (Interview: 17/07/2017)

The social benefit of the volunteering was significant to these volunteers, it took them beyond the confines of their homelife and into a different setting where they found purpose and routine. It was also notable that many of the volunteers wanted to fit their volunteering around other aspects of their lives such as family commitments, holidays and other activities in which they were involved, and this influenced how often they volunteered and when. This had an impact on the management of the volunteers, which is discussed later in the thesis, because, unlike staff in a paid role, most volunteers expected sufficient flexibility from the hospice to allow them to carry on with, and on occasions give priority to, their external interests and commitments.

Whilst some volunteers looked for something which provided them with aspects of the working life they missed, in line with research of Guirguis-Younger and Grafanki (2008) others were anxious not to duplicate their past working role. For example, Bryony had been a maths teacher with a senior management role in a school. She now volunteers one day a week at Fernbank working closely with the paid Volunteer Coordinator in her role focusing on project work and supporting other volunteers. When we spoke about her decision to come to volunteer at the hospice, she was looking for something following her retirement, but was not looking to replicate her paid employment.

'So when I retired, don't get me wrong I was well ready to retire but I wasn't ready to stop working. I'm the sort, I don't really want to work in accounts and finance because I am a mathematician, I've got a maths degree. I've pushed numbers for enough years ….. and I think accountings a bit boring, er, so I thought but I'd like to work with people, I don't mind doing manual things you know If she says go and help on the wards, do the trolleys, do a bit of this that and the other, interact with people, that's fine That will stimulate me in a different way. (Interview :19/10/2018)

I would contend this is a distinctive feature of the liminal space of volunteering enabling these volunteers whilst they are in the workplace to draw upon some of the benefits, as they perceive them, of paid employment, without some of the inherent constraints and demands. Bryony did not want to deploy her skills in mathematics but preferred to interact more with people than she had in her working life. The motivations of an individual volunteer, whose primary motivation is volunteering per se as opposed to a specific volunteering role can however present the volunteer coordinator with a dilemma. When speaking to members of staff, there has been an intentional drive more recently at the hospice when recruiting volunteers, to look more closely at the application stage at the skills and experience of an individual volunteer with the aim of aligning them more closely with specific roles within the organisation. There was agreement amongst some staff that such alignment was beneficial. During a Lego session, two members of staff explained how volunteering at Fernbank has changed over time in the ways that volunteers are recruited and the roles they take on:

Sometimes what I feel is some volunteers that have done a lot of years were set up in a different era of volunteering and I think there is something in how we describe that role – and for them as well as us I think we're getting better at pulling job roles together so that they've got something to work from … Cos I've noticed the newer volunteers, they know what they're coming for, they know the role whereas in the past all the roles kind of intermingled. Within day hospice now they come for specific roles which I think is better to manage …so the boundaries are clearer and it clarifies what they're expected to do …so I definitely think the newer volunteers not all of them but a lot of them, because their roles are more defined , they're easier to manage.

I can see that in two years. I think we are much better at identifying a role and looking for the skills to match the role rather than the role to match the skills if that makes sense? I think we are getting much better at I need somebody who can do x y and z and has those skills and then she goes out and recruits to that specifically. …I'm thinking of some of those new roles in helping with scanning of notes and things like that. The person we've got had those skills in a previous role and so is well matched to them and I think it's worked well on both because actually you can allow someone a bit more freedom if they know the role …

(Lego session 16/09/2015)

These extracts exemplify perceived benefits to the organisation in changing the ways in which volunteers are now increasingly recruited to particular roles, and these members of staff were also of the opinion that this approach was helpful in managing the volunteers. Had that approach been used when Bryony applied to the hospice, she might have been

encouraged to consider volunteering within the finance section of the hospice where her explicit skills and experience from her working life would be of value in augmenting the paid staff in that department. Guirguis-Younger and Grafanki (2008) highlight the sense of freedom, choice and agency which can characterise volunteering and with that in mind I would contend that there is a strong argument to suggest that such matching up, whilst offering certain advantages should be managed with a degree of caution, with careful consideration of the individual volunteer's wishes alongside those of the organisation (Rochester et al 2012). Some volunteers are explicit in wanting to avoid some of the challenges and complexities from their working lives or are looking to try out a very different role in their volunteering. This has implications for the ways in which volunteers are recruited and managed and also requires an understanding on the part of staff involved of the importance of flexibility. In a paid role an individual would usually apply for a specified role but adopting such an approach routinely with volunteers can in some cases not be appropriate for all volunteers. Some volunteers might be looking to replicate their work role, others might be looking for an alternative. Other volunteers underestimate their abilities and suitability for a particular role all of which emphasises the importance of getting to know volunteers and allowing some flexibility in recruitment and deployment.

There were a number of volunteers in the study who, unlike paid members of staff, undertook multiple roles concurrently while others changed to a different role over time. An example of this theme within the data was Stella, who had volunteered for seven years starting out in the housekeeping and kitchen areas, then later moving to reception and she now also volunteers in one of the furniture shops. Sheila explained that she had volunteered in reception for ten years but then in the last year, following a knee operation had moved to the finance department which she felt better suited her because of her limited mobility, she also found that role more amenable to accommodating her family commitments. Such flexibility within the organisation towards individual volunteers is indicative of a difference between volunteers and those in paid positions. Avoiding the use of an application process to volunteer which too closely mirrors the application process for a paid position and enabling an individual to undertake multiple or different roles as a volunteer over time, I would argue helps to sustain the liminality of volunteering and, reverting to the beach metaphor, limit the coastal erosion of the space, so sustaining volunteering involvement.

The volunteering role provides some with a place to gain experience prior to going into paid employment or specific career paths. Morris et al (2013) reported that younger volunteers have strong careers motivations for volunteering. At Fernbank the data confirmed there were younger volunteers, typically attending school, college or university who come to volunteer

at the hospice for work placements or to enhance their CV or university application. This would be an example of ‘transitional liminality’ and a sense of being not-X-anymore-and-not-Y-yet (Bamber et al 2017) where in this case, However, it is important to note, there were also younger volunteers registered with Fernbank, whose volunteering was not directly connected to career aspirations and who involved themselves with community activities and fundraising. These volunteers were not directly involved in this study but given the importance of expanding the number and demographic of hospice volunteers (Morris et al 2017; Scott et al 2018), determining the original motivations and secondary drivers of the younger volunteers in the community would be an area which would merit further research.

Saaed was one of the younger volunteers at Fernbank; he volunteered within the Inpatient Unit. He was in year 12 at a local sixth form college and was hoping to apply to University to study medicine. He was also working towards the Gold Duke of Edinburgh award scheme which required a 12month placement. He volunteers one day a week at the weekends on the inpatient unit at the hospice. On the days he is at Fernbank, whilst in the ‘liminal space’, Saaed and others like him are able to gain experience of aspects of a paid workplace prior to making a more informed decision. Inhabiting the ‘beach of volunteering’, he steps away from his land of home and college and can metaphorically view and also dip his toe into the activities of a hospice. Saeed told me although he had originally intended to limit his volunteering to the time required for his award, on the basis of his positive experiences he had decided to continue volunteering until he left school to progress to university and furthermore it was his intention to, subject to his availability, continue volunteering as an undergraduate. This is an example of the initial motivations of a volunteer being satisfied but then replaced by other secondary motivations which sustain their volunteering over time. Whilst Saeed exemplifies findings of Planalp and Trost (2009a) who found that younger volunteers are commonly motivated by their career plans, that initial motivation in the case of this young person was overtaken by his sense of meaning and personal satisfaction (Guirguis-Younger and Grafanki 2008) which he derived from his volunteering over a period of time.

Other volunteers combined their volunteering with paid employment elsewhere. This was particularly the case for some of the hospice trustees and volunteers in the areas of counselling and alternative therapies. Julia is a trustee at the hospice. In her paid employment Julia has a senior role in Corporate Affairs. She explained her reasons for becoming a trustee:

'So it was two-fold. One was to do something in the community and I think actually all this stuff that I'm doing at work, surely somebody, I've got some skills somebody can find useful and equally I'll probably learn loads that's going to really help me as well, you know, leadership and things. (Lego session:14/09/2017)

Julia is an example of many of the volunteers who bring with them significant skills and professional expertise which the organisation can benefit from. The process of recruitment of trustees at Fernbank has also changed over recent years. Historically, the Board comprised individuals, often retired, who had long standing connections with the hospice or people associated with it who were invited to become trustees based on those connections or because they were well known in the local community. There is now a policy designed to ensure the Board represents a skills mix which covers all areas of strategic management eg clinical, financial, legal and individual trustees are often appointed on that basis. This approach is in line with the recommendations regarding trustee recruitment now made by advisory and regulatory bodies with which hospices are associated (Charities Commission 2014; Hospice UK 2017). The trustees in the study all indicated their altruistic motivations and a commitment to the hospice and all were in paid positions of employment or very recently retired. It was evident from the data that there were obvious benefits to the organisation in recruiting trustees with particular professional skills, experience and in some cases contacts within the community, where these could be utilised to advise and support members of staff, particularly those in senior roles.

Altruism was a central theme which volunteers cited as a motivation to get involved in hospice volunteering. This was particularly evident where they had previous connections with the hospice through personal experience of family and friends being cared for in a hospice (Field and Johnson 1993; Planalp and Trost 2009b) or had themselves been bereaved. The notion of 'giving back' and supporting the work of the hospice following significant events in their lives were recounted by individual participants. There was evidence of real commitment and support for the work that hospices provide and their underlying values and ethos. An example of this from the data is provided by Pam who was a trained nurse. She began volunteering in one of the hospice shops, then in the day hospice and now has a role as a Hospice Biographer. Hospice Biographers are part of a project which the hospice had recently begun and involved selected volunteers spending time with a patient, supporting that patient to create an audio recording of themselves, talking about aspects of their lives which could then be given to their family so they have a lasting memory of that patient's voice. When I talked to Pam about her reasons for choosing to become a hospice volunteer she explained:

I had a sort of a little bit of a history around hospices in the sense that, well first of all my sister-in-law worked as a sister in the day Hospice in Oxford. So, I've heard a lot of her reflections on, on being in the hospice world. And then my mum actually died in the hospice in Oxford and I was absolutely knocked out by the care that she had. I was just, just in love with everybody down there. I thought it was just a marvellous situation so, urm, very enamoured with the whole hospice movement. (Interview 6/11/ 2018)

Lucy is a nurse who volunteers at the hospice once a week. She also came to volunteering following the death of her mother some time previously. Lucy volunteers on the inpatient unit and whilst at the hospice her volunteer role is that of a nursing assistant. She had connections with the hospice for many years through her Community Nursing role and then personally when caring for her mother at home.

Fernbank was there for me ..reassurance, support, guidance, on the end of the telephone. So it's kind of very close to me really. After redundancy and caring for mother, I lifted my head up and thought, well I should use my skills really. I knew some of the clinical staff at the hospice so made contact with one of them by email. (Inpatient Unit 6/06/2018)

Whilst not replacing a member of paid staff, Lucy is able to contribute to the work of the clinical team by virtue of her skills and qualifications as a nurse, thus benefiting the organisation as well as deriving personal satisfaction through her volunteering. Whilst there may be the possibility of tensions and concerns where paid staff fear being displaced by volunteers (Thompson and Russell 2017), or staff making assumptions and underestimating the skills of volunteers and professionalism of volunteers because they work without payment (Scott and Kumar 2014), there was no evidence of this in the study. However, that is not to say such tensions and concerns do not exist, only that they were not evidenced in the data. It is something which management and trustees should be aware of in their policy deliberations relating to future volunteer deployment. There were some challenges and contradictions which emerged in the data relating to volunteers with a professional qualifications and experience and the extent to which they could be utilised within the hospice. During one of the Lego sessions (22nd July 2015), when participants were asked to model and discuss their ideas for volunteering in the future at Fernbank, some of the difficulties were raised regarding the recruitment and use of volunteers with professional qualifications as they saw it and the potential benefits, perceived risks and limitations associated with governance.

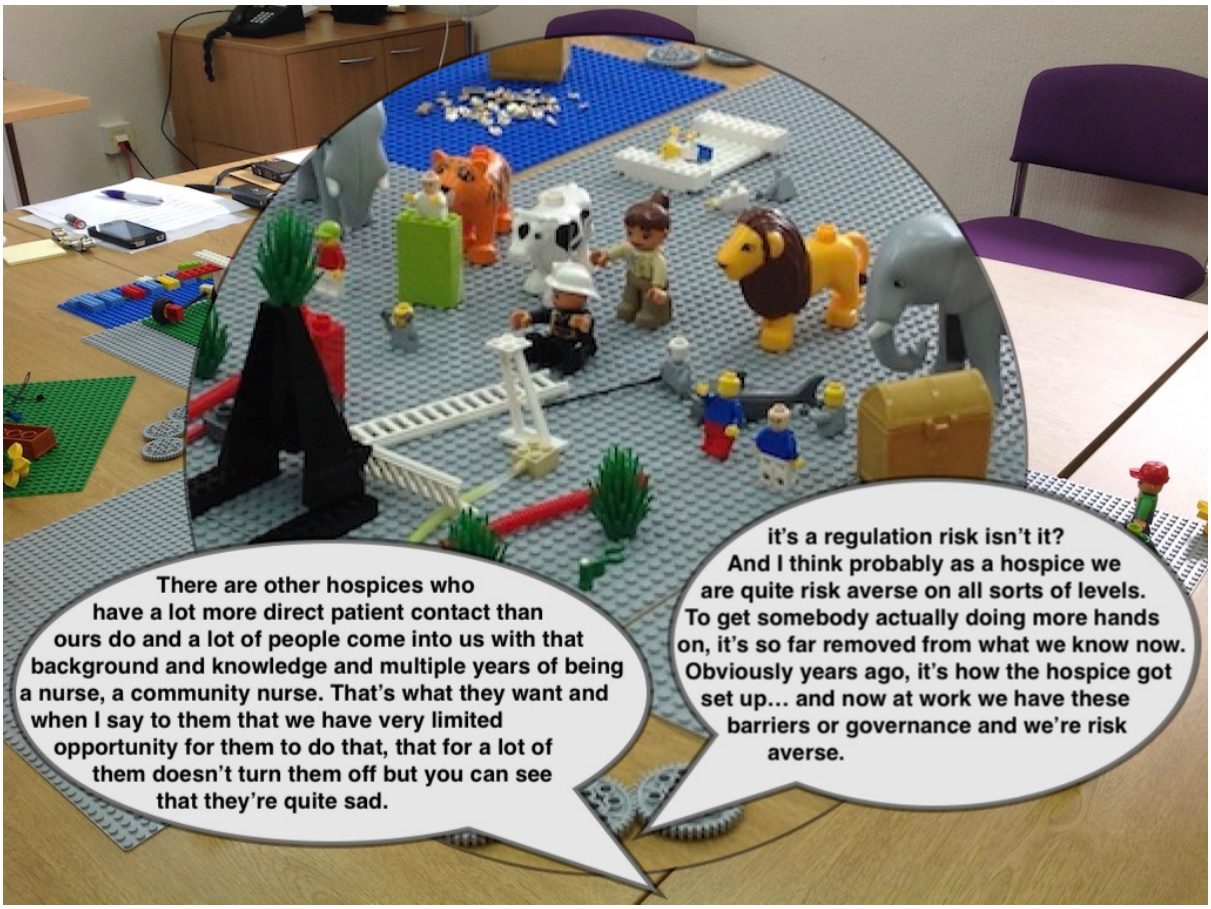


Figure 5.1 Discussion about risk and governance and the impact on the hospice

Some departments have integrated volunteers fully within their teams, whilst some have limited what individual volunteers are able to do. In other cases, although in principle they would welcome their inclusion, in some of the clinical areas in particular, senior staff were of the opinion that requirements for supervision, training and ongoing professional development, which are now a requirement for most healthcare professionals, were prohibitive in terms of the time and costs that would be required, especially in a charity with limited staffing and funds available. Historically, when the hospice first opened, much of the clinical care was done on a voluntary basis by doctors and nurses, in their free time. However, with the increasing regulation and governance of doctors and nurses which now applies within healthcare services, whilst there are a small number of professional volunteers in the clinical areas at the hospice, this has shown itself to be a limiting factor for volunteering in those areas. This resonates with Lean and McDermott's (2009) findings that when utilising hospice volunteers in professional roles: 'the largest underestimated resource implication is the hidden cost of the management, support and supervision of professional volunteers' (2009:116).

Pam, who is semi-retired and a qualified nurse with many years' experience was approached to consider volunteering on the inpatient unit but she felt uncomfortable with the responsibility. However, in the day hospice, unlike the inpatient unit the volunteers are not allowed to give any physical care to patients:

I felt slightly tied because making cups of tea and chatting, fine, I don't mind doing it but I, we weren't, as volunteers you can't accompany anyone to the toilet, or help them in and out of a chair, or, or anything kind of physical at all. And in a way that was hard because you know, that's my first instinct again. Oh come on let me help you, or help you with a drink, or you know. But you can't because obviously there's rules and regulations about that as well which is perfectly understandable, I, I got it but, it felt a bit weird at first. (Interview: 6th November 2018)

Another volunteer receptionist, and more recently also a trustee at the hospice, who was a qualified and experienced social worker and who had maintained her registration, expressed her frustrations at not being able to make use of these professional skills as a volunteer:

They said it would undermine what they did, which is understandable, you know someone coming in for free, thinking, well hang on, they might manage, if she's free, they'll manage to do away with us. It's a bit of a conundrum isn't it? (Interview: 6/11/ 2014)

There may be inconsistencies in the agency of volunteers in the liminal space, depending on their role and rules in different parts of the hospice. The volunteer co-ordinator told me she had been proactive in extending the role of volunteers with an aim where possible, to include volunteers in all departments in the hospice. Her experience had been that on occasions the use of volunteers was dependent upon the attitude of individual paid staff within departments:

Physiotherapy, urm, one paid member of staff has got three volunteer therapy assistants working with her. Now she's come from a previous hospice where she had paid assistants. She herself was very reluctant to having a volunteer, she wanted paid assistants and then she was told no I'm afraid not, this hospice will not give you a paid assistant. She's tried it and it's worked. I think they're not doing everything she would like them to do because they're not qualified but, she's having them doing more than I think she originally envisaged. I just think it's been broken down and over time when they realise that, that these people are really, really useful.

The use of volunteers then did vary from one area of the hospice to another and there were inconsistencies and restrictions. Sometimes this was dependent upon paid staff, especially line managers in particular departments and depending upon their experience of working with volunteers. In other situations, particularly in clinical areas involving direct patient care, regulation and governance was a determining limiting factor. This suggests there are concerns in some areas of the hospice about professional boundaries between volunteers and paid staff (Payne 2002: Towers et al 2003; Claxton-Oldfield et al 2011). It raises the possibility that there is scope for more training and sharing of good practice between departments to maximise the potential use of volunteers and address concerns in order to mitigate barriers. There are clearly challenges for hospices in sustaining and developing volunteering, and making full use of volunteers' skills and expertise, especially in relation to their involvement with direct patient care. As noted in the review of the literature, Help the Hospices (2012) recommend that hospices should be looking to expand use of volunteers but recognise that this might challenge health care professionals' notions of accountability and ownership of patients (2012:12), whilst Hartley (2018:172) goes further, arguing that whilst they value and respect volunteers, most professional staff would rather keep them where they can see and control them. The data from this study suggests that the extent to which some volunteers are deployed is limited by increased regulation, coupled with risk which is both actual and perceived. This particularly applied to volunteers in clinical areas with professional qualifications and to volunteers with direct contact with patients. With an increasing demand for EOLC in hospices but also in other health and care settings and the communities, I would argue that this should be considered in future policy decisions in hospices in order to maximise the use of volunteers and the skills and expertise they can offer. As the literature review showed, in countries in other parts of the world it is much more common to find volunteers involved in direct patient care in the community and for expert holistic EOLC to be more widely available in UK, the use of volunteers could enhance and support that expansion of services.

Another recurring motivation was the companionship and social function which the volunteers derived from their role over time. Freda is retired and has a chronic mental health condition. She has experienced volunteering on the inpatient unit and day hospice but her current role is as a driver, bringing patients to and from their home to the day hospice. During one of my visits to the day hospice, Freda talked to me about the reasons she volunteers:

I suppose it's a feeling of being needed and well here, I've made so many friends here, and yeah, made so many friends here and I like coming. I mean I never think oh God It's

Wednesday again, I think oh good, it's like the centre bit of my day, of my week, and it sounds bizarre really, but to be honest, I'm not a person who can just sit in the café with some friends and then go for lunch somewhere else and I don't mind going out, but I prefer to go in an evening, you know, and it's just trivial to me, is that. Whereas I don't think life is trivial. (Observations in the Day Hospice:17/02/2015)

As well as finding friendship through her role, Freda's response also suggests an existential element of purpose and value which underlies and sustains her volunteering, providing further insights into the benefits volunteering can afford an individual.

Clare previously worked as a MacMillan nurse and as such has experience of hospices and EOLC. She now volunteers as part of the chaplaincy team. She talked to me about the differences she has noticed between being in a paid role and her volunteering:

I think it is different because I suppose when you've been in a leadership role particularly as a paid employer you haven't got that same responsibility as a volunteer. It's a commitment. It's a very, very big commitment. I don't feel that I can just come and go as I like, and neither would I want to do. You know I'm committed to it and, I have to say Liz, I really look forward to every Tuesday. I look forward to coming every Tuesday And I never ever leave Fernbank without feeling full of hope. (Interview:17/07/2018)

Rosie, aged 68, retired 8.5 years ago and has volunteered at the hospice for six years in the finance department. She derives great satisfaction from the atmosphere at the hospice and the people with whom she works:

You cannot believe how happy and upbeat everybody is here. You know, it's sort of, I don't know, it just makes you feel really good when you leave you know and I'm sure the patients feel that…. I just love it, I feel so good, the girls are so nice, so much younger than me! But saying that, I've always worked with people a lot younger than me. So you know, and they don't talk to me as if I'm an old woman, you know, or is I'm, or as if I'm their mother, or their grandmother in some cases. Erm, no, they just, just treat me, totally treat me as an equal and even the first year I worked here, I went on their Christmas do. (Observation 3/09/2014)

I would argue this supports my contention that the liminal space which volunteers occupy has characteristics which distinguish it from the space occupied by paid employees in the organisation and is different to the space the volunteer occupies when they are not engaged in volunteering. The Volunteer Co-ordinator provided me with a volunteer testimonial which

she had received, and the following extract captures the concept of liminality which this volunteer experiences:

Every Thursday means that I step out of my world and into the real world of spending time with fantastic people, who in normal circumstances I would never have the opportunity or the time if I wasn't volunteering for Fernbank. It's a privilege, it adds such a lot to me and my life and it's great to volunteer in a place that is so full of life and a great place to volunteer in!

It was evident from the study that as their volunteering progressed over time, there are secondary motivations and additional factors which sustain them in continuing with their volunteer involvement. Volunteers were able to articulate these reasons, but it is also important to note that some of the motivations and reasons for individual volunteers continuing in their work were noticed more by the staff who worked with that volunteer, rather than the volunteer themselves. This supports the argument that having an awareness and understanding of volunteers' motivations and how they may change over time is instrumental in keeping them within the organisation (Howlett 2009; Rochester et al 2012). Whilst sustaining the volunteer workforce offers apparent benefits to the hospice, being responsive to meeting expectations and changing motivations can also present challenges. It requires flexibility and responsiveness on the part of the organisation, for example allowing volunteers to change their role over time to better suit their interests, capabilities and motivations.

It is important to note that there is no 'one size fits all' representation of a hospice volunteer and far from being an homogenous group, their backgrounds and motivations were symptomatic of a complex, interesting and nuanced group of individuals. A staff member at the first Lego session captured this when she spoke about her model of a hospice volunteer:

I don't think you can pigeonhole a hospice volunteer. I think, you know, everybody brings something. But the underlying thing is the fact that they care and they want to come through that door and hopefully they won't leave us…… to standardise what a hospice volunteer is, it's very, very difficult because we try and I think that's what we do really, really well, we play to people's strengths and we don't put them in pigeon holes, we try to, you know, to put them in roles that we think suit them because it's as important, not only that they're a resource for us, but they get out of it what they want to get out of it and so that they'll remain with us for as long as they can. (Lego session: 22/07/2015)

This not only captures the complexity of volunteers but also the challenges involved in meeting the needs of both volunteers and the organisation.

Summary

In response the RQ1, the study has revealed that there are numerous and significant benefits which can be derived from volunteering and these vary for individual volunteers. For some, volunteering provides a structure and routine in a place away from home. which is particularly important to individuals who are no longer in paid employment. Entering the liminal space of volunteering allows some of the volunteers to access some of the benefits and opportunities afforded by a workplace, whilst at the same time being in a space which provides the flexibility and agency which volunteers look for which were not always available to them in paid employment. This includes individuals who are no longer able to continue in paid work as well as those who choose not to and is particularly relevant to some of the older volunteers or those with chronic health conditions. The liminal space enables some volunteers to actively participate in a workplace in order to inform and facilitate career choices and progression. This could include, for example, school leavers, university undergraduates and trainee health professionals. Enabling these volunteering opportunities can be of benefit to both the individuals concerned and to the organisation. In response to RQ1, accessing the liminal space also offers the opportunity for valuable social and emotional connections which were seen as beneficial to many of the volunteers. When volunteers access the liminal space, it provides the organisation with a wealth of professional skills, knowledge and life experience (Doyle 2002), upon which it can draw to enhance the delivery of hospice care. However, such benefits may be tempered by the requirements associated with increasing regulation and governance within the workplace and the demands placed on members of paid staff in supporting some of the volunteers. The extent to which some volunteers are deployed was sometimes limited by increased regulation coupled with risk which is both actual and perceived. With an increasing demand for EOLC in hospices but also in other health and care settings and the communities, it is important to maximise the use of volunteers and the skills and expertise they can offer (Help the Hospices 2013). I would argue that this will require a degree of confidence, creativity and flexibility on the part of paid staff and policy makers to sustain and develop the potential which volunteering affords.

This chapter has addressed RQ1 by discussing the motivations of volunteers entering the liminal space of volunteering and some of the factors which can influence their continuing involvement. In so doing I have identified benefits to both the individual and to the organisation which volunteering can afford as well as some of the inherent challenges. I

have also drawn attention to some of the organisational and cultural factors which shape the volunteer experience (RQ2) within the liminal space. The next chapter will open up that discussion further examining ways in which volunteers and staff work together and the various influences and support which exist within those working relationships.

Chapter 6 Volunteers and paid staff working together: Symbiosis and the liminal space

Introduction

The previous chapter explained reasons why volunteers in the study were first drawn to become actively involved in volunteering. Responding to RQ1, some of the factors which were important in sustaining their volunteering activities were discussed and how hospice volunteering can afford benefits and challenges to both individual volunteers, the paid staff with whom they work, and the hospice organisation as a whole. This chapter addresses ways in which volunteers and paid staff work together, their working relationships and how cultural and organisations factors can affect those aspects of the hospice volunteering.

The primary function of the hospice is to provide specialist EOLC to the patients and their loved ones. The study revealed an ethos of care within this organisation which extended further to include volunteers, staff, patients and members of the public. It is a hospice in which there was a culture closer to what Lopez (2006) termed 'organised emotional care' and 'compassionate caregiving', as opposed to more coercive aspects of emotional management characterised by emotional labour (Hochschild 1983). There were examples of symbiotic relationships whereby staff and volunteers each mutually benefit on occasions from the existence of the other and this support and care appeared authentic and genuine. One such example from the data was from Clare, who had previous experience of paid work in another hospice and she now volunteers in both the inpatient unit and the day hospice. When I met Clare she told me:

So, I actually think that within a Hospice setting in my experience, the care that volunteers and paid members of staff give to the patients and families is mirrored in the care that they give to each other. (17/07 2017)

A further example of extended care was shared by a member of staff during one of the Lego sessions:

When I started, we have a volunteer and she's volunteered for quite a long time. Her daughter died here, probably now fifteen years ago and when I started, so six years ago, probably, it'll be sixteen to seventeen years ago and when I started, she had not set foot in this place since her daughter died. She'd volunteered in the shop, she'd volunteered every week, anything in the community, she would do anything you wanted her, but she'd never ever walked back through those gates and we talked and I said if you want to come, I'll come and meet you, whatever, and I just, I was at my desk, wasn't I, one day and I got a

phone call from reception and they just said can you pop down, there's somebody to see you. And I went down and she was sat in reception with her husband last year and said 'I've come through the door'. She said 'I've come through the door', and I just burst out crying. I was just like oh my God, you know, you're amazing and it gave her then that she could move, you know, because obviously her daughter was only like sort of in her forties, grandchildren and that and, a difference, but she has never ever stopped volunteering. She's been out in the community and she will do anything and everything for you, but she'd never ever been, managed to get through the gates, she just couldn't do it. But she did it and I just…… We've all got a role to play in that, haven't we?

(Lego session: 16/09/2015)

There was a symbiosis here between the member of staff and the volunteer. Returning to the notion of the liminal space of volunteering, inhabiting that space had helped this volunteer over time in her bereavement and enabled her to access support offered from a paid member of staff. This reinforces the idea that the liminal space is not limited to the physical confines of the hospice building but rather extends to represent hospice volunteering, wherever that takes place. Throughout this time, this individual derived personal benefit from carrying out her role as a volunteer and was able to maintain her ongoing association with the hospice, albeit for a while at a physical distance, whilst the organisation also benefitted from her sustained volunteering and commitment. As noted previously, the focus of this particular study has drawn upon the experiences of those volunteers who mainly carry out their volunteering within the hospice building. However, Fernbank also has many volunteers who volunteer in various roles within the community and with the expansion of hospice provision this could impact on volunteers working physically distant from the hospice, experiencing a lessening in their sense of intimacy and belonging (Field and Johnson 1993). This opens up the possibility for further research to examine any similarities and differences in the ways those volunteers are supported and the extent to which the symbiosis between volunteers and paid staff is applicable.

The study has shown many examples of a workplace which is inclusive and adaptable in its approach to volunteers and revealed where this approach had enabled some volunteers to become actively involved in volunteering. In some instances, this was accommodating volunteers with physical disabilities and learning difficulties to become involved in volunteering, but there were also individual examples of volunteers being supported and cared for by staff, including accommodating illness and disability to enable them to continue in their role. This was particularly evident amongst some of the older volunteers who over the time they had been volunteering at the hospice, had subsequently developed health

conditions, including dementia. The examples which follow are illustrative of a culture of extended care and support for volunteers, which in some cases can result in tensions and difficult decisions for staff and the organisation. One such example was discussed by two members of staff who both work in the day hospice. They talked about their experience of working with one of the long serving volunteers who continues to come to unit:

We've got volunteers who are becoming ill and that and you can't just say thank very much, you know, I wish you well, see you, you know and we've got a volunteer who keeps coming in and bless her, she's no use nor ornament to anybody but I think her husband's just died, she has, she's never paid a bill in her life, she's never, and he had a heart attack didn't he and died. She's never, she didn't even know how to use the tv remote and then she's suffering, we think she's some sort of early onset dementia.

We seem to have become her family though haven't we?' (Lego session: 22/07/ 2015)

This raises the problem of how to manage volunteers who may need to face retirement from the role (Russell et al 2019) and also represents circumstances which are more likely to apply to volunteers than to members of paid staff. These members of staff were talking in terms of becoming that volunteer's 'family' and supporting her, rather than looking to revert to a policy or procedure as would be the case, if similar circumstances occurred with a member of paid staff. There may be times when individual volunteers can make demands on staff time and attention and in some cases could even become a liability. This suggests a balance needs to be struck between the needs of the volunteer and those of the organisation.

There was also a sense of support and care for individual volunteers which sits alongside the benefits that volunteers get from their volunteering sustained by their considerable commitment to the organisation. Following an observation of her working, Sheila told me that despite her ongoing chronic health problems, she had found care and support from staff and did not let her ill-health deter her from volunteering, finding it proved to be for her a useful distraction. Furthermore, having watched this volunteer working, it was clear that the supportive culture she had experienced from others in the workplace had enabled her to continue with her volunteering and far from being a liability she was making a significant contribution thus ensuring both the volunteer and the organisation benefit from her ongoing involvement:

I know that if I'm not feeling particularly well, it's really strange, you don't like to let them down but K sometimes looks at me as I've come in hobbling in and she'll say should you be

here? And she sent me home a couple of times and she said you shouldn't be here. But this is my outlook, you know, if I'm doing something here, no matter what, whether I'm stuffing envelopes, marking fluffy toys for whatever, I'm not focusing on my own problems. I just love, I love the place. I mean I think it rescued me in a way, you know, and I think, you know, I think it does for a lot of people. (Observation: 3/09/2014)

These are powerful examples of the demands placed on the staff within the organisation but at the same time the lengths they are prepared to go to support and care for individual volunteers, which I would contend, would not necessarily be the case for paid employees in many workplaces. However, some problems arose for staff from this extension of care to individual volunteers and whilst there were only few examples, it is important they are not ignored. A member of staff from the day hospice shared her experience during one of the Lego sessions:

We have a volunteer that comes and she offloads to the patients and you think to yourself the patients have got enough going on in their own lives dealing cancer or whatever they've got. They don't need to hear about your personal life …you know listening to things about you children or general everyday things is fine but listening to: 'Oh my husband has done x y and z or my daughter's going through a divorce .. and you think patients don't need that . I were trying to intervene to get the patient out because it's not fair on the patient ..it's quite difficult…. It's almost like an extension of ..you're caring for them? It's not just they're giving up their time but they're actually getting something else out of it. Almost a caring thing in itself. (Lego session: 22/07/2015)

Another member of staff raised similar concerns during the same Lego session that whilst there may be social benefits to individual volunteers in their volunteering, this can have consequences for staff with whom they work:

I have seen volunteers who actually make work for the staff ..I think really because they come for a social element … and that can be quite time consuming and frustrating for staff sometimes . They're busy and they know someone's coming on they don't feel the added benefit…We had one volunteer, she's not with us anymore but she came with a broken leg …… but it were getting her out of the house for that day and she was more of a nuisance to us, not being awful because she was taking a chair up and her leg stuck out… and very demanding and you thought she's harder work than the patients.
(Lego session: 22/07/2015)

So, problems can arise where the needs and demands of an individual volunteer outweigh their contribution and create additional work for members of staff in the hospice. Furthermore, it is possible that the individual volunteer may not be aware that what may be beneficial for them may be problematic for staff and the organisation more broadly. Such conflicts and tensions are not limited to individual volunteers and members of staff. It can extend to management and policy decisions. For example, at a Board meeting I attended there was discussion about the development of Fernbank's charity shops. The HR manager and Director of Retail were relatively new to their roles at the hospice and neither had previously experienced working in TSOs or a hospice specifically. The exchange related to the role of the volunteers in the shop and the age profile of the volunteers in that area. My field notes at the time included my reflection on this exchange and its implications:

More examples at the Board meeting of the formalising of volunteers. Move towards 'work' presentation in terms of 'very clear role profiles' (HR Manager).
R (Director for Retail) in developing the shops for the future was 'very excited by the possibilities.' There would have to be some difficult conversations. There are volunteers who have been there 10-15 years and it may be we will have to ask them to go.'
HR response was to 'tighten up role profiles' and more training was required.
No acknowledgement of wider aspects of volunteering – social / 'normality / representative of the community – rather than workplace which inevitably requires tolerance of the limitation of some volunteers as well as taking advantage of the benefits they bring.

(Field notes: 22/3/17)

With an aging population and the majority of volunteers being drawn from older age groups, this is likely to be an ongoing challenge for staff to address and has implications for policy decisions in managing volunteers within the organisation. There will be a need for a workplace culture in which older age groups can reap the benefits of volunteering (Kahana et al 2003) and the hospice benefits from their commitment, expertise and life experience, whilst at the same time policies and support is in place when the prospect of leaving or retiring from volunteering needs to be addressed (Russell et al 2019). Once again, this underlines a feature of the liminal space of volunteering which sets it apart from the rules and culture of a paid workplace.

However, the presence of volunteers was overwhelmingly valued by staff in the study, and some were able to articulate the positive impact they had experienced. Individual members of staff talked about this directly in interviews and in the Lego sessions. One of the advantages of the ethnographic approach was that as well as staff telling me, I witnessed

volunteers and staff working together within the setting and what I observed resonated with what I was told by individuals. If anything, I was surprised by the lack of any apparent hierarchy, especially when it came to interactions in reception, the day hospice and the admin offices I spent time in.

One of the members of staff who works directly with volunteers, and had herself been a volunteer before she secured a paid post at the hospice, recalled her relationship with an individual volunteer who had mentored her when she started her paid role:

I remember when I, I mean I obviously started as a volunteer, but when I started as a member of staff and I worked with a Friends' Group and I was twenty and this volunteer took me under her wing and she said, and she'll say it now, she said when they employed you I thought who's this young girl, she won't have a clue and she was amazing and I wouldn't, probably wouldn't still be here if it weren't for her because she introduced me to everybody, she told me all the history. She said, you know, you've got to know how to play it with these supporters and you've got to make sure you're friendly to everyone. And she showed me what to do, because at that time there wasn't a fundraising team. So she showed me how to be a fundraiser……. It's a two way thing isn't it, not only do we get something, well not only do they get something from us, we get so much from them in terms of personal development and coming in contact with their personalities, their experience. (11/06/2014)

This is further evidence of mutual benefit and symbiosis between volunteers and paid staff. Here, the member of staff had derived great benefit from the skills and experience of a long-standing volunteer whose knowledge of the hospice and TSOs had supported her learning in the early stages of her new role in fundraising.

The presence of volunteers can also provide staff with motivation. A senior member of the clinical team explained the positive emotional effect she derived from having volunteers present in the workplace:

I think volunteers inspire me, anyway, when I'm having a miserable day, thinking oh why do I bother, to think oh gosh, if they can bother…….. Somebody has got up today, come into the Hospice to give some time, okay yes, they get something out of it, but they may suffer distress or inconvenience or other things that I don't see and, erm, I think it's good for my morale. (Conversation with member of SMT 24/11/ 2016)

Another member of staff seemed motivated as a result of the presence of volunteers and their work ethic. When I was sitting in reception, she chatted to me about volunteers being in the hospice:

Even walking about the Hospice, you never really see volunteers sitting around gossiping or on their phones or anything. The majority of the time, you just see them grafting and it often makes me think oh yeah, come on, get a grip. So, they do often motivate me to work a little bit harder, which is nice. (1/10/2015)

During one of the Lego sessions, a member of the nursing staff captured her experience of working with volunteers:

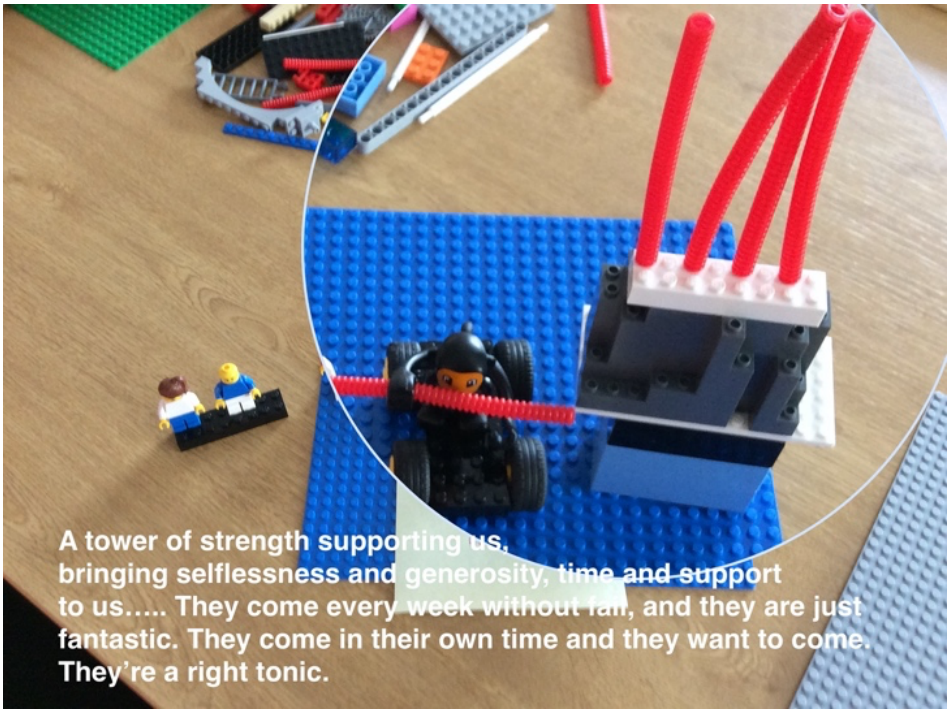


Figure 6.1: Metaphorical model - 'Working with volunteers'.

She spoke in very positive terms of that experience, choosing to focus upon the support and motivation she gained from working with the volunteers and recognising the gift of self and time inherent in their volunteering. During the same session, one of her colleagues captured the diversity amongst the volunteers and also some of the challenges of working with them:

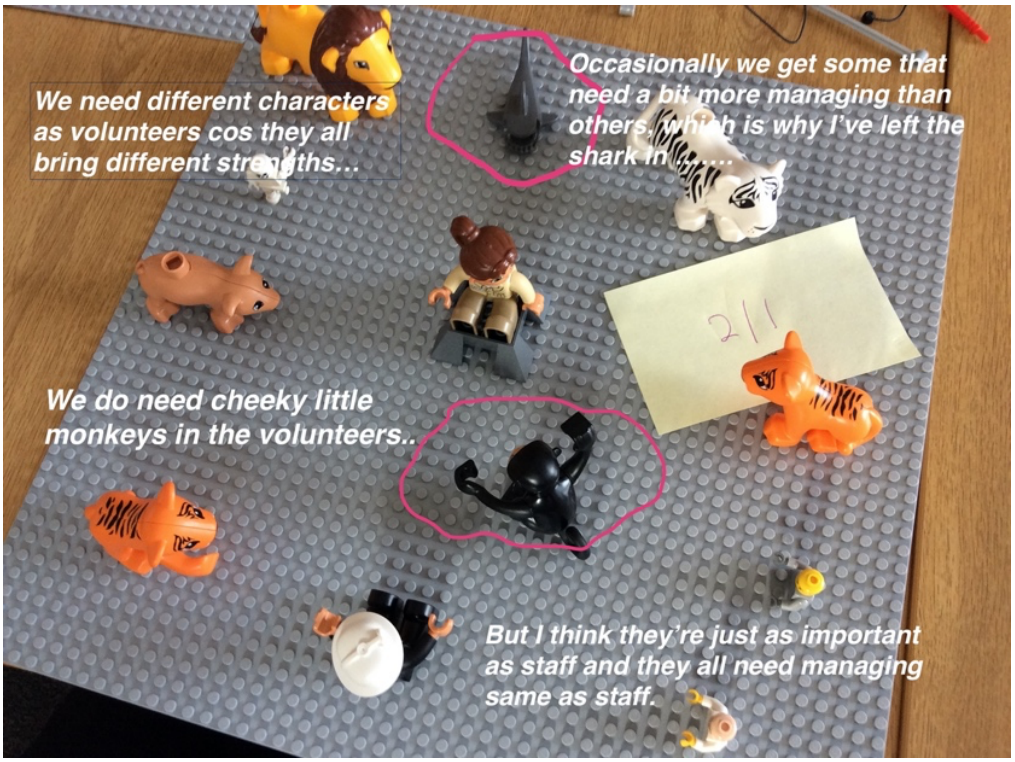


Figure 6.2: Metaphorical model – 'Working with volunteers - Messy to Manage'

In the time since the hospice opened in 1981, regulation and governance has become increasingly evident in healthcare settings (Watts 2012a; Morris et al 2017), and this hospice is no exception. During the study I tried to find out more about regulation and management of volunteers. To do this I asked the opinion of a number of staff who worked with volunteers in their teams, I looked at some of the relevant hospice documentation and I was present in management meetings where such discussions took place. Speaking with individual members of staff, perhaps not surprisingly exposed different opinions as to how volunteers should be managed. Whilst there was general agreement that volunteers like staff needed management, one of the senior members of staff who had considerable experience of working with volunteers in within and outside of the hospice had concluded that: 'Volunteers are messy to manage'. The period of research for this study coincided with the SMT, in conjunction with the trustees, working on developing a number of new policy documents or updating existing ones. The process exposed that this 'messiness' also applied to the regulation and management of volunteers within the organisation when writing and implementing management policy and underlined once again the liminality of volunteering. Examining some of the policy documents which related to volunteers including Human Resources, Education and Training, Equality and Diversity, and listening to the discussions during meetings, even the language and content of the documentation proved difficult.

Documentation often started off referring to ‘staff and volunteers’ but then further into the written draft policy the term ‘volunteer’ disappeared within the policy as if volunteers had become subsumed as one and were the same as paid staff. When I raised this with some of the authors of the draft documentation, we explored the detail together; the inconsistency was acknowledged but this only raised further problems for the authors of the policies. It emerged that much of the detail whilst relevant to paid staff could not be applied to volunteers. On the other hand, there were some points of policy within the documents which could be important for volunteers in practice, but unless this was made explicit in the policy there was the potential that they could be overlooked, and an argument presented that it only applied to paid staff. It became apparent that there were differences between volunteers and paid staff in the context of their working practices and there was the potential for managers and trustees to be unaware of such differences or to overlook them in constructing policy for the hospice and in enacting those policies in practice.

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In accepting that volunteers occupy a liminal space, policies and regulations designed for paid staff can present a challenge. If strict controls and regulation are put in place such that the boundary on the ‘liminal beach’ ebbs away and the beach becomes subsumed by the high tide or coastal erosion, the volunteer effectively becomes an unpaid member of staff. Morrison (2000:109) argues there is a particular and very significant tension between a professionalised managerial approach and a more traditional volunteering ethos. Operating within the ‘professional’ discourse of quality, accountability and regulated practice, some voluntary work has been made closer to the experience of paid work. (Watts 2012a) and Noon et al (2013) suggest that in the broad care sector this may be particularly the case. The presence of volunteers within the organisation presents particular challenges. Reverting back to the Lego model where it was concluded by the person who built the model that volunteers can be: ‘Messy to Manage’, unlike paid staff they can to an extent work on their own terms in relation to: availability; time; ways of working and training; and can say ‘no’. Their volunteering fits in with other commitments such as: holidays, family and work which in some cases take priority. Volunteers therefore can have agency and arguably be more difficult to control, requiring sensitivity, tolerance and more creative approaches to management from individual staff and managers who cannot naturally assume conformity and performativity from volunteers. The rules and practices of the workplace cannot then necessarily be applied successfully within the liminal space of volunteering but ‘volunteers cannot fully and successfully contribute to a hospice unless they are recognised and planned for by the management and staff’ (Lean and McDermott 2009:117). Conversely, some rules and expectations are necessary to protect volunteers and to help maintain excellent standards in the organisation.

Summary

In some of the departments, the volunteers were well integrated, and staff were very used to them being there, 'doing such a good job behind the scenes' such that their contribution and the difference their presence made was only evident when they were absent. A member of staff from the inpatient unit told me after a Lego session, about a couple who volunteer regularly in the inpatient unit and had been away because of illness:

*It's not that we take 'em for granted it's just they're good, they' re just part of daily goings on. Even I know it's Friday when I come on the unit. Oh, it's Friday because you know they'll both be here. And they do give you a lift, they do. (*22/07/2015)

This research confirms that the contribution of volunteers is often intangible and can be difficult to articulate. In order to better understand the contribution and difference volunteers make, I asked the question of many people when I was carrying out the research: 'What would the hospice be like without volunteers?' Most people found it difficult to give a succinct response and whilst recognising it would be very different, found it hard to capture that difference in just a few words. One response from one of the senior management team however captured some of the illusive complexity and touches on many of the points discussed in this chapter:

It would be beige! It would be boring! You know, we have a lot of staff, but volunteers bring something different. Erm, some, I'm not going to lie, some elements of my job would be a lot easier, if there were a paid member of staff that, you know, I could be maybe a bit more firmer with and it was consistency, they're in every day. Erm, but the other things, I don't think you can match the commitment of some of them and the enthusiasm and we couldn't afford certain skills that they bring. I just think it would be a much sadder place, not just for staff, but for patients, because they do talk to volunteers when they're on their shifts and erm, and particularly in Day Hospice, you know, making crafts, well it's not just about making a fuzzy felt picture, they're telling this volunteer about their illness and how it makes them feel and I'm not sure if somebody being paid to do that day in day out would do it in the same way a volunteer would do. I could be firmer with paid staff and they'd be in every day – but it would be a much sadder place. The extra sparkle – we'd lose so much. (Recorded conversation: 18/06/2015)

This chapter has examined what the research revealed about how volunteers and staff work together in a hospice and the benefits and challenges which ensue as a consequence. The analysis also exposed some of the organisational and cultural practices and how they impact

on those working relationships. As discussed in Chapter 3, the concept of liminal space is helpful in understanding volunteering and the data confirms that when enacting out their role, volunteers are neither paid staff nor members of the general public. Furthermore, volunteers have agency which in turn has implications for volunteer management in a professional workplace. In order to protect and maintain the liminal space, some policies and regulation may need to be adapted and a degree of flexibility and creativity applied in enacting rules and practices which apply to volunteers. However, Howlett (2009:17) highlights the particular challenge of such an approach in the context of hospices which he points out are workplaces which highly regulated and subject to the scrutiny of of a range of regulatory bodies and as such may require systems and processes which replicate the world of work. This dilemma highlights the fragility of the liminal space of hospice volunteering and the danger of its erosion when volunteering begins to look like paid work but without the pay (Rochester 2006).

The next chapter moves to consider in more detail what the study revealed about the nature of the work of hospice volunteers in carrying out their role, using the concepts of workplace responsiveness, emotion work and the gift of time to better understand the complexity and importance of the work of hospice volunteers.

Chapter 7 The Role of Volunteers and their work in the Liminal Space: What goes on in that space?

Introduction

The previous chapter examined working relationships of volunteers and paid staff within the organisation. In this chapter the focus shifts to look specifically at the nature of the work of volunteers in the hospice. Spending time hanging around in the hospice and watching the volunteers carrying out their role in real time, as well as talking to them and others about their role, was instrumental in discovering more about what volunteers do in the course of their work and what their role entails. This chapter relates to RQ2 and RQ3 in finding out what characterises the work of volunteers and the extent to which some of the existing theories of workplace learning and emotional labour are helpful in understanding this aspect of hospice volunteering.

Work as described and work in practice

Burbeck et al (2014:2) noted the difference between job descriptions of volunteer roles and the actual role which volunteers do in practice which can involve elements which are harder to describe. The hospice website lists the various options for volunteering, with a succinct descriptor of the roles. The roles are also now laid out in individual job descriptions which have been designed to relate to specific volunteer roles. These role descriptors would be examples of what Brown and Duguid (1991:41) 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. This contrasts with what Brown and Duguid term, 'Non-canonical practices' which are the actual practices that staff, or in this case volunteers, engage in and learn through to get the work done. For example, on the hospice website, the advert for volunteer receptionist provided only a very brief description of the role which did not reflect the complex and sometimes challenging role which I observed when I was in that area of the hospice:

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. I spent time 'hanging around in reception and I was struck by the variation in pace and demand.

It's like a magnet. A hub. Everyone who comes through reception seems to be drawn to it. There's quite a lot of 'through traffic' with staff going to and from the IPU and the offices up the corridor. They nearly all stopped for a chat with the receptionist, or at least called out to her as they were passing. What a vibrant happy place! Then a lady came in to collect a death certificate and the receptionist was so kind with her. She broke off from what she had been doing, no waiting involved and spoke to her quietly for a few minutes. Then rather than just direct her towards IPU she took her there herself. She could just as easily have pointed her in the right direction and let her find her own way. That's usually what happens in reception areas in other places I've been. She made sure the desk was covered by calling out to one of the admin team in the office behind the desk. There was no fuss, no gaps. When the receptionist got back to the desk, she answered a couple of phone calls, then took the payment for a sandwich from a visitor. It would have been easy just to take the money, but again she took the time for a friendly exchange between herself and the visitor. 'Enjoy your sandwich' as the visitor was leaving the reception area. As I was getting up to go a patient came out from IPU and settled himself down on the sofa. He seemed very much at home! All of the tasks seemed to be stretched out – the chat, the care, the extra mile.
(Field notes 8/10//2014)

When I observed volunteer Sheila, she talked about her previous day on the reception describing 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? (31/072014)

These extracts from the data provide examples of 'workplace responsiveness' which is a term I first introduced in Chapter 3. It characterises the more complex aspects of work as practised by some of the hospice volunteers, especially those who are in roles which may

appear to some to be simple and low skilled. These roles require frequent and usually unplanned responses and interactions with patients, families, and members of the general public, so have important social and emotional dimensions which adds to the complexity and demands of the role and may be largely hidden or unacknowledged. Discussing the work and learning of student nurses, Smith (2012) comments:

> These 'little things' or 'gestures of caring' are still difficult to capture and they slip by unnoticed in the daily routines and the hustle and bustle of institutional life.
> (Smith 2012:2)

Illustrative examples from the study support my contention that workplace responsiveness is a feature of working in the hospice setting and whilst many of the volunteers I observed exemplified it in practice, others explained some of the resulting demands and consequences. Workplace responsiveness comprises elements of spontaneity, intuition, cognition and emotion on the part of an individual dealing with a situation as it unfolds. Observing this enacted in practice by some of the volunteers, showed that an immediacy was required, especially when interacting with patients or members of the public which did not allow time for consultation or reflection and required a degree of confidence on the part of the volunteer. Brown and Duguid (1991:42) when talking about work in practice use the analogy of a road map to navigate a journey. The map, whilst useful to the driver does not take account of changing conditions and as the journey unfolds, ad hoc decisions which are required in response to those conditions. The actions of the volunteers required an awareness of the context and the practices of the setting, and their actions include physical, cognitive and emotional responses. When the receptionist responded to the lady coming in for the death certificate, and when Sheila dealt with the family, each exemplified these elements in practice. This aspect of their work was not reflected in the description of the volunteer's role as laid out in the hospice documentation; the research provided other similar examples of that dissonance between role descriptors and actual practice.

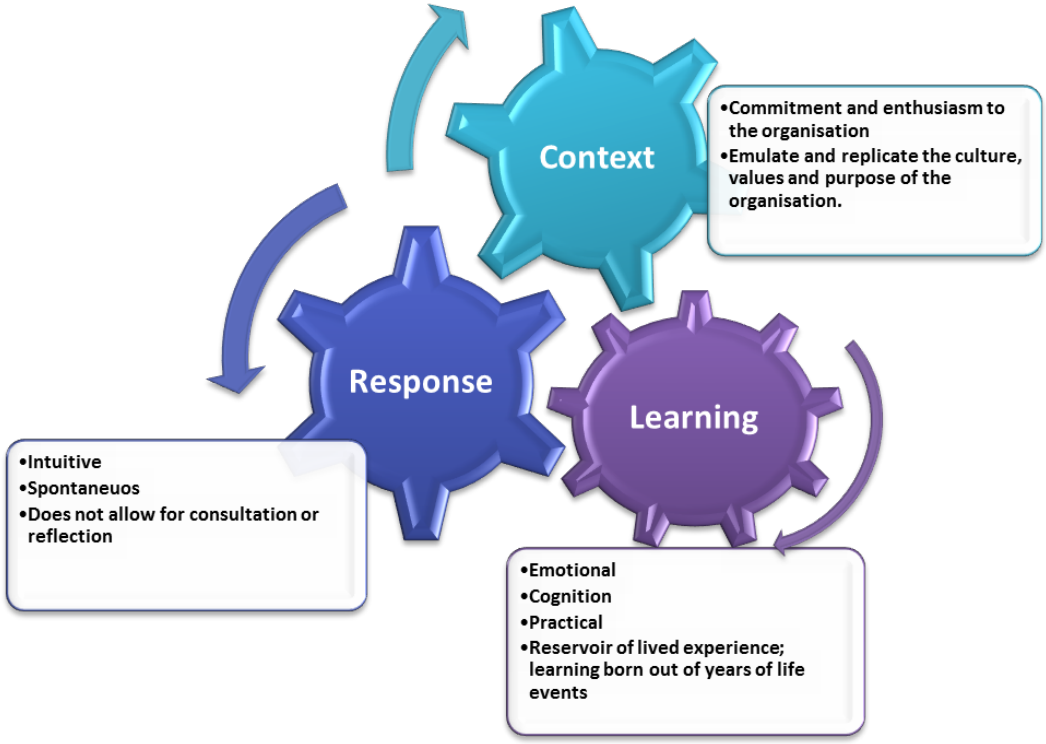


Fig 7.1: The component parts of Workplace Responsiveness

Most volunteers have not had formal training or worked in similar settings and some have never been alongside people going through EOLC. Volunteers are often confronted with complex situations which have no apparent 'blueprint'. This aspect of their learning, or workplace responsiveness is characterised by a complex interaction of finely balanced emotional, cognitive and practical judgments. This way of working is similar to what Wrzesniewski and Dutton (2001) term 'job crafting' as discussed in Chapter 3, but in the case of some of the volunteers, as well as the physical and cognitive elements, there were examples where emotional responses were also an important component as a consequence of being in a hospice setting. Some of the volunteers I spoke to and observed were able to draw upon lived experience and learning from life events, which I would argue informed their decision making and actions. Furthermore, responses were rooted in the volunteer's commitment and enthusiasm to Fernbank, and in the enactment of their role finding opportunities to emulate and replicate the culture, values and purpose of the hospice, all of which supports the significance of an individual's biography, values and disposition (Hodkinson et al 2004; Fuller and Unwin 2005) in this complex workplace activity.

One of the volunteers, Rosie, however described being over faced with a situation which occurred in the course of her work; that she had not appreciated at the time what the role

actually involved and what might be required of her. I included this extract from the data as it was one of only a few examples where a volunteer had acknowledged experiencing difficulties. Overall volunteers in the study offered very positive accounts of their work and this was supported by the data obtained from participant observation. Nonetheless, as noted in Chapter 4, I considered it important in the ethnographic account to recognise cases which ran counter to the narrative of others, not least because such cases underline the nuance and complex picture of hospice volunteering. Rosie, who has been a volunteer for six years described her first experience of volunteering on reception:

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. 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 but 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 afterwards I just said 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. (Interview: 16/12/2016).

On this occasion, Rosie did continue her volunteering. Having said she did not wish to continue in the receptionist role she moved to another department in the hospice where she was less likely to come into direct contact with patients or members of the public. Whilst Rosie was prepared to ask to volunteer in another area and the organisation was flexible in accommodating her request, not all volunteers would necessarily share their concerns with others. Therefore, where there is a dissonance between how a particular role is advertised and how it translates in practice, whilst not presenting a problem to some of the volunteers, it can also be distressing for others who feel ill-equipped to deal with such complexities. There is a paradox however that drawing attention to the hidden demands of a volunteer's job, which many individual volunteers demonstrate they are more than equipped to deal with, could deter some from volunteering or result in those roles only being available to paid staff with very specific training and experience. It does however suggest there is a place for ensuring support is available for volunteers, especially when they are relatively new to a role where the description of the job betrays the underlying complexity and noncanonical aspects of the role. Support could be a consequence of a volunteer's access to membership of a community of practice (Lave and Wenger 1991; Brown and Duguid 1991) and this is discussed further, in the next chapter.

For some of the volunteers in the study, their role required them to work quite independently, spending time away from the hospice building. In the case of volunteer drivers, they also spend time alone with individual patients, transporting them to and from the hospice. The description of the Volunteer Driver role on the hospice website reads:

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 have a life-limiting condition 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. Maria, a volunteer driver for 22 years explained the uncertainty inherent in such visits:

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. (Day Hospice 2/03/2015)

The drivers have talked about conversations they have with patients and 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 patients as a turning point in their 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. Freda, one of the volunteer drivers recalled one such occasion:

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.

(Day Hospice Meeting 18/02/2015)

This highlights challenges which may be faced by some volunteers which are often not anticipated or planned for. Again, the dissonance of described and actual practice is apparent along with the workplace responsiveness inherent in the role. The research has shown that there is an emotional component which overlays the work of many of the volunteers, especially those whose volunteering brings them into contact with patients,

families and the general public and the nature of that work is often unplanned and unpredictable.

Emotion work in the liminal space: support and coping strategies

As discussed in Chapter 3, Hochschild (1983:7) refers to management of emotions in the workplace at work as 'emotional labour' sold for wages and in private as 'emotion work'. This is a further example of liminality when applying concepts and terminology to hospice volunteers where they are neither in the workplace for payment, nor are their activities private. Emotion work in healthcare settings is the act or skill involved in the caring role and recognising the emotions of others (Smith 2012). Some staff did recognise some challenging situations involving emotion work which individual volunteers may need to deal with in the course of their work. One of the senior nurses in the day hospice explained to me how patients can choose to confide in a volunteer rather than a member of the clinical staff in difficult circumstances and on occasions away from the hospice building. She emphasised her own role in being available to support volunteers, and making sure that volunteers are aware that support is available:

They [the volunteer drivers] 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 are there. But they're fantastic, couldn't do without them.

(Recorded Conversation Day Hospice 2/03/2015)

With that in mind I asked one of the senior members of the medical team about this and the support available to volunteers:

I don't think that most of us appreciate……. I know I appreciate that people who volunteer here may witness and be party to distressing events, but I don't know how they feel when they go home really. And they put a very brave face on it when they're here, because they're here to help people…… But there must be things that people see that they relate to, because I go round and I think wow, I was like you when I was that age, or Oh gosh you remind me of my mother… Yes, but then those unanticipated personal identification with people in distress triggers something that, yeah, as you say, you can't predict and it's very hard. And then the volunteer just goes home with that and hopefully has somebody to talk to, but I don't know that. (Interview: 24/11/2016)

This response exposed a potential problem relating to a lack of recognition or acknowledgement of the possible impact of emotion work on volunteers. When I was

speaking with staff about this aspect of volunteering, it was apparent that it was not something some of them had really considered. It could be explained in part because for most of the volunteers there is no formal or regular means of support or supervision. That is not to say staff were unsympathetic or unsupportive; on the contrary the volunteers in the study, without exception said they felt well supported by staff they worked with. My observations of working practices suggested such support was informal and a feature of the hospice culture. When asked about available support, apart from those involved in the chaplaincy team where there was formal supervision in place, most volunteers said they did not think they needed support, but if necessary, they said they could always go to the Volunteer Co-ordinator and this was confirmed by that member of staff who viewed it as part of her role. Most volunteers spend a short time each week at the hospice, compared with staff in a paid role, and having done their shift the volunteer will go home until their next session. That lack of sustained presence in the workplace in the working week by individual volunteers could be a contributory factor in protecting volunteers from some of the demands and pressures of emotion work which volunteers can be exposed to. Furthermore, the volunteers in the study were largely very positive about their volunteering and what they derived from it, which supports Noon et al (2013:193) who suggest that the negative impact of emotion work can be offset when individuals are gaining personal satisfaction from their role and there is a fit between personal values and job demands that attracted them to the job in the first place.

Support for volunteers was discussed in one of the Lego sessions and this extract is further evidence of how that limited awareness can arise in the workplace:

I don't think it's a consistent and I don't think it's because we're mean and horrible people. I think … we perhaps don't think of the impact it has on them. I think we underestimate sometimes the friendships that we do strike up and we might see somebody deteriorating for a while and they [the volunteer] might not be on for a few weeks and then come in and that patient's died and we might say, I don't mean it matter of factedly, but you know, just inform them that the person has died, so they're very upset then. (Lego session 22/07/ 2015)

When I asked the volunteers about the support available to them, with some prompting, most 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 formalised 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. Maria, one of the volunteer drivers told me:

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 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. (Interview: 2/03/ 2015)

Maria went on to say she had attended several funerals of patients throughout her years of volunteering. This supports findings of Morris et al (2013) who listed funeral attendance as one of several coping strategies which individual hospice volunteers use to cope with stress in EOLC. Maria explained that in her role as a volunteer driver, she had formed relationships with not only the patient themselves, but also members of their family whom she met when taking an individual to and from their home. Maria saw attending the funerals as a natural extension of her role and arguably gained some personal comfort given the emotional work her role had involved.

One of the volunteers, Clare spends much of her volunteering time talking with patients, staff and families. This extract encapsulates the unpredictable nature of her role and the emotion work contained within it, in this case extending to support a member of staff:

Some days I can come in and, it can be quite sort of not casual but you know just chatting to patients and families about everyday things And then I might, I might come in another day and it's, it's really kind of like deep and meaningful…….I've kind of got to really kind of centre myself to cope with whatever kind of the patients and family, urm, spring on me …. I support the staff as well. I have lots of conversations with staff like for example I've just had a long conversation with another volunteer in the kitchen….. she gives out the tea and she's kind of got to know two young patients who died just recently she was quite upset actually I don't think they have the formal support,….. so that was just a kind of a casual conversation that happened in the kitchen, you know it wasn't planned. (Interview 17/07/2018)

She went on to talk about her own ways of managing the emotion work inherent in her role drawing on her previous experience of working as a MacMillan nurse:

I do reflect on the work that I've done with patients and family and staff when I leave the Hospice, or perhaps just sitting in the garden for half an hour before I leave, just to look at

areas where maybe perhaps I should have, perhaps I could have said that, or introduced this. So it's just a learning curve really for me is that. I reflect on the situation usually before I go home or in the car going home. It doesn't build up because, urm, probably because of my experience in this area. So I don't, I don't take it home and fret about it.

(Interview 17/07/ 2018)

Moreover, because of the specific volunteer role she has at the hospice, she can also rely upon support and supervision from paid members of the team with whom she works:

X is around for supervision…..I think the formal part of supervision has probably only happened twice but I used to work with X on a Monday and there's a lot of informal supervision that goes on. And you know, like I said earlier she's always said my doors always open ring me….. Emma as well the other Chaplaincy Volunteer we've kind of got to know each other a little better so there's that comradeship and the support there but also, I feel now that, urm, you know I share the office with the Social Workers, so, you know, we do a lot of talking And there is a lot of support going on within the office as well So I never ever feel alone.

It is worth noting that this level of formal support was quite unusual and not available to all of the volunteers in the study. This extract from the data provides an example of what Brewer (2000:17) refers to as a 'negative case', as discussed previously in Chapter 4. It would appear that this formal support and supervision was a consequence of the working practices of that particular team which had been extended to include the volunteers who were working within that team. Furthermore, Clare stressed the importance of her working biography which had given her useful tools and confidence to draw upon in dealing with emotion work.

A number of the volunteers did not appear to have sought any support in relation to demands of emotion work. Some were keen not to want to 'bother the staff', others found their own ways of dealing with distress they encountered and there were some individuals who 'counted their blessings'. It is also possible that few had witnessed specific 'triggers' as referred to by the member of the medical team. With regard to the ongoing cumulative impact of sustained emotion work which a member of paid staff in the hospice might be exposed to, in the case of most of the volunteers, the study suggests that as a consequence of their liminality, such effects are tempered by their volunteering time being limited to a relatively short period each week and offset by the positive benefits they experience through their volunteering.

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 organisations 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 this hospice, whilst this cannot be ruled out, I would argue that in this study most staff and volunteers are unaware of the complexity. As a trustee, before doing this research, I now realise that I had not fully appreciated what some volunteers may be exposed to in the course of their work, especially those who are assigned to what may be seen as mundane and simple roles. Furthermore, I would suggest it may be safe to assume that the same may be true of others who work with volunteers. In gathering the data most individuals have needed considerable prompting during the research process to acknowledge complexity and challenge within their role, but having done so were able to provide examples, confirming my own interpretations in the setting. Furthermore, there was an apparent what I would call 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' or 'I'm *just* doing……' were recurring phrases in their narratives. This resonates with Lean and McDermott (2009:113) who argue that to combat what they refer to as 'I'm only a volunteer syndrome', it is important that volunteers receive feedback that they are essential and valued members of the team, a view which I would strongly support.

The non-canonical aspects of the volunteer role are often those which require emotion and care. As discussed in Chapter 3, a body of literature exists which explores emotion work in the context of nursing. Emotion work is described by Bone (2002:148) as: 'the least visible and least accounted for dimension of nursing'. Moreover, Theodosius (2008) suggests that it is where there is an absence of emotion work in nursing, that it becomes more visible. Whilst most of the volunteers in this study were not directly involved in nursing, they were part of the holistic care provided by the hospice and often involved in interactions and care of those with whom they came into contact including: patients, their families, paid members of staff and the general public. The research has shown emotion work to be an important and arguably less visible part of the volunteer role. The impact of such work can be both beneficial to and demanding of volunteers and a variety of different strategies for coping and support can be helpful in minimising negative consequences.

Emotion work and the gift of time

One clearly defining characteristic which distinguished all of the hospice volunteers in the study from paid staff is that they *give* their time to the hospice *freely* and receive no payment in return. Bone (2002) makes an inextricable link between emotion work and the time required to carry that work:

> The biggest structural constraint to doing emotion work is the lack of time ……..Time spent doing "invisible work" does not count in production models that treat time as a commodity.
>
> (Bone 2002:45)

A gift is typically something which is freely given to another. A gift can take many forms: for example, it may be useful to the recipient, it could be a token of thanks; it may be given with the intention of getting something in return or conversely with no expectation of reciprocation. The time which each volunteer gives is determined by each individual. The participants in the research carried out most, if not all of their volunteering, at the hospice and did so on a regular basis. It is important to note that the hospice in the study also includes within its registered volunteers, many individuals who are involved in fundraising activities; such their volunteering is not necessarily done on a regular basis. As explained in Chapter 4, these volunteers were deliberately not included in the study. Most of the volunteers in this research offered at least 3-4 hours a week on a regular basis, for example a morning, afternoon or evening volunteering on reception, driving or in the day hospice or working in the in-patient unit. However, some volunteers gave significantly more time, especially those involved in more than one volunteering role. For example, Wendy is a trustee but also volunteers for at least one shift on reception each week at Fernbank and a weekly session in one of the hospice charity shops. Trustees attend monthly Board meetings which typically last at least 2 hours but in addition they are all involved in different sub-committees which again take place at least monthly and last up to two hours per session. All trustees spend time preparing for meetings, reading documents and responding to emails and telephone calls. In addition, individual trustees give their time to work with and advise members of staff, dependent upon their skills and professional knowledge, which staff often rely upon to support their own role. Typically, this could be a trustee with a financial background who often comes into the hospice to work with the senior financial manager or another trustee who has vast experience in retail management and he works with and advises the retail manager who has responsibility for the hospice shops. The Chair of Trustees explained that she spends several hours a week at the hospice working with the Chief Executive and other senior members of staff in addition to the administrative work which is integral to the role. Whilst I did not quantify individual trustees' use of time, speaking

with them it was evident that their gift of time was considerable and cumulatively would equate to many hours in each year.

The volunteers' gift of time ensures that some roles within the hospice are carried out entirely by volunteers. Where this is the case, it requires many more individuals than might be the case if paid members of staff were recruited to that role. For example, at the time of the research there were 25 volunteer receptionists who between them provided cover on reception seven days a week, including evenings and bank holidays. The number required is considerable because each volunteer would usually work in reception for a morning, afternoon or evening, unlike a paid receptionist who would be employed full time or on significant part time hours. Some of the volunteer receptionists preferred to work alone but often, especially during the busier periods I noticed there would often be two volunteers working together. Speaking to individual volunteers and attending their monthly meetings, it became apparent that some individuals had limited availability and their volunteering took place at very specific times and days whilst others were extremely flexible in their gift of time and made themselves available, often at very short notice to cover for holidays, illness or unexpected absences in addition to their usual timetabled allocation, ensuring the reception area was consistently covered by volunteer receptionists such that paid staff were rarely required to undertake that role. In the case of the receptionists, there was sufficient flexibility to accommodate individual volunteers' preferences with regards to their availability and their preferred ways of working. This is beneficial to both the individual volunteers involved and the organisation (RQ1); the different preferences of volunteers are accommodated, which is important in sustaining their ongoing contribution, whilst the reception work is carried out effectively and with a much-reduced economic cost to the hospice. However, those beneficial outcomes are predicated upon a closely knit group who work together towards a shared goal of ensuring the smooth running of the reception area and who are prepared to be flexible, tolerant and supportive of individuals within the group. It was interesting to note that the management of the volunteer receptionists was shared between a paid member of staff and one of the volunteers. The way in which this team and others in the hospice work and learn is discussed further Chapter 8, as it relates to RQ2 and RQ3 and in particular the application of the concept of communities of practice in a hospice setting.

Observing volunteers and speaking to both staff and volunteers, it was clear that in some cases, the volunteers' gift of time enabled paid staff to allocate tasks to a volunteer, thus enabling them to do additional work, or if a volunteer had complementary or additional skills or abilities to enhance the role of the paid member of staff. The member of staff with whom Bryony works explained to me how they work together, and Bryony's volunteering

complements and supports her in her paid role:

She is over and above what you'd expect a volunteer to do She is my, definitely my assistant. But she thinks strategically and with her I'm managing to get things done. If Bryony ever decided to stop, I would be scuppered. (Interview: 6/10/ 2017)

Here, the contribution of the volunteer is evident, as was the interdependency which had developed between these two individuals.

The two Hospice Biographers in the study are both involved in a project which as explained earlier in the chapter is a recent initiative which aimed to offer patients the opportunity to make audio-recordings which they can give to their relatives or loved ones. The decision was taken to allocate these roles to volunteers, rather than paid staff, the rationale being that the time involved to carry out such an activity was so considerable that it would not be practically possible for one of the nurses, social workers or chaplains to take on the additional workload. Pam talked to me about the value and benefit she believed such activity can be for patients:

I mean one of the women I've been working with over the last few weeks, you know, she feels like she hasn't got much of a story either. And, actually sitting down with her she's got so much to tell actually. It isn't, you know she hasn't had a complicated life. She hasn't been off travelling the world or anything like that. But she's had a life . And she's had you know, she's had a busy, busy family and all the rest of it. So allowing her the time to actually think about it and say wow you've got lots to talk about. So you know, but her children will really love to hear that. It takes time, yeah, yeah, that's the biggest factor. (Interview: 6/11/ 2018)

The time that Pam is able to offer to undertake this activity augments the care the staff are able to provide and adds to what the hospice is able to offer to its patients.

Another example of a volunteer working closely with paid staff was provided when I observed Sheila who volunteers in the finance office. On the day I was with her she spent the morning counting money in cash and cheques totalling over £8000, using a machine to separate the coinage, recording the monies systematically on a spreadsheet the totals of which she balanced at the end of the session. It included donations which were in envelopes and included letters which required individual acknowledgment of receipt. The counting was an important but very time-consuming job which has to be done accurately and on a regular basis; it was clear that Sheila had the requisite skills and experience to take on a

considerable workload which would otherwise have fallen to one of the paid members of staff in the team to complete. We discussed the session together later:

I was here, usual time, half past nine and I didn't get away until about twenty past one and I just had a sandwich at my desk in between because I did the balance yesterday…….. There was about nearly eight thousand pound and a lot of that was in, you know, big bags of coins and yes we had a lot of cheques, but you know, all those bags had to be counted.
(Conversation following observation: 3/09/ 2014)

In the time I observed Sheila, although she spoke to me and the two staff members in the office whilst she was working, and explained to me what she was doing, she was extremely focused throughout. This was a striking feature about other volunteers and their approach to work when I was observing in the hospice. Sheila did not take a break and it was her intention to complete the task before she left for the day. Her experience of working in a bank enabled her to work independently of the two paid members of staff and she went on to tell me how the way she works reflects her many years of working in banking, to the amusement of one of the paid members of the finance team:

She laughs at me because having worked in a bank, we always had to have the notes the same way, you couldn't have them all mixed up, so I'm sorting them all out and she just laughs at me…..I think you've got to, as a volunteer they've got to be comfortable what they're doing, because I think if they're not, they perhaps don't think as though they're contributing in the way that they should do, because you want to do a job well.
(Conversation following observation 3/09/ 2014)

Sheila normally volunteered until 12.30 but she told me that time varied depending on the work she was doing. Clare, who works with the chaplaincy team when asked about how often she volunteered explained that she volunteered once a week, every Tuesday morning and she left when she was ready, when she felt that she'd done all she could. Similarly, commitment and flexibility in carrying out her work as a volunteer was exemplified by Lucy, who works with the nursing staff on the inpatient unit:

You know I work as hard as they do and I make sure I do. I make sure, urm, I was kind of only once gone early because it was my daughter's prom and I needed to go home. But I have the same kind of work ethic and principles as they do. I wouldn't be any different. I suppose potentially you could say 'Well I'm sorry I've got to go', because there's nothing to stop you but you, but you have that inbuilt I'm not going to do that. (Recorded conversation: 17/07/ 2018)

The flexibility of volunteers enacting their gift of time in practice is often linked with the unpredictable nature of their work and not always being sure from one session to the next what they will be doing. Pam provided one such example from her volunteer role within the hospice chaplaincy:

But for example last Wednesday, I was ready, nearly ready to go. And I was just walking down the corridor and I saw someone and this person just started talking to me about things. Urm, so you do find that, it's usually just in passing it's not usually a structured thing, Not organised, no you know, it's just from my experience, it's just sort of you know, when I say how are you? I have to be prepared for, you know …..that it's not just, it's not just patients.

(Interview: 6/11/ 2018)

Here she was responding to a person in the hospice who needed to talk. Pam took the decision to stay and have that conversation, rather than deferring it to another time or passing it on to someone else. These was typical of many examples demonstrating the flexibility and generosity of volunteers in gifting their time. Volunteers often extended their volunteering session to ensure for example, a particular job had been completed or to ensure continuity where another volunteer had been delayed. When I observed volunteers, it was also clear that they wanted to fill their time and the receptionists in particular would ring up the fundraising department if there was a lull during the day and ask them if there were any jobs they needed doing. This was confirmed by one of the members of staff who told me:

If the reception area is quiet, the receptionists will always call up to Fundraising and say look, there are no phone calls, there's nobody coming through the door, have you got any envelopes I can stuff, I'm really bored. So, on a simple level like that, they bring loads to the Hospice and they're proactive, definitely. (Observation: 2/03/ 2015)

That said, an advantage to some of the volunteers inherent in volunteering was that they could say 'No'. Where their gift of time to the hospice might clash with other things such as holidays, childcare or family commitments, a volunteer could be unavailable and staff and other volunteers at the hospice would need to work with flexibility to accommodate their absence or on some occasions accept that gap could not be filled. Based on my research findings, I would argue that 'time' is worthy of significant consideration in the work of hospice volunteers. Volunteers all give freely of their time and as such it distinguishes them from paid members of staff. If time is central to emotion work, which is itself an essential component of high-quality care, the donation of time by the volunteers is instrumental in supporting and extending the care which the hospice is able to provide.

I'm only a volunteer: everyday conversations and 'just being there'

Building on the work of Goossensen et al (2016) and Vanderstichelen et al (2020) discussed in Chapter 2, this study lends weight to the argument that 'being there' is an important aspect of hospice volunteering and that presencing' and 'performing tasks' are not contradictory (Goossensen et al 2016:190). During the course of their work, it was evident that many of the volunteers spent time 'being with people'. This might be the receptionist who I observed sitting talking with a patient who said he wanted a change from the ward and had wandered into the reception area. (Waiting in reception before a meeting: 14/12/2014). It turned out this is not an uncommon occurrence with some of the patients on the inpatient unit. The receptionist made a decision to move away from the reception desk where she had been working and sit with the patient on the sofa to chat with him. In the reception area there are items on sale to raise money for the hospice and most of the conversation revolved around the items on display. Whilst on the surface this might seem an inconsequential conversation, it is likely that it was of benefit to the patient to have a change of scene, away from the ward area and an opportunity to talk about 'everyday things'. The volunteer looked at ease, unhurried and focused on the patient while their conversation appeared relaxed and punctuated with laughing. This is an example of emotion work described by Bolton (2000:584) as 'gift exchange', where the volunteer allocates themselves the time to offer extra emotion work as a gift to patients, which is given with little or no expectation of a return on their investment other than the satisfaction they derive from being able to `make a difference'. Observing in the day hospice it was evident to me that an important aspect of the role of volunteers was sitting with patients, using their time to be with them, having conversations, sometimes doing activities but often not. Whilst the volunteers were talking with patients, 'being with them', it enabled the nurses as well as talking to patients to engage in some of the necessary physical and clinical tasks which patients required as part of their care. During one of my visits to the day hospice, I spoke with a patient who told me about his experience; this brief extract highlights the value he placed on people being there and those everyday conversations;

I thought it was somewhere to go to die. Well I am doing but … there's everything you want, people are always there and there's the chit chat. (Field notes: 17/02/2015)

There was much evidence of a relaxed and easy interaction between volunteers and paid staff in the day hospice and the time provided by the volunteers' presence enabled and supported the work of paid staff as well as providing emotion care to patients. One of the senior members of the nursing staff in the day hospice chatted to me about the ways in which paid staff in the unit work with the volunteers, and the importance to the patients of those 'everyday conversations':

There's something about volunteers, the way they interact with patients and maybe sometimes a patient doesn't always want to talk to a nurse…….. We try and make the Day hospice so it's not very clinical in the aspect, but they're probably fed up of hospital appointments, seeing doctors, seeing nurses and actually just to have a chinwag or whatever…. (*Visit to Day Hospice:* 17/02/ 2015).

When I was in the day hospice, one of the volunteers spoke to me about her work and this extract exemplifies the value to patients of 'ordinary conversations', juxtaposed with the necessary clinical interventions which are all part of a patient's care:

I mean patients come here and they don't want to be reminded of their illness all the time…And in fact one new man in the Day hospice today and I just went to introduce myself and then one of the staff came with a list of questions and he said 'oh there's a lot of questions in this place isn't there? You know I could be on Mastermind all these questions I'm being asked.' Because they don't always want to go through their story, and I acknowledged that with him. They just want to be as normal as possible. Plus, it's exhausting going over your story. And a lot of patients have to do. You know each time they go back for their outpatient appointment you know, any professional they come into contact with, they very often ask a patient to repeat their story. And it's exhausting for them. So, it's nice to introduce some hobbies and interests.

(Recorded conversation: 17/02/ 2015)

This particular extract from the data provides an illustrative example of an important theme which emerged during the study relating to the emotion work of volunteers and their liminality. Volunteers whilst engaging in ostensibly ordinary conversations and activities provide a unique function which contributes to the holistic care of patients and complements the clinical care provided by paid staff.

One of the younger volunteers, Saeed spent much of his volunteering time talking to patients on the inpatient unit. As mentioned earlier, Saeed is hoping to train to become a doctor in the future. I asked him to tell me what sort of things he talks about with the patients:

It's usually family. Family is always a good one. Visitors, the kind of day to day what happens. What their interests are, or have they been outside - things like that. Then you know, as the conversation develops, we tend to kind of go with it. It can be anything, it can get to like religion, or you know like school. Things like that yeah, cos when I first started, I'd only just started college, so they'd be able to tell me about their new experience of being in the hospice and I'd be able to tell them about my new experience of being at college. None of them that I've

met have ever had a problem with, you know, recognising their illness or anything. They're all quite, you know, matter of fact about it and just say you know that's how it is. Sometimes, a lot of them when they hear the career path I wanna do, they all start to tell me a bit more. I think that they say, 'I'm telling you this you know so that you can use it in the future for something to look back on'.

It's just nice to meet people with new experience, I mean there was a gentleman I was talking to, urm several weeks ago and he'd actually been part of the D Day Landings. So yeah, things like that, er, it was crazy to think you know you're sat with these different people. And some people had set up a clinic in South America for like children and things like that ….and it was amazing to see the kind of width and breadth you have and just on your doorstep.

(Interview: 21/10/18)

Such conversations with patients take time, but Saeed said it was often how he spent his volunteering session. This data suggests such conversations and time spent are beneficial to both the patients and this volunteer and Saeed recognised this himself, telling me it was something he really enjoyed and was one of the reasons he intended to continue with his volunteering. Another of the volunteers, Clare, with whom I talked to about her role, was herself aware of the importance of 'being there' with patients and spending time with them:

I think the being there really is the important thing and to be able to, to gain that trust….And to gain that trust, it's not always about going in deep and meaningful. Urm, its, about, about just chatting about everyday things and one thing leads to another doesn't it….so that ordinariness is what's important, definitely. (Interview: 17/07/18)

Clare volunteers in the Chaplaincy team. She is not ordained but her main role is to provide support to anyone within the hospice including staff, patients and families.

I'm not a trained chaplain, I'm just a volunteer. It's not about religion, it's not about kind of pushing anything down patients and families throats It's about helping them, it's about befriending them And just getting alongside them and helping them to find some meaning really to what they're experiencing and that might mean anything, urm, it might be God, It might be some gardening, It might be, urm, grandchildren. I've just had a conversation with a patient out in the garden and her two daughters and she loves the garden. There she is outside with her two daughters, a great big oxygen cylinder… And, do you know it was a lovely conversation. (Interview: 17/07/18)

It is worth noting that Clare underplays her role referring to herself as being 'just a volunteer'. Ironically, later in our conversation Clare was talking about her experience working alongside paid members of staff:

And I have to say that I have found that I've never felt that anybody's said, 'Oh she's only a volunteer'. Like, this morning I was talking to a patient and a nurse had to come in to do something. Excuse me Clare, sorry to interrupt. You know, so they're always very courteous and respectful of my role. (Interview: 17/07/18)

This perhaps implies something about Clare's own perception of her position as a volunteer, rather than something she has inferred from the paid members of staff. However, it was not uncommon to hear volunteers unconsciously underestimating the work they were doing with words such as 'just' and 'only' not unusual in their narratives. One such extract from the data, was when Tom recalled an incident on the Inpatient unit:

There were a lady once, her son came in. He brought her dog in for her and she were obviously pleased to see it, …. I went back in later on and she were crying. So I says, 'come on, I'll sit with you'. I just sat with her, you know, and I think it was the upset of she'd seen the little dog and then all of a sudden, she were left on her own. I mean I didn't put my arm around her or anything, I just sat with her and I says if you want to chat about it, ***……****you know, and it were just something and nothing, you know.* (Interview: 3/11/16)

Those simple acts of 'just sitting', 'just chatting' or 'just saying nothing,' can be invaluable components of human interactions but particularly in the context of hospice care. Such actions require an investment of time, and the presence of volunteers in the workplace can extend the capacity for these essential parts of emotion work and care to be enacted in the hospice.

Summary

This chapter has drawn upon the data and relevant literature to examine in detail the nature of volunteers' work in the hospice with discussion and analysis relating to RQ2 and RQ3 and further defining features of the liminal space of volunteering being brought to the fore. The hidden complexity of certain volunteer roles has been made explicit, particularly with regard to the social and emotional components of such roles, and explained using the concepts of non-canonical practice, workplace responsiveness and emotion work. The work of volunteers included many examples of the often illusive yet vital role of emotion work in hospice volunteering. Such work was shown to be predicated on the 'gift of time' and gave weight to the importance of 'being there' and everyday conversations, which were shown to

be essential components of care and of particular significance in the context of hospice volunteering. The liminal space then represents a place where volunteers can engage in overtly simple tasks which can be juxtaposed with complex emotional work and social interaction and are central to the holistic care and ethos which hospice seek to provide.

Chapter 8 Learning in the Liminal Space of Volunteering

Introduction

The findings so far have included discussion of motivation, working relationships and support, and the nature of the work which volunteers do in carrying out their role. This chapter is the final part of the data analysis where the focus of attention turns to learning, and how learning is enacted in the context of hospice volunteering. This chapter is pertinent to RQ2 and RQ3 and specifically considers what characterises the workplace learning of volunteers and the extent to which some of the existing theories of workplace learning are helpful in conceptualising this aspect of hospice volunteering.

As discussed in Chapter 3, a range of studies of workplace learning examine learning associated with a formal workplace and paid employees whilst other studies have explored learning in the context of work in the home and family and associated issues of gender and care (Daniels 1987; Livingstone 2003; Billett 2004; Fuller et al 2005; Benozzo and Colley 2012). All of these were worthy of consideration since they have some relevance to work and learning in the context of a hospice setting. The philosophy of hospice care was laid out in Chapter 2, but in summary the aim is to demedicalise death and dying, whilst providing excellent specialist and holistic EOLC. A hospice then could be said to encompass aspects of both a formal workplace and home care and as such presents something of a hybrid. The ethnography has already revealed the work of volunteers to be complex and nuanced, and uncovering and understanding some aspects of volunteers' learning was similarly challenging.

Formal Learning for volunteers

Volunteers in the study needed prompting to recognise and articulate their experiences of learning, and in conversations they initially tended to hone in on formal, cognitive or skills-based aspects of learning. For many, their first experience of formal learning as a volunteer at Fernbank was attending a Volunteer Induction event at the start of their volunteering. However, there were also some long serving volunteers for whom induction events and other formal training were not part of practice at Fernbank when they commenced their volunteering. It is now a requirement that all new volunteers attend an induction event. Depending upon their role and length of service, some volunteers in the study had also attended some mandatory training including manual handling and health and safety but with the exception of the two hospice biographers, there was little awareness on the part of the participants of other training available to them in the hospice. Some described learning from other volunteers when they first started their role at Fernbank, working alongside a more

experienced volunteer for their first few sessions, others said they had shadowed a member of staff in the initial phases of their volunteering. There was no evidence of volunteers being made aware of, or trained for, the complexities associated with workplace responsiveness which as explained in the previous chapter, was inherent in many of the volunteer roles.

Induction sessions for new volunteers take place every few months at Fernbank, depending upon the numbers of volunteers recruited in a particular period. All new volunteers are invited to attend such an event, but depending on timing, some individual volunteers will already have commenced their volunteering role before they attend Induction.
When I attended one such event, functional aspects of hospice activity and its aims and philosophy formed a central part of the formal induction process.

There were 11 volunteers, and the session was led by the Volunteer Co-Ordinator and the Facilities Manager. The room was arranged with tables and chairs in a semi-circle and each volunteer was given a pack of general information about the hospice. I was rather surprised that although the staff both introduced themselves, there were no more introductions so there was no opportunity for volunteers to get to know each other. …. The session started with a brief history of the hospice and some stats of use of the hospice covered basic mandatory training relevant to all volunteer roles, including: health and safety, safeguarding and confidentiality. It was all done with reference to Powerpoint slides and it was very much 'one way traffic' with very little input from the volunteers….. All very welcoming and there was great emphasis on 'Team Fernbank' – logo on the slides. It was very much a session of two halves. The first part was very much focused on general information about the hospice including history and ethos and much emphasis on value of volunteers 'worth your weight in gold' 'crucial member of the family', 'things might make you sad but people are there for you'. Second part : confidentiality, health and safety, procedures. There was an opportunity for Q and A – there were none. Code of conduct signed and returned. It all seemed rather functional and about giving out information. (Field notes 6/10/2017)

The session also included an optional guided tour of the hospice, which for some of the volunteers was their first opportunity to see the working hospice environment. For many volunteers this was the only formal learning undertaken. During the time the research was taking place, a member of staff was working with one of the volunteers to develop a package of online training materials for volunteers. The intention was to try to reach as many volunteers as possible and offer them the opportunity to complete the materials in their own time, rather than attending sessions at the hospice. The project was also seen as a means by which some mandatory training and updating could be offered to volunteers. However, in

the early stages of the project it was evident that electronic training packages would not be a suitable means of learning for all volunteers, due in some cases to limited access to technology at their home or for others their ability to use it. Furthermore, there was a concern by some of the staff that some volunteers would not see this additional training as something they would want to complete in addition to their volunteering time at the hospice. The approach to formal training was another example of methods used for paid employees not necessarily being appropriate for training those inhabiting the liminal space of volunteering. Where online training packages might be used as a tool and in some cases a requirement for paid employees in workplaces, including healthcare settings, the hospice volunteers represent a very diverse group of individuals: some may be very receptive and welcome the opportunity of training, others may feel they should conform, whilst others may not choose to engage.

Exceptionally, there were some volunteering roles which did attract explicit formal training. In the case of the hospice biographers, they went to a day of training at another hospice and they attended this event with two paid members of staff who would be acting in a supervisory role during the project. This was formal training which the volunteers concerned said they had found essential in taking forward the work they were being asked to do. It had put them in contact with staff and volunteers in other hospices at the training session who had a shared interest or expertise in producing audio biographies for patients.
Another example of formal training was for the receptionists when a new till system was installed, including the implementation of electronic card transactions and recording of Gift Aid for specific donations and purchases based in the reception area. This training was offered to the receptionists who would be directly affected at the time when the new systems were introduced, but it also became apparent when I spent time with the individual receptionists, that subsequent learning had occurred over time as they used the new systems in practice. This learning was variously described by the volunteers as: ‘trial and error’; ‘asking for help from volunteers or staff;’ or ‘explaining to new receptionists who were unfamiliar with the system as they joined the team’. Such examples of learning would resonate with Brown and Duguid’s (1991) concept of ‘learning-in-working’ which they argue ‘represents the fluid evolution of learning through practice’ (1991:41).

In summary, in terms of formal learning, there were some training opportunities made available to volunteers at Fernbank, and the current policy required all new volunteers to attend an Induction event. In addition, there were some specific roles which carried with them particular training such as Basic Food Hygiene training for volunteers in the kitchen or housekeeping roles. However, the ethnography found the main site of volunteer learning

was that which takes place as a consequence of enacting their role in situ, through what Fuller and Unwin (2005:24-25) term 'learning as participation, which, referring to paid workers they describe as: 'participatory activities such as interactions between employees, undertaking tasks and through playing their work roles'. Considering learning from this perspective, using an ethnographic approach, was helpful in exploring this aspect of volunteers' workplace learning.

Informal learning in the liminal space: been there, done that. The importance of work and lived experiences

Carrying out the ethnography led me to conclude that much of the volunteers' learning is a consequence of them being immersed in the setting where they are exposed to EOLC and the culture and practices of the hospice. This resonates with the position of Hodkinson and Hodkinson (2005), that much learning in the workplace is unplanned and unintentional. Furthermore, as cited in Chapter 4, previous studies argue that an individual's previous biography has an impact on their workplace learning (Hodkinson et al 2004; Fuller and Unwin 2005) and this is particularly relevant to hospice volunteers. Some of the volunteers in the study were able to talk about knowledge, skills and experience relating to their working biographies which they had acquired in previous paid roles and how they apply and adapt these to their volunteering role. One volunteer had many years working in finance and was now applying her skills and expertise to her role in the finance office at the hospice. However, she had also previously volunteered in the reception area and again she felt her working experience had been transferable to that role. One of the drivers had worked for many years as a radiographer. She was now retired but felt that her years of working in a healthcare setting equipped her well for what was involved in her role, driving patients to and from the day hospice. A trustee spoke of how she had been able to transfer her knowledge of working in financial service to the hospice. She admitted that 'I still don't understand all the medical stuff,' but she was surprised how many parallels and similarities in terms of governance and regulation there were with her own area of work. However, she had found it very interesting to learn from the senior clinicians in particular how what she already knew was relevant to the hospice context. A number of the trustees had joined the Board as a consequence of their skills and expertise in particular areas and for them much of their learning had been related to the transfer and application of knowledge and expertise to a different context. In addition to their working biography, significant to many of the volunteers in the study was their life experience, including their experience of personal bereavement (Baugher 2015), and hospice care.

Volunteers had in some cases been able to transfer their knowledge and experience seamlessly from one context to another whilst others described how they had learned to adapt. Stella, who had worked for over 30 years in an engineering company and started volunteering when she retired, shows in this extract how she has learned to adapt to different workplace cultures and practices at Fernbank:

The most difficult thing, change, in the years since I was at work and now, in the business world, because this is a business, is the use of Christian names - I shouldn't say that, first names, and I'm still struggling with that because we've got two (Marias) and three (Clares), but we've only got one (Richardson), we've only got one, you know, second name, they tend to be unique. So when somebody rings up and says can I speak to (Clare)? Well, which one? Well, I don't know. So that's a bit of a struggle. But I'm not going to be able to change that workplace ever, I can't think what the word is, common use now ……. culture, yeah'.

(Observation 31/7/2014)

The hospice volunteers between them comprised a wide and varied range of knowledge and expertise emanating from working history including: telephone skills; confident interpersonal skills; and competent IT skills; experiences emanating from senior management positions; legal and financial expertise; and volunteers who had worked in settings such as the NHS and the voluntary sector. As noted in Chapter 2, Doyle (2002:9) asserts that hospice volunteers do not constitute a group of 'untrained people, with hearts of gold and with some time to spare to help those less fortunate than themselves' and given findings from this ethnography I fully endorse that view. Furthermore, whilst it is in the interests of the organisation to acknowledge and reap the benefit of this expertise within the volunteer cohort, I would argue it is equally important to understand that volunteers need to learn to apply and adapt such skills, knowledge and expertise to the context of a hospice.

When volunteers take on their role, there were many different accounts of how they learn and the extent to which they relied upon other individuals or groups. In the case of the receptionists, one member of staff was responsible for managing the group and she was supported in this by one of the longest serving volunteer receptionists. Speaking with individuals who had been in that role for many years, it was apparent that the role had become more demanding over time and individual volunteers are now introduced to their role with more support and guidance than had been their experience. New receptionists are now paired up with a more experienced volunteer for the first few sessions they volunteer. That said, the line manager explained the experiential approach which is often taken when introducing the new volunteer to their role:

You can always tell if they start at nine and finish at one, by about eleven, the receptionist will say to them right, you answer that phone then x, and they force them to do it, so no, I think all of us see little point in having volunteers who just watch. I think everybody understands the concept of doing it is the best way to learn.

(Recorded conversation: 10/06/15)

Some of the volunteers told me they had learned to recognise limits of their knowledge and expertise; they gave examples of where they felt a decision to be taken was beyond the scope of their role and needed to consult with someone more senior, usually a paid member of staff. However, there were examples where volunteers were clearly reluctant to 'bother' paid staff who were 'far too busy' and individual volunteers preferred to work things out for themselves where possible, 'learning through practice' (Brown and Duguid 1991:41). I would argue that this independent approach to learning through practice may be bound up with the volunteer's commitment to the work and ethos of the hospice, highlighted previously in the thesis, and that by carrying out their role as a volunteer they wanted to free up the paid staff to focus on their own jobs within the hospice.

Communities of practice: do they work in the liminal space of volunteering?

In the time I spent carrying out this ethnography it became apparent that some of the volunteers were either loosely, or very closely aligned with specific, organised groups or teams dependent upon their particular volunteering role. Some of these groups comprised volunteers, but much more commonly were made up of both volunteers and paid staff. However, there were other volunteers for whom attachment to specific groups of volunteers was much less evident. For some this was because their role required them to work quite independently and away from other volunteers or paid staff; there were others who volunteered in more than one role and did not align with any one specific group; there were also individuals who carried out their volunteering session independently and did not choose to get involved with activities such as meetings or training events, beyond their designated volunteering shift. Furthermore, it transpired that most volunteers in the study generally only made connections with other hospice volunteers who either shared a similar role or whose volunteering shifts at the hospice coincided, with the exception of networks which existed through social media. That said, all of the volunteers I encountered in the study whether or not they were attached to a distinct group, nonetheless were connected and actively involved in the hospice and there was evidence of situated learning occurring as a consequence of their volunteering activities. It is important to emphasise that a discernible group of people does not necessarily constitute a community of practice (Wenger 1998), and

the overriding essential characteristic of a community of practice is a 'socially configured space that necessarily involves learning as an aspect of membership' (Tummons 2018:4). In response to RQ3, I will now consider the extent to which the concept of communities of practice can provide a useful theoretical framework to examine the informal, situated learning associated with hospice volunteering. Wenger et al (2002:34) provides a definition of a community of practice:

> A group of people who interact, learn together, build relationships, and in the process develop a sense of belonging and mutual commitment.

As detailed in Chapter 3, Lave and Wenger (1991:100-101) laid out certain prerequisites for membership of a community of practice:

> To become a full member of a community of practice requires access to wide range of ongoing activity, old-timers, and other members of the community; and to information, resources, and opportunities for participation.

Brown and Duguid (1991:49) draw attention to the value and often informal nature of communities of practice. They refer to these informal communities of practice as 'noncanonical communities' which are described as:

> More fluid and inpenetrative than bounded …….. and their shape and membership emerges in the process of activity, as opposed to being created to carry out a task.

These definitions do resonate with the experience of some of the volunteers in this study. Turning to membership of communities of practice, as explained in chapter 3, Lave and Wenger's initial studies focused on the learning of apprenticeships and how newcomers progress to full membership of the community. Whilst this relatively linear progression might explain the situated learning of novices, when applied to the volunteers, I would concur with Fuller et al (1995 :51-52) in that:

> The theory did not pay sufficient attention to the ways in which the learning of experienced workers differs from that of newcomers …… and largely ignored the effect on communities when they import 'old timers' from elsewhere.

Many of the volunteers bring with them significant knowledge, skills and experience with them to their volunteering role as a consequence of both their employment history and their life experience. When the biography of the volunteers is taken into account, it is too simplistic to consider even an individual who is new to hospice volunteering, as a 'novice'. In considering the liminality of hospice volunteers, the thesis has already argued for an acknowledgment of some notable differences between paid workers and volunteers in a workplace. I would now contend such differences and nuance extend to volunteers' learning

in the workplace. As has been mentioned previously, in contrast with most paid members of staff who would apply for a very specific role at the hospice (eg. Fundraising Assistant; Staff Nurse; Senior Housekeeper), most of the volunteers apply in the first instance to be a 'hospice volunteer', and the particular role or roles they take on is determined later. Furthermore, in many cases, the volunteers in the study have already acquired considerable skills, knowledge and experience prior to becoming a volunteer which are required for the role they will undertake. Having talked to volunteers about their learning and watched them in the hospice, the main focus of their learning does not relate to the canonical, explicit aspects of their working role. I would contend that much of the volunteers' learning relates to three main areas: i. learning about the context and culture of the hospice in which they work ii. learning how to be a volunteer and iii. adapting their existing learning to the context of a hospice. To support that learning, volunteers access multiple communities of practice, membership of which is both fluid and flexible. Some may be 'small, self-constituting communities' (Brown and Duguid 1991:50), and in some cases the volunteer will occupy a peripheral position, whilst in other communities they might take on the position of 'old timer'. Through their membership of these communities, volunteers: 'pick up invaluable "know how"- not just information but also manner and technique – from being on the periphery of competent practitioners going about their business (Brown and Duguid 1991:50).

When an individual applies to become a hospice volunteer, they might be assumed by paid staff or other volunteers to be a newcomer or novice. A volunteer may present as a newcomer in terms of their unfamiliarity with the specific context of their volunteering work or because they have no experience of that particular hospice setting. However, volunteers do not present as a blank slate and even those who may not have experienced directly that specific hospice setting, they will nonetheless have some knowledge and preconception of hospices and EOLC. Where the volunteers in the study did have prior knowledge or experience of the setting, the nature of that experience was variable. For some it was borne out of experience as a carer for someone who had been the recipient of hospice care, for others it was attributable to having worked in EOLC whilst for others it was based on local knowledge of their community and an awareness of the services provided by Fernbank. There were also individuals who had extensive prior knowledge and experience of hospices and EOLC but had not previously been involved with the particular volunteering role they were to undertake at Fernbank. Exemplars of this would be Lucy, an experienced nurse volunteering in the inpatient unit as a nursing assistant and Clare, a retired Mac Millan nurse who volunteered within the chaplaincy team. This suggests that when account is taken of the knowledge, skills and experience which volunteers bring with them as a consequence of their biography, in a hospice context, they can exist within a community of practice as both

novice and old-timer (Lave and Wenger 1991). This supports findings of Fuller at al (2005:62) in which some newcomers to a community of practice can adapt expertise they already have to the existing community and change the community by their presence and initiatives. The study has found further agreement with Fuller et al (2005) in that a new volunteer's pre-existing knowledge, skills and experience can also be a source of new learning for more experienced volunteers and paid staff, in some cases disrupting their prior learning, whilst if the volunteer has access to the community of practice through the process of legitimate peripheral participation (Lave and Wenger 1991), they can also learn about the hospice and the new context in which their pre-existing knowledge and skills will be applied.

In applying the concept of communities of practice, it is important to first revisit the three defining characteristics of communities of practice, namely: mutual engagement; joint enterprise; and shared repertoire (Wenger 1998:73). These have previously been described in chapter 3, but they will now be considered in the light this research. These characteristics were clearly discernible from the ways in which particular volunteers and staff interacted; their mutuality in terms of working with one another and their working goals; shared resources; routines; amended routines; and particular ways and means through which practices have evolved over time. Observing people working in the hospice, face to face interaction was arguably the most explicit means of volunteers communicating with other colleagues. Electronic communications including email and social media were widely used. There were also examples of some volunteers working closely with each other and with paid staff, and on occasions providing support for one another when needed. Such support included for example, a volunteer stepping in at short notice to cover the reception area when a fellow was unavailable for her usual shift at the weekend. Similarly, some volunteer drivers were very flexible in ensuring someone was always available, even at short notice to transport patients to the day hospice, when regular volunteers were unavailable. A further feature of mutuality 'requires individuals to help each other, and to know how to give and receive help rather than to try to know everything yourself' (Wenger, 1998:76). There were many examples of individuals helping one another such as the volunteer receptionist who spoke to a member of staff in the adjacent office for clarification about restrictive visiting arrangements for a particular patient. However, there were also some situations where volunteers did act alone, rather than asking advice, as well as individual volunteers who said where possible they preferred not to ask for help. In those situations, as previously mentioned, the individuals did not want to distract paid staff or take up what they considered unnecessary time and were sufficiently confident in their working practices to work independently, understanding there was a backdrop of support from members of staff, other

volunteers and shared resources. Some volunteers and staff also routinely came together either for meetings or for social events outside the hospice.

The volunteer receptionists were a very clearly defined working group in the hospice and could be said to constitute a community of practice. When they are working, individual receptionists are usually positioned at the reception desk either alone or with one other volunteer. and there is an office directly behind this area where paid members of staff are located. When I spent time in this area it was apparent that the volunteers and these members of staff were working together, albeit whilst individuals were also engaged at any one time on their own piece of work. Frequent interactions were evident, and support was available if required for example when a receptionist had to leave the desk for a short time to take a visitor to the Inpatient Unit. She informed a member of staff from the office who immediately came out to take her place at the desk until she returned. There was also a system in place whereby new receptionists were always paired up with a more experienced volunteer in the early phases of their volunteering. This group had monthly meetings, organised by some of the volunteer receptionists and to which all the volunteer receptionists were invited. Members of staff who work with the receptionists, together with those with particular responsibility for volunteers also attend. The meetings were an opportunity for volunteer receptionists to come together and for those who attended to raise concerns, be informed of changes, news and events in the hospice and particular information which directly related to their role and impacted on their day-to-day activities on reception. These meetings had an element of formality in that there was a formal agenda and minutes, juxtaposed with an atmosphere which was friendly and welcoming, much informal chat and banter and an assortment of homemade cakes which were a standard requirement of the session. When I went to observe these meetings, it was evident that for this group of volunteers, the events were an important point of regular social contact, an opportunity for disseminating information and provided a means through which issues relating to the volunteers' working practice could be shared. Minutes of the meetings were recorded and sent to all volunteer receptionists so that detail was disseminated to the group, whether or not they attended the sessions.

By contrast, the staff of the day hospice organise meetings, to which volunteers whose role is associated with that unit are invited. Those events which I attended took the form of very informal discussion but again they were an opportunity for those volunteers who chose to attend to be informed of any relevant organisational issues and raise any problems or concerns. For example, one of these meetings which I attended took place at the day hospice in the evening. There were fourteen people present at the meeting including

volunteer drivers and hospitality volunteers and three members of the nursing staff who work in that area of the hospice. Similar to the receptionists' meeting, there was a degree of formality in that there was a written agenda and minutes of the previous meeting were circulated. Otherwise, the atmosphere was relaxed and informal, everyone seated in easy chairs arranged in a circle and there was tea and homemade cake on arrival, made by one of the staff. They discussed social events which included both staff and volunteers and they also considered how they might fundraise together to recognise 20 years of the hospice. Whilst all the monies raised would go into general fund, they were keen it should be generated by the day hospice themselves and lots of ideas were forthcoming. This was suggestive of a close-knit group of staff and volunteers with a clear identity centred upon the day hospice. The agenda was not stuck to rigidly; other issues raised included concerns about an ongoing problem raised by the volunteer drivers of the obscured exit due to cars parking on the road too near to the hospice entrance. The drivers were clearly anxious, and they made it clear that they felt a personal responsibility for their patients. This prompted a wider discussion about the drivers being the first point of contact for patients. One driver said that week he had to deal with a nude patient, clearly confused when he called to collect him, and others agreed they never knew what they would find when they arrived at a patient's house. The conversation included staff and volunteers talking about the best way to tell patients in the day hospice when someone had died. As the evening progressed it was clear that the meeting was an opportunity for volunteers and staff to learn together and despite there being an agenda, the content of the meeting was extremely flexible and in the main led by the things which volunteers wanted to share with the group. It was further evidence for me as an observer of the noncanonical aspects of the volunteer role and that the volunteers whilst enacting their role can be exposed to unplanned, unexpected and upsetting events. This meeting was an opportunity for learning and enabled those volunteers and staff who attended to interact and learn together, through reflection, on some of their experiences. I would contend that this is an example of a community of practice where membership is fluid, and is a channel for learning particularly relating to noncanonical aspects of the work undertaken by some volunteers. For those volunteers who become involved in such groups, there were opportunities for learning, communication and support with and from other members of the group.

Within these organised groups there were numerous examples of volunteers who had developed ways of working together, another feature of a community of practice. One such example was what the volunteers called, 'the blue folder' created and used by the volunteer receptionists and was a shared resource kept available behind the desk. This shared resource had evolved over time and was a point of reference and a means of

communication within the group. One of the volunteers explained to me that it was a place where individual volunteers could add information they thought might be useful for other receptionists to refer to, especially those who were new or were working alone behind the desk. Examples included: protocols for allowing visitors into the inpatient unit, hints and tips for finding particular items on the IT system and some basic instructions for the till and the computer. There were also lists of contacts which had developed over time. The volunteer said she thought it was: 'getting out of hand' because of the amount of information it now contained and: 'maybe it's time we put all this on the computer'. The receptionists also each contribute to the 'log book' whilst they were on their shift, recording notes of communications they had with people coming through reception in case there was limited time for a formal handover at the end of the shift. The log book also had various post-its attached with notes and messages for reception staff.

In the day hospice, the drinks trolley round was an example of the 'shared repertoire' of volunteers and staff in the day hospice. This was part of the daily routine which took place half an hour before lunch when patients were served by a volunteer and offered the option of what was referred to as a 'tipple', before their meal. The 'tipple' was an alcoholic aperitif (sherry or brandy on the day I observed), which to an outsider might seem somewhat incongruous in a healthcare setting. However, in the context of the day hospice and to those 'in the know', it was important for those patients who clearly enjoyed their 'tipple' and looked forward to that part of the day, but also it can act as an appetite stimulant, which for some patients was an important aspect of their care.

The hospice trustees make up another clearly defined group within the hospice, constituted on the basis of their specified volunteer role, which showed many of the defining characteristics of a community of practice. The work and learning of the trustees within this group was also influenced by members of the SMT who had regular and frequent ongoing communication and interactions with this group of volunteers. Although the trustees come from a wide range of professional backgrounds, most of which were unrelated to healthcare, during the Board meetings all of the individual trustees showed they had, over time, acquired a sophisticated knowledge and understanding of aspects of EOLC and hospice practices. This was evident in the language used, the questions asked and the discussions which took place with senior members of the hospice staff who were also present at the meeting. During meetings, clarification relating to context or specialist areas was often required. These might relate to clinical, financial or legal matters for example. The answer could be provided by a particular member of staff or a trustee with specialist knowledge in that area. In some cases that trustee might be a long-standing trustee but in others a new volunteer. During the

meetings it was evident that, in terms of learning within a community of practice, the trustees and staff appeared to be working collaboratively and individual trustees, whether new or experienced, oscillated between a 'newcomer' and an 'old-timer' role, depending upon the issue under consideration. That said, a conversation with one of the recently appointed trustees provided an illustrative example of someone with considerable existing knowledge and expertise finding it difficult, as a newcomer to adopt the position of 'old timer':

I would say that we had some strong personalities there that dominated, and it didn't feel like a collective decision making or whatever and actually I felt, I felt like they didn't value my opinions and so you've got a bit of a confidence knock there …. So you've got to, it takes time for me to build that back up and have the confidence to keep pushing at something.
(Recorded conversation following a meeting: 14/09/2017)

Wenger (1998) emphasises within the interpersonal engagement there can be disagreement and conflict within the community of practice and: 'it is the shared practice that connects participants to each other in ways that are diverse and complex' (1998:77). Such tensions were evident on occasions between individual trustees and between trustees and senior members of staff, especially during formal meetings. For example, where trustees had experience of working in the private sector, there was sometimes a difference in views as to the extent to which some of those practices would transfer to a hospice. Similarly, there were examples of significant differences of opinion in discussions relating to budget and allocation of available funds, most notably linked to those characterised by cautionary approaches versus risk-taking. Arguably, this was predicated upon individual members' knowledge and experience of funding in the private sector or public sector and how that applies in the context of a charitable organisation. However, such tensions and disagreements and constructive criticism were also integral to healthy debate and did not apparently disrupt the shared practice of their community of practice. Speaking with trustees outside of meetings, it was evident that much of their learning was situated and a consequence of being immersed in hospice activity, attending meetings, spending time with individual members of paid staff and other trustees outside of formal meetings, and being provided with documentation and access to specialist information.

The groups described thus far with reference to communities of practice are clearly defined groups within the hospice, centred upon specific volunteer roles and in some cases could support non-canonical learning associated with those roles. Each of the groups comprise both volunteers and paid staff, and for each group the study found examples of the three defining characteristics of a community of practice: mutual engagement; joint enterprise; and

shared repertoire (Wenger 1998:73). However, this apparently neat alignment between Lave and Wenger's communities of practice (1991) only partly explains volunteer learning and falls short of explaining the experience of all the volunteers in the study. Such clearly defined groups were not available to all volunteers if their role was not linked to specific areas of the hospice. For example, there were no such organised groups in the inpatient or housekeeping areas. Furthermore, there were individual volunteers who seemed to operate more independently with less obvious alignment to groups which could be associated with particular designated roles. However, that is not to say there are not communities of practice to which these volunteers belong, and I would suggest that there are much less observable but nonetheless discernable communities of practice available to hospice volunteers, staff and arguably others who are affiliated to the hospice. Building on the concept of communities of practice (Lave and Wenger 1991; Wenger 1998), in their study of multiple work sites within a large organization, Boud and Middleton's (2003:13) found a variety of networks supporting informal learning, some of which met some of Wenger's definitive characteristics whilst others, they contend, reflected more loosely coupled grouping or communities. I would argue that volunteers' informal learning was similarly supported through multiple networks and communities at Fernbank, with varying degrees of formality, and volunteer membership was not necessarily limited to one single community. Findings were broadly in agreement with those of Boud and Middleton in that these multiple networks were loosely coupled and did not necessarily neatly align with all of the defining characteristic of communities of practice.

The final parts of this thesis were written during the coronavirus pandemic and during that period, volunteers were unable to be physically present at Fernbank. Despite that, creative use of social media was instrumental in maintaining important communication and interaction with volunteers, sustaining their contact and involvement with the hospice. I would contend that this represented more than a means of keeping in touch but rather provided evidence of an existing community of practice. Despite restrictions, through their active engagement within the community volunteers found innovative ways of working together to raise funds; information was shared about working practice at the hospice and how the service was continuing, adapting and evolving in the light of developing circumstances. There was also ongoing mutual support and care between the volunteers and staff in that community underpinned by their shared involvement with and commitment to the hospice.

The notion of communities of practice as a framework for understanding aspects of volunteers' workplace learning is useful in many respects. The main shortfall is in line with

Fuller et al (2005), and their contention that: 'implicitly Lave and Wenger (1991) treats their newcomers as tabula rasa' (2005:67) which this study has shown is not applicable in the case of hospice volunteers. A cohort of hospice volunteers comprise a complex group of individuals. The study has exposed this complexity associated with the hospice volunteers' learning whereby individuals could be: a newcomer to the role *and* to the context; a newcomer to the role but expert in the context; a newcomer to the context and an expert in the role or an expert in the context and in the role. Furthermore, these positions were not fixed, nor was there a linear progression, with variation over the time a volunteer volunteers. Volunteers, even as newcomers, contribute to the community and other members of that community are influenced by their presence. Wenger et al (2002 :15) emphasise the value of what they consider to be the intangible outcomes of communities, such as the relationships, the sense of belonging, trust and the spirit of inquiry they develop and the professional identity they confer to the members. These softer outcomes I would argue are important in the context of hospice volunteering: particularly when considering learning associated with workplace responsiveness and the non-canonical practices inherent in some volunteer roles, perhaps more so than those relating to skills and other more discernible outcomes.

Learning and unlearning: in the hospice and beyond

Transmission of knowledge and practice to, from and between volunteers and others at the hospice takes many forms at Fernbank. As mentioned above, there are defined groups connected by a shared role at the hospice. However, a central part of this thesis is that volunteers' informal learning is linked to noncanonical aspects of hospice volunteering. They can 'pick up invaluable 'know how', not just information but also manner and technique' (Brown and Duguid 1991:50) by being with and around other volunteers and staff. Volunteers learn about death and dying and EOLC through their conversations and interactions with patients and families, staff and other volunteers. This learning arguably occurs within a loosely coupled community integral to the liminal space of volunteering. The study has shown that in carrying out their roles, the volunteers learned about the work of hospices and the culture and ethos of the organisation. For some volunteers such learning challenged their previous understanding and assumptions. Freda, a long-standing volunteer explained her misconceptions of hospices prior to volunteering and what she has learned through her volunteering:

I mean I just thought you went into the Hospice and came out in a box, to put it crudely. But it's not like that, the number of times they go in, just to have their medications sorted and respite, which is for them and for the carer, isn't it? So, I mean and it's just such a happy place. (Interview: 11/03/2015)

This contrast between the volunteer's prior perceptions of hospices, and knowledge and understanding acquired as a consequence of her experience of volunteering in the hospice, is an example of situated learning and was exemplified by other volunteers in the study.

A volunteer, Tom, who does refreshments on the Inpatient Unit described his training for his role. As can be seen from the extract below, this focused upon the physical tasks he would be doing as part of his housekeeping role and involved him shadowing a member of the paid housekeeping staff in the Inpatient Unit as part of his first volunteering session:

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. (Interview; 3/11/2016)

This contrasted with his description of experience which encapsulates not only workplace responsiveness, but also Tom's learning about death and dying which has occurred in the process of his volunteering and specifically as a result of his conversations with patients:

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. (Interview: 3/11/2016)

Tom attributes his volunteer experience to enabling him to confront some of his personal fears of talking with others about death and dying and he went on to explain about how, at the time of the interview, he was supporting his wife and other members of her family

through a personal bereavement in a way he felt he would not have been able to do previously. For some volunteers, a significant aspect of their situated learning experience related to gaining an understanding of the work of the hospice. That learning is situated and was a consequence of that individual being physically present, 'immersed' in the setting. Saeed, shared with me his first impressions of the hospice, which demonstrated significant learning about the hospice and the people within it.

You think everyone's gonna be really old, everybody's gonna be ill and quite depressing but when I got here they were still looking old, the majority was elderly patients, but, of the elderly patients they were also very varied in personalities. You know they weren't all just bedridden kind of sat there. They were willing to have a chat, they were willing to go outside and things like that And you kind of, you don't really think about the palliative kind of side of things Because you're living in that moment, or you're working in that moment So, urm, there's, I'd never really kind of been in the situation where it's kind of met that stage like with serious illness. (Interview: 21/10/2018)

A sense of this learning experience was captured by a member of staff describing her own experience of working with young people volunteering for short periods at the hospice for short periods:

A lot of the volunteers that we have come on a short placement, either from university or from school, come for say a week or ten days and some people are just doing it because they need to for credit for school and don't know much about us, but you get them calling up and saying oh, I've got to do this for my Duke of Edinburgh, my mum says it's a good place, so I'm going to want to come to you. So they clearly know nothing about us and they're sort of the most interesting volunteers, in that they come on the first day and they spend time in all the different departments and you can see the change in them in the week …… that they have no idea what it [the hospice] is and by the end of the week, they're, they've completely transformed, in that they understand what we do and why we do it and that's really nice to see, especially with the sixteen, seventeen year olds from school, because you can see how much its opened their eyes, which is really, really nice. (Recorded conversation: 10/06/2015)

Here the volunteering experience, being immersed in the setting and being part of a community of practice provides an opportunity to learn about hospices, the service they provide and for some, deeper existential concepts. As mentioned previously, there are many misconceptions and taboos associated with hospices and the work that they do. The learning and experience of these volunteers will benefit them but also offers the potential for

them to educate others in their community in the light of that learning. There were such examples in the data where individual volunteers were able to recount how they do take their learning beyond their work in the hospice and provide an important conduit to educate others in the wider community, often dispelling myths and misconceptions about hospices. One such example was from Sheila, who has volunteered at the hospice for eleven years:

I mean people actually said to me, that I kept in contact with at work, I don't know how you can go there, it must be so miserable, and don't you get upset all the time and I said well actually if you actually came to the place, I said when you walk, even just down the drive, and particularly if you carry on and you look at the surroundings, I said it is so peaceful. I said you get like this sort of air of calm and peacefulness. I mean in actual fact, they think it's a sad place and it isn't. It can be and yes, you know, you've got to be respectful of certain instances. But there can be a lot of laughter in death and you know because people sometimes will want to come out and talk. (Observation: 3/09/2014)

This supports research cited in Chapter 2 (Doyle 2002; Naylor et al 2013; Morris et al 2017; Scott et al 2018), demonstrating the part volunteers play in educating the public, so making communities aware of the work of hospices and making hospices more accessible. A consequence of the learning of some of the volunteers in this study had enabled them to not only share their experiences and knowledge outside the hospice but also were prepared to have difficult conversations in order to tackle some of the taboos about death and dying. Freda, recounted one such occasion where she had been able to share her own knowledge and experience of the hospice acquired through her volunteering:

I had a colleague and, who, we retired at the same time and then unfortunately he started being really poorly and he wanted to die at home and I said right, you know, I don't know why, because he lived alone and I said I really don't understand your big issue about wanting to die at home. Well he was like this, but as he got worse and worse and he knew I helped at the Hospice and he said can you tell me something about the Hospice and he said how much does it cost and I said well its free, I said and the care you get is just unbelievable and you wouldn't be on your own if your family couldn't be there and I said and if you can't die at home, that's the best place to be. Actually, I think it's better than dying at home, I think really, personally. (Interview: 11/03/2015)

Some volunteers recognised the opportunities there were to publicise their work in the community and raise awareness of the hospice. One volunteer told me it was important for

school children to learn about their local hospice and she thought volunteers could play a part in this by talking about their work.

I see students come in and I think they're the volunteers of the future……I pick my great nephews up every week and one of them is eight almost and he'll look at me and say have you been to that place today Auntie, where people are poorly and I'll say yes and I'll say I've been counting a lot of money, you know, and they know what the place is. (Observation:3/09/2014)

This extension of learning and community education is potentially an important outcome of volunteering whereby the work of hospices is promoted and better understood, and individuals can play a part in 'changing knowledge, attitudes and behaviours around dying, death and bereavement' (Dying Matters 2018). One of the senior members of the medical staff at the hospice, when asked about the benefits of having hospice volunteers was assured in her view of the importance of this educative role:

The obvious answer is sixty thousand hours a year of financially unrewarded work that we couldn't fund otherwise. But that almost goes without saying doesn't it? But then I think there is a much, well not more important, but a less obvious, but still very important role of spreading the understanding about what we do at the Hospice and within the community spreading understanding about issues to do with death, dying, illness, speaking openly about these sorts of things. (Interview: 24/11/2016)

The part which volunteers can play in providing links to specific groups within the local community and educating them about the work of the hospice in providing EOLC is also of great importance. The volunteer co-ordinator explained to me about recent efforts of the hospice to reach out to the local Asian community as there was a low uptake of hospice care within those groups, and also because she was keen for the age and ethnic demographic within the volunteers to better reflect the local community per se. She told me some members of staff had visited a local mosque which had generated a great response from that community and specifically four Asian girls had started volunteering once a week in the local hospice shop. It was hoped that establishing those connections and the young girls' involvement in volunteering could result in learning within the wider community about the work of the hospice:

They weren't using the hospice, for, you know for their own reasons, but they didn't even know about us either. So, because we've got these young girls they were going home talking

about us. Hopefully their families will think about us, you know, if they need to use us and our services. (Interview: 6/10/2017)

However, whilst most of the volunteers I spoke to about it said they were open with friends and family about their volunteering, and in a number of cases had been able to use their experience to explain to people outside about hospice work, there was one volunteer who chose to be more private about his work as a volunteer. Saeed explained why he had chosen to share his experiences with only a select few:

There's a couple of lads that I've known since secondary school who know, but it doesn't really come up, and I don't feel that if you're volunteering, I don't think it's necessary for you to always promote it. Like obviously you have to kind of write it down on forms and say your personal statement and things like that. But I think there's a time and a place and if you're volunteering it's nice that you do it and you know that you do it, as oppose to everybody having to know. I think it would take away from it if everyone knew all the time cos I think it would take away from the experience, because you'd just kind of forget how lucky you are.
(Interview: 21/10/2018)

This volunteer's preference to be discrete with regards to his volunteering activities arguably limits his educative role in the short term to his close friends and family but his learning will nonetheless be a part of his own education in the future beyond the hospice and possibly influential should he fulfil his ambition to become a doctor.

Summary
In conclusion, hospice volunteering involves both formal and situated workplace learning. With regards to formal learning, provision of induction and on-going training is an important consideration in developing an inclusive volunteering programme (Rochester et al 2012:203), However, I would contend that the approach taken by the organisation needs to take account of the liminality of hospice volunteers. Some formal training may be a requirement in the context of hospice volunteering such that the volunteer in carrying out their role does not detract from the excellent provision of care the hospice seeks to provide. Other training such as health and safety, equality and diversity and manual handling may be a mandatory requirement for working in a hospice setting and other roles, especially those relating to clinical or medical roles will be subject to a regulatory requirement for ongoing continuing professional development. However, beyond those required aspects of formal learning, other training may be dependent upon the role of the volunteer, their existing skills and biography, motivations and desire to access additional training. For some individuals

they are likely to embrace opportunities for formal learning, but others may exercise the agency afforded by their liminality and choose not to engage. Attitudes and expectations amongst volunteers with regards to training is variable. As Doyle (2002:53) puts it, training may be seen as: ‘a perk, threatening, a necessary evil or as a great opportunity’. This has implications for the hospice in terms of expectations and requirements of the management and the volunteers they have within their organisation. Further implications for the organisation lie in the resource implications for training volunteers and the extent to which the management choose to invest in the volunteer cohort and prioritise them within any financial constraints of the charity. Once more, in order to preserve the unique liminal space of volunteering, a balance needs to be struck whereby formal training and the appropriate investment of resources is made available to volunteers but at the same time the requirement for training takes account of the particular role of volunteers and their individual requirements.

Volunteers are learning as they enact their role, learning with others and as a consequence of them being immersed in the setting. In response to RQ3., some of the existing theories and concepts of workplace learning have been useful in abstracting the data and explaining some of the unique features of learning as a volunteer in the context of a hospice. Communities of practice provide a useful lens to explicate some aspects of learning associated with hospice volunteering. However, of particular importance in the context of hospice volunteers is consideration of working biography and life experience and the impact of these on a volunteer’s learning and their contribution to the learning of others within the hospice and the wider community. The involvement of volunteers in hospice work also affords the opportunity for them to act as both catalysts for learning and educators within and beyond the organisation. The research has shown a range of groups and networks at play within the organisation, which involve hospice volunteers, and which contribute to workplace learning, aligning with some of the features of communities of practice. These loosely coupled networks may comprise volunteers and staff in their membership and provide a valuable conduit between the liminal space of volunteering, the paid workforce and the wider community.

The critical analyses in this and the previous three chapters, have sought to address the three overarching research questions and have provided new ways to conceptualise hospice volunteering offering some fresh insights into the complexities of this important aspect of EOLC.

Chapter 9 Conclusion: Bringing it all together and some final thoughts

This chapter sets out the central arguments of this thesis, starting with a review of the background to the study and a reflection on the research process. The main findings of the study are then brought together including how the thesis contributes to new knowledge. The chapter also includes suggestions for further research and policy recommendations.

Back to the beginning

There is a common misconception as Doyle (2002:9) cautions, that hospice volunteers are 'untrained people, with hearts of gold and with some time to spare to help those less fortunate than themselves'. Moreover, the phrases 'only' or 'just' a volunteer may be throwaway remarks but are symptomatic of a wider debate. The research sought to better understand the role of volunteers and present a more accurate picture, based on systematic and extensive research into the lived experiences of volunteers in a hospice. The thesis exposed some of the complexities of hospice volunteering and contributions hospice volunteers make in the provision of EOLC, contending that hospice volunteering can offer tangible benefits to individuals who volunteer and to the organisation in which they work. The volunteers in the study were involved in a range of different activities which supported and enhanced the service the hospice was able to provide. Whilst there were relatively few individuals with roles involving direct clinical care, the work of the volunteers in many different ways supported the holistic care provided to patients and their loved ones. The findings are relevant to those who work with and manage hospice volunteers as well as those with responsibility for strategic planning and sustainable hospice services in the future. They may also be of interest to other organisations who work with volunteers, especially those involved in EOLC.

Reflecting on the research process

The literature review confirmed that research into hospice volunteering was often derived from large scale surveys, questionnaire and interviews and the respondents were typically volunteers or paid staff. This presented an opportunity with regards to the methodological approach. The ethnography provided a rich and complex data set involving both volunteers and staff as participants in the study. An ethnography is not an easy option for research in a hospice setting, and as discussed in previous chapters it presented context specific, ethical, and emotional challenges. One of the main demands when undertaking an ethnography is time, and this does not always sit well in an academic culture where there is a push for outcomes, demonstrable impact and what a colleague of mine once described as 'quick and dirty' research. Notwithstanding those limitations, I would contend that perseverance with the methodology provided me with some clarity and a different perspective on hospice volunteers and their work and learning. Ethnographic methods opened up new insights

which may have been more difficult to discern if conventional data collection tools such as surveys and questionnaires had been used. In particular the approach helped to bring to the forefront aspects of work which centred upon care, time, and emotion work and the workplace responsiveness inherent in the volunteer role. The ethnography afforded me the opportunity to spend time with the volunteers and staff in the hospice in a way that I would not normally do in my role as a trustee. That time spent watching them work and listening to their stories and experiences was invaluable to the research.

As noted in the Chapter 4, use of creative research methods in the field of EOLC is underdeveloped (Goodman et al 2012), but in this study the use of the metaphorical modelling groups proved successful, although not entirely for the reasons I had expected. The main advantage of this approach was with groups of paid staff and the trustees. In the sessions all participants had the opportunity to express their views and hear those of others in the group. The trustees usually only come together in formal meetings and this approach helped to dissipate some of that formality, helping to make the familiar, strange (Mannay 2010). The staff groups included individuals from different areas of the hospice at varying levels of seniority. Feedback from participants suggested the sessions were of value in providing a novel forum for discussion. Whilst I was instrumental in directing these sessions, the participants were active in the research process, gained experience of a research technique, and perhaps most importantly rehearsed some of the discussions about policy and practice affecting them and hospice volunteers, arriving at some conclusions for themselves with regards to future developments. At the start of the study, it was my intention to arrange Lego sessions for groups of volunteers. I invited volunteers and went to meetings to explain the approach. However, there was a limited response and those who did express an interest were from individuals who were already participating in the study in other ways. I was not successful in extending the number of volunteers involved and I was anxious not to overburden those volunteers who were already contributing in other ways. Furthermore, there were logistical challenges in finding time slots which suited the availability of volunteers, so I took the decision not to pursue these events. Given the rich and detailed data relating to the volunteers which I was able to collect using other techniques, I do not think on balance that the decision had a negative impact on the study. However, I do consider the technique could be used with volunteers and other groups in future research in the field of EOLC.

In addition to using the Lego technique with the research participants, I also used visual metaphors in a different way to enable me to make sense of my data. As discussed in Chapter 4, my use of coastal photography turned out to be an unexpected beneficial outcome of the thesis. The process of taking the photographs when used in conjunction with what Coles and Thompson (2016) refer to as 'inbetween writing' was a very helpful tool for giving a permanence to my otherwise transient thinking. The photos helped to disrupt my thinking and to play with new and emerging ideas, providing different perspectives on existing positions. They also provide a channel of communication which can be used to convey and share complex or nuanced ideas with others, without 'dumbing down', and as such could be valuable in extending the reach of discussion and debate to a wider audience.

My own positionality as a hospice volunteer, trustee, ethnographer and academic, notwithstanding the particular challenges of such an identity (which have been considered in detail in the thesis), were instrumental in providing a different perspective and new insights into hospice volunteering. Indeed, such a profile arguably supports my claim to originality of this thesis. That said, my own declared interests will have influenced and possibly limited the research process where I was aware of or discounted particular narratives and emerging themes. A central part of this thesis was to better understand the emotion work of hospice volunteers. However, carrying out the research also provided me with a lived experience of emotional aspects inherent in the research process as discussed by other researchers (Widdowfield 2000; Nicholson 2009; Humble 2012). I would argue that any research journey, including doctoral study is likely to be something of an emotional rollercoaster but such effects were magnified in this study as a consequence of the nature of the research topic, the site of the research and the chosen methodology. There is scope for further research into the emotion work of researchers and that a better understanding of this important aspect of the research process would be beneficial to: researchers, irrespective of their level of experience; supervisors; and particularly those engaged in potentially emotionally demanding areas of research such as EOLC.

A strength of the methodology was participant observation and shadowing and the part it played in gaining insight into volunteers' work in practice. However, for reasons I explained earlier in the thesis, I took the decision not to shadow volunteers whose role mainly involved one-to-one interactions with individual patients. Having established elsewhere in the research the value of emotion work in hospice volunteering there would be value in finding research approaches which could capture such experiences and establish their value in the role of volunteers. The multimethod approach enabled me to actively involve a range of volunteers and paid staff in the research. However, although I was also able to have

conversations with some of the patients, one of the limitations of the study was that it did not include detailed data from a range of patients exploring their perceptions of hospice volunteering. Notwithstanding the ethical and practical challenges in gathering such data, I would suggest it would be an important and interesting area of further research. It could be argued that the study was also limited by the use of a single research site and participants who were all working within the hospice building but these limitations were offset by the rich and detailed data which resulted from the ethnography in the selected hospice. It was a deliberate decision on my part but there is scope for aspects of this research to be developed in the future with further ethnographic adventures designed to explore the experiences of community-based hospice volunteers.

Main findings and contributions to knowledge

In the introduction to the thesis, I laid out the research questions but also indicated that given the complexity and nuanced nature of hospice volunteering, the discussion and analysis in responding to those questions, would inevitably involve some overlap. In this final summary of findings, I adopt a similarly holistic response but within that will offer a considered response to each of the three questions.

Research questions:

1. What are the benefits and challenges to individuals and to the organisation of hospice volunteering?
2. What characterises the work and learning of hospice volunteers?
3. How adequate are existing theories and concepts of emotional labour and workplace learning in explicating the work and learning of hospice volunteers?

The study found that volunteers can derive significant benefits from their volunteering. Such benefits varied amongst the individual volunteers, but there were some common themes. Sometimes those benefits were linked to a volunteer's original motivations for volunteering being met, but in addition, over time, secondary motivations and benefits became important. The findings relating to volunteers' motivations were broadly consistent with previous research (Starnes and Wymer 2000; Planalp and Trost 2009a; Claxton-Oldfield 2013), including altruism, social relationships, career motivations and personal satisfaction. There were certain motivational factors and benefits however which did emerge strongly from the study. Firstly, irrespective of other factors which underpinned the motivation of the volunteers in the study, the desire to support the ongoing work of the hospice was a recurring and common theme. In most cases, this carried with it a strong commitment centred upon that particular institution resulting from either local knowledge or because of having previous connections with the hospice. Secondly, volunteering provided opportunities

for some individuals to access beneficial aspects of a workplace which they valued, whilst still having the flexibility and agency to pursue other important aspects of their personal lives, and work within their own limitations and constraints which could be variable. In the case of some older age volunteers, access to the workplace offered a transition following retirement from paid employment which was beneficial to their well-being and consistent with the findings of other researchers (Kahana et al 2003; Russell et al 2019). Volunteers with chronic health conditions or disabilities which were prohibitive factors in them retaining paid employment also benefitted from their active involvement as a volunteer in a supportive workplace. Findings identified beneficial outcomes for these volunteers including a regular routine and structure, social contact and a sense of purpose. Amongst the younger volunteers, some were primarily motivated by career aspirations and volunteering enabled them to gain access to aspects of a specialised workplace environment which they could combine with school or university requirements. Finally, it was evident from the study that motivations, personal circumstances and the benefits volunteers gain from their volunteering changed over time which has implications for the retention of volunteers. It supports the view of other researchers (Howlett 2009; Rochester et al 2012), that organisations need to know their volunteers and be aware of such changes, where possible being responsive in accommodating fluctuations and altered needs. To meet the changing circumstances and motivations of volunteers requires flexibility on the part of the organisation and perhaps adopting a different approach to management than might be applicable to the paid workforce. The study found examples of this in practice where paid staff knew the volunteers they worked with and were aware of changing needs of individual volunteers; these were responded to with sensitivity and care sometimes enabling volunteers to change their role to better suit their interests, capabilities and motivations, or take time out as appropriate. Such an approach is important in sustaining the volunteer cohort but is dependent upon the culture and practices of the organisation. However, the study found that flexibility and commitment to volunteers along with a genuine desire to support them, did present challenges for the staff. The social function and companionship which many volunteers derived from their volunteering were found in some cases to be problematic for staff where such outcomes assumed priority for individual volunteers over their contribution in the workplace. Furthermore, in line with findings of Russell et al (2019), there were long serving volunteers, especially those in the older age range, who derived significant personal benefit from their volunteering role but had reached a point where their contribution was limited and, in some cases, they were becoming a liability. Where the prospect of retirement from their role needed to be addressed (Russell et al 2019), it was perceived by staff to be potentially distressing for the volunteer and difficult for paid staff to manage. Such difficulties are compounded by the liminality of volunteers where the position they occupy within the

workforce is different to that of paid staff and this research suggests that even where policies are in place, they can be difficult to enact in practice. Given the aging population, the increasing number of older people living with multiple chronic conditions and the age demographic of hospice volunteering typically including a large proportion of older volunteers, it is an area which would merit further research. `

Whilst there are inherent benefits to the volunteers themselves, the study confirmed that hospice volunteers also bring significant benefits to the organisation. The economic benefits are widely acknowledged in the literature and whilst this research did not attempt to quantify that contribution, it was evident that in economic terms, the contribution of volunteers was significant in sustaining the service and that employing paid staff to replicate the work and expertise of the volunteers would not be an option within the financial constraints of the charity. In line with the findings of Doyle (2002), the organisation reaped significant benefits from the knowledge, skills and expertise which emanated from the working biographies and life experiences of the volunteer cohort. This enabled the work and expertise of paid staff to be supported and enhanced and extended the services which the hospice was able to provide. Many volunteers were able to work with a degree of confidence and independence where they were able to draw upon their existing skills, knowledge and experience reducing the need, in some cases, for formal training and supervision.

Findings also indicated that the organisation benefitted from the professional skills and experience of some volunteers. Many volunteers had professional qualifications and experience, but it should be noted that not all volunteers chose for these to be the primary focus of their volunteering role. However, there were volunteers where their professional background was central to their role, including trustees, and volunteers with clinical and medical backgrounds, which as a consequence afforded significant benefit to the organisation. The study found that the recruitment of trustees to the Board had become increasingly formalised, in line with Hospice UK (2017) recommendations, focusing on achieving an appropriate mix of particular skills and expertise to meet the requirements of the hospice. This approach offered some potential benefits to the hospice and there were examples of these in practice. Staff benefitted from working with and learning from individual trustees, drawing upon their relevant skills, expertise and professional contacts for advice and support. Furthermore, the wide range of professional skills and expertise represented within the trustee cohort was valuable in informing and developing policy at a strategic level. However, whilst acknowledging the scope of professional knowledge and expertise amongst the trustees, the study also highlighted the importance of being able to adapt and transfer these to the context of the hospice. This involves learning relating to EOLC and the workings

of a TSO and trustees benefit from the time and support of paid staff and other trustees for this to take place. A contextual understanding of TSOs and hospices is essential for those involved in strategic planning and management and it may help to mitigate concerns of potential loss of independence of voluntary organisations as a consequence of the blurring of boundaries and influences of the public and private sectors (Billis 2010). In Chapter 8, the ways in which trustees and staff work and learn together was discussed. The concepts of communities of practice and legitimate peripheral participation (Lave and Wenger 1991) were helpful in explicating some of the ways in which this group of trustees and staff work and learn together but exposed a limitation which was applicable not only to trustees but also to other hospice volunteers. Taking account of their biography, in a hospice context volunteers can exist within a community of practice as both novice and old-timer and in line with Fuller et al (2005), a volunteer's pre-existing knowledge, skills and experience can also be a catalyst for new learning for more experienced volunteers and paid staff.

So, volunteers with professional qualifications offer great potential benefit to the organisation but the study also exposed some challenges and missed opportunities which limited the extent to which such benefits were utilised within the hospice. Particularly in clinical areas, some of the limitations were attributed to governance and professional regulations such as the requirements for supervision, training and ongoing professional development. These were seen by some as prohibitive due to the financial and time implications, findings consistent with Lean and McDermott's (2009:116) assertion that 'the largest underestimated resource implication is the hidden cost of the management, support and supervision of professional volunteers'. Within the organisation there were some inconsistencies as to volunteers' involvement in direct patient care. In some areas there were strict limits in what volunteers were allowed to do, for example with feeding, toileting and lifting patients, which were not always consistent with practice in other departments. The extent to which volunteers with appropriate professional qualifications were utilised in different areas of the hospice was usually determined by paid staff, especially line managers and in some instances, this was associated with their experience of working with volunteers. The volunteers depending on their role were integrated within small teams and were found to work closely with staff albeit often not extending beyond their defined team. As such, in areas within the hospice where staff had limited involvement with volunteers, they may need persuading as to their value. The study found no examples of paid staff fearing being displaced by volunteers (Thompson and Russell 2017), although that is not to say there were no such concerns. However, there was a view that in some cases, there was inherent risk, both real and perceived, associated with deploying volunteers to roles involving direct patient care. In order for organisations to gain maximum benefit from volunteers in delivering

and extending their services, these findings have implications for policy decisions and future research which are laid out later in this chapter.

The research revealed a culture within the hospice characterised by a strongly supportive network between staff and volunteers, often more akin to a family than a workplace. There was evidence of a symbiosis of care and support which was mutually beneficial to both staff and volunteers. This appeared to be a feature of the culture rather than something imposed or required. However, I would tentatively suggest that the culture was dependent upon and enabled by the staff and volunteers and their shared ethos and values and as such is not fixed and could be easily displaced. Given the positive influence of the culture on the volunteers' experiences it is important not to overlook its vulnerability and assume such a culture is a 'given' in a hospice. As mentioned above, such care and support can sometimes present challenges but based on the findings of this study I would contend that the benefits to volunteers and to staff of the supportive, symbiotic culture of extended care within a hospice outweighed the difficulties.

A further benefit to the hospice which emerged from the study was the educative role of volunteers as a consequence of their volunteering experience. This is consistent with the findings of others (Doyle 2002; Naylor et al 2013; Morris et al 2017; Scott et al 2018,) whereby volunteers can be instrumental in informing the wider community about hospice care, challenging some of the taboos of what hospices do and encouraging more discussion of death and dying (Dying Matters 2018). Part of this process rested with the volunteers' situated learning through enacting their role. Being part of a workplace where they are exposed to different aspects of death and dying and through their interactions with other people, including patients, volunteers developed their knowledge and understanding of hospice care. In some cases, volunteers recognised that their own misconceptions and assumptions had been challenged and their understanding changed. There were also individuals in the study who as a result of their volunteering experiences felt more confident to talk about death and dying. Not only was this learning beneficial to individual volunteers within their volunteering role but it had also been of value to some in dealing with such events in their personal lives. There were numerous examples where volunteers had been instrumental in using their learning to tell others in the wider community about their volunteering, demonstrating the part volunteers can play in educating the public, making people aware of the work of hospices and making hospices more accessible. It is important that this aspect of volunteering is not underestimated, Volunteers should arguably be recognised as key stakeholders with valuable volunteer and life experience that could be better integrated and recognised as a valuable training resource.

A main focus of the ethnography was to find out more about the work and learning of hospice volunteers. One of the significant findings related to the less tangible aspects of the work of volunteers who undertook ostensibly simple roles in the hospice. The dissonance between the job as described and the work as practised in such roles was evident. Participant observation were helpful in revealing that the demands and complexities of such roles were linked to the emotion work inherent in those roles which required volunteers to interact with and respond to patients, families and members of the public. To help to explain the detail of such interactions I introduced in Chapter 7 the term: 'workplace responsiveness'. Just as Bone (2002:148) contended that emotion work was 'the least visible and least accounted for dimension of nursing', I would argue this is similarly the case for some aspects of hospice volunteering. Speaking with volunteers engaged in such roles often provided examples of 'I'm only a volunteer syndrome' (McDermott 2009:113), where volunteers underplayed the importance and complexity of their work. Although most of the volunteers in the study were not directly involved in clinical aspects of patient care, emotion work to a greater or lesser extent is a significant component part of the role of hospice volunteers. Through their interactions and care of those with whom they came into contact including patients, their families, paid members of staff and the general public, volunteers' emotion work is an essential part of the holistic care provided by the hospice. As discussed in Chapter 7, the research revealed some elements of emotion work which were particularly important in the volunteer role: the gift of time, the act of 'being there' and engaging in everyday conversations. Each of these could be dismissed as simple, undemanding and go unnoticed but in the context of hospice care their value is immeasurable. Whilst the emotion work of volunteers was considerable, the findings suggested any negative consequences of such work in the context of the hospice volunteers were largely offset by support from within the organisation, a variety of personal coping strategies and the personal satisfaction which volunteers derived from their volunteering.

Having uncovered the complexity inherent in the work and learning of volunteers, the research has exposed some dilemmas. The dissonance between role description and role enactment highlights the importance of careful consideration as to the requirement and nature of training and support required and/or made available to volunteers. Where volunteers are using the role for personal and/or career development, it is likely to be in their interests to make explicit to them the considerable learning associated with their role and provide ongoing opportunities for support and development. Training focusing on workplace responsiveness however presents particular challenges. The unknowing or unconscious naivety of many volunteers about the nature of their work, does appear to enable the sophisticated workplace responsiveness which characterises much of their work and

learning, most notably those volunteers in ostensibly simple roles which involve contact and interactions with patients, staff, families and the general public. The study would suggest that older volunteers in particular, with considerable work and life experiences, are able to draw upon these experiences to respond to new and arguably unique situations. Significant training for many of these individuals could be unnecessary, especially given that formal training focusing on responsiveness is likely to be outcome based and reductionist in nature. For some volunteers 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. However, organisations have a duty of care towards their volunteers and need to be aware of potential vulnerabilities of volunteers and be willing and able to support them appropriately in their role and learning. The learning which volunteering in a hospice affords is indisputable but there is further work to be done to fully understand the processes and complexities of informal learning of volunteers in a professional workplace. The research made more explicit the rich and often hidden complexity of the role of some volunteers. The organisation's descriptions of these volunteer roles and in many instances the volunteers' own accounts, oversimplified the role they actually perform, and those descriptions belie the complexities of the volunteers' work and associated learning. Allen (2014) argues that so-called simple tasks of gerontological nursing are actually highly complex but made to look simple because of the expertise of nurses, and this study suggests that the same can be said for the volunteers' activity within the hospice.

Conceptual reflections

Throughout the thesis, the lens of liminality as an overarching theoretical concept and as a metaphor was useful in explaining unique aspects of volunteering in a hospice. In the context of hospice volunteering, liminality represents a permanent state of neither x nor y, betwixt and between (Ybema et al 2011; Concannon and Nordberg 2018), in which the individuals when they inhabit that space whilst volunteering are neither paid members of staff or members of the general public. The 'liminal space of volunteering' has been shown to have certain distinctive features. Acknowledging the liminal space which hospice volunteers populate, helped to articulate the value and importance of hospice volunteers, and their place in the organisation. It explained characteristics of volunteering which distinguish it from paid employment and lead to a realisation that there are important implications for management and policy involving volunteers. Extending the metaphor to a beach as a liminal space (Shields 1991), such visual representation provided a reminder that the liminal space is not static and just as a beach can be hidden by high tides, its access affected by weather, or disappear over time as a consequence of coastal erosion, so the liminal space

which affords volunteers their liminality can also be at risk. Understanding the potential fragility of liminal space can mitigate against erosion of volunteering, intentional or otherwise, such that volunteering becomes no more than an unpaid employment. Key findings from the study suggest volunteers make a unique contribution to the hospice attributable to their liminality. As explained in Chapter 1, hospices were established to provide excellent holistic care and demedicalise death for patients in the final stages of life, offering an environment which might be said to be more closely aligned to being cared for at home, whilst at the same time providing expert clinical expertise. This thesis contends that it is that liminal space and the volunteers who occupy that space which help to sustain the unique character and ethos of hospice care. The liminal space of volunteering provides both benefits and challenges to volunteers who inhabit that space, to the staff, and to the hospice organisation. The lens of liminality exposed unique aspects of volunteering in a hospice. Recognition of liminality justifies the use of flexible and agile responses in management (Rochester et al 2012), avoiding the duplication of practices of a paid workforce and responding to the range and diversity within the volunteer cohort in terms of, for example, age, qualifications, motivations, availability and level of commitment. The concept of liminality was helpful in highlighting the differences between volunteers and paid staff and the particular contributions of the volunteer workforce in sustaining the work and ethos of the hospice. These findings are likely to apply in other hospices. Furthermore, the management of volunteers and the importance of preserving the liminal space with responsive and flexible approaches have been explicated, with consideration of the potential for the erosion of liminality in a setting where working practices are subject to scrutiny and accountability. These findings are of particular relevance to hospices and other health care settings but there is also potential for generalisation of these findings to other organisations where volunteers work with paid staff.

Theories of situated learning and emotional labour were key to understanding more about the work and learning associated with hospice volunteering. The concept communities of practice was applied to explicate aspects of situated learning associated with hospice volunteering. As discussed earlier in this chapter, the concept of communities of practice was helpful in explaining some aspects of volunteers work and learning. It was particularly applicable where volunteers sharing a specific designated role (eg. trustees, receptionists, nurses), worked closely with paid staff whose work directly linked with those volunteers' roles. However, as explained in Chapter 8, the theory falls short in some areas, most notably that 'implicitly Lave and Wenger (1991) treats their newcomers as tabula rasa' (Fuller et al 2005:67) and in the context of hospice volunteering, the pre-existing work biography and life experience of volunteers is of particular relevance to their work and learning. The study

suggests that the concept of situated learning is a valuable construct in understanding the work and learning of volunteers in other settings and findings from this study will be particularly relevant to institutions where volunteers work with paid staff and where professionals undertake their role in a voluntary capacity.

Theories of emotional labour and emotion work have been valuable in understanding particular aspects of hospice volunteering. Interestingly, the detail of these terms in themselves provided another example of the volunteers' liminality in that in Hochschild's (1983) original definitions emotional labour was associated with paid work, and emotion work was associated with the private sphere; volunteers occupy a position 'betwixt and between' the two. Notwithstanding that difference, the concept of emotional labour and emotion work were important in explicating some of the less visible aspects of the work involved in hospice volunteering and extending the reach of this research beyond the site of the ethnography. This aspect of the study is important to other hospices and also in the many other settings involved in EOLC including care homes, hospitals and community provision, most notably where the role of the volunteer involves them working directly with patients, families and members of the public.

The literature review showed that perhaps because of the multi-disciplinary nature of the existing research, the use of theory to conceptualise hospice volunteering was limited. The use of theory in this research enabled me to abstract the data and elevate the findings of the study such that the reach of the findings can be extended beyond the immediate site of the research (Collins and Stockton 2018). The value of this ethnographic study lies not just in its significance to the site of the research but also that it offers some modest generalisations which could be relevant to other settings and theoretical explanations are helpful in providing such wider applications (O'Reilly 2012).

Further research

In responding to the research questions and given the limitations of the study, there are areas which I suggest merit further research.

1. The study was successful in discerning secondary motivations of volunteers which were instrumental in sustaining their involvement with the hospice. For the participants in the study their motivations were generally met and there was little evidence of dissatisfaction. Further research into reasons behind why volunteers decide to leave their role would be helpful in retaining and sustaining the volunteer workforce in the future.

2. The culture of symbiotic support between volunteers and staff in the hospice was found to be of significant benefit. A large number of the hospice volunteers however carry out their role in the community and further research into the extent to which similar supportive cultures extend beyond the hospice building to this large group of community volunteers would be of interest.
3. This study was carried out in a specialist hospice building. However, as hospice care and EOLC more broadly extends and develops its services into other settings including care homes, hospitals and care at home there is scope for further research to explore volunteer involvement in such provision.
4. Continuing to develop the use of creative research methods within EOLC, particularly with a view to enabling the voice of patients to be heard within the research.
5. The place of emotion work in the research process and its impact on the researcher was touched upon in the thesis and I would suggest this is an area of interest which warrants further exploration.

Policy Recommendations for the future development of hospice volunteering

1. The thesis included some discussion of the role of volunteers undertaking professional roles for no payment, and exposed some challenges and obstacles relating to areas such as professional boundaries, regulation and governance, and risk. Financial support for TSOs and clarification of requirements for supervision and governance of such professionals acting in a volunteer role could be helpful in extending and developing the involvement of such individuals in hospice care.
2. In the interests of sustaining and developing the volunteer cohort, implementation of recruitment and management approaches which take account of the differences between volunteers and the paid workforce,
3. Just as volunteers often come in not knowing about the setting, staff and trustees are also recruited who are not used to working with or managing volunteers. Training for hospice staff focusing on the role of hospice volunteers and their contribution to EOLC would be particularly useful to new members of staff and trustees with no previous experience of working with volunteers, and those involved in operational management and strategic decisions involving volunteers. This could be helpful in sustaining the liminality of volunteering and avoiding avoidable hybridisation.

And finally ……

The research set out to provide new insights into hospice volunteering with a particular focus on the work and learning of the volunteers. This thesis has succeeded in illuminating some of the challenges and opportunities volunteering affords in hospice care and the 'liminality of

volunteering' provides a conceptualisation which elucidates the distinctive nature of hospice volunteering. It has exposed some of the complex, less visible aspects of volunteering, especially those associated with emotion work. The thesis has addressed the research questions but in so doing it is clear this has only scratched the surface and is but a starting point into further research into hospice volunteering. There are clearly challenges for hospices in sustaining and developing volunteering, and making full use of volunteers' skills and expertise, especially in relation to their involvement with direct patient care. With an increasing demand for EOLC in hospices but also in other health and care settings and the community, I would argue that these are issues which should be considered in future policy decisions in hospices in order to maximise the use of volunteers and the skills and expertise they can offer.

The more time I spent with the volunteers, the more I became aware of a complex and nuanced landscape that is hospice volunteering. I hope that my time spent in the hospice will have generated interest and given confidence to others to involve themselves in hospice research and that actively involving the volunteers in the study went some way to recognise and value their work as volunteers.

Epilogue: A hospice without volunteers during the Coronavirus pandemic

At the time of writing up this thesis, the global Coronavirus pandemic is at its height and the response of society has thrown into sharp relief the importance and value of volunteers and volunteering. It has also seen an apparent shift in the importance and value of health and social care and the associated 'front line workers' as, drawing upon a narrative of war, the healthcare workers have come to be known. The population of the UK has been subjected to unprecedented 'lockdowns' and restriction of social contact, whilst at the same time being faced with daily accounts of spiralling infection rates and real stories of individual tragedy and death. The relative importance of health and wealth has been challenged on so many levels and thrown up some very difficult questions and choices for the immediate and longer-term future.

Early in the crisis a request went out from the government for up to 250,000 volunteers to act as NHS Volunteer Responders to help up to 1.5 million people who were being asked to shield themselves from Covid-19 because of underlying health conditions. Members of the public were asked to sign up with a view to supporting others with tasks such as: delivering medicines from pharmacies; driving patients to appointments; bringing them home from hospital; or making regular phone calls to check on people isolating at home. Within 48 hours of the request being made, over 500,000 people had volunteered their services. Coupled with that, significant numbers of retired workers from the health and care sectors responded to a call for them to consider volunteering to return to the front line to support colleagues in the NHS and care sector to enhance capacity and augment expertise. It was felt that at this time of crisis the service could not rely purely on the paid staff as an already stretched service faced the possibility of being overwhelmed by increased demand of seriously ill patients and with staff unable to work due to sickness or precautionary self-isolation. Throughout the crisis there has been unerring public support and admiration rarely seen before for doctors, nurses and ancillary workers, encapsulated by weekly displays of clapping on Thursday evenings at 8pm across the UK by members of the public standing outside their homes, royalty and politicians on doorsteps, outside hospitals and on Westminster Bridge to mention but a few places, to demonstrate a shared public gratitude and recognition for their work and dedication. It remains to be seen if such sentiment extends beyond the period of crisis of the epidemic. There have also been countless examples of individuals and groups coming together and stepping in to support and care for individuals on a voluntary basis within their own communities. With the unprecedented urgency required for a speedy and efficient rollout of vaccinations across the UK, volunteers once again stepped in to support the efforts. Across the country there was an undercurrent

of activity, often in the background, involving a selfless commitment from people with a will to make something happen and a shared focus on a specific cause.

When research was carried out for this thesis, one of the questions I asked of many of the participants was, 'What would the hospice be like without volunteers?' At the time, none of the participants had any experience of the hospice without volunteers, so the question was purely hypothetical. During the pandemic the decision had to be taken at the hospice to temporarily suspend all the formal volunteer activity and whilst it continued to provide EOLC to patients the service was provided by specific key members of paid staff. As time went on, it occurred to me that the question I had posed during my research was no longer hypothetical. So, I contacted some of the staff by email who were still working and asked them the question: 'What is the hospice like without volunteers?' These are some of the replies:

It is a concern because volunteers are the heartbeat of the hospice.

Feelings of guilt because most volunteers I would normally see are older, and some are already isolated, with some relying on their volunteering roles as a way of staying in touch with people and the world.

'The team runs a virtual Day Hospice by Zoom. Some volunteers join in, partly I think because they want to help as always, and partly I think because it alleviates their isolation as well. It's a win-win.'

'The first floor felt like a ghost town – with the absence of volunteers compounded by the absence of those staff who were working from home.'

'Given the workload of the Board, it's sometimes easy to forget that those roles are voluntary, and they have proved key in supporting the SMT through the pandemic.'

Speaking about the few volunteer receptionists who have now started to return:

'Their return has brought me hope because their presence signifies that things are safe enough in society for us to allow them to come in, and that feels good. And it's great to see the receptionists for a few minutes in the evening and have those trivial and small talk conversations that I didn't have the energy for in the first peak of Covid.'

'I don't think I knew how much until Covid-19 meant that we asked our volunteers to remain at home for their safety. This meant that out 700 volunteers stayed away from the hospice and our shops. The impact of this was felt immediately. We missed volunteers' skills and it meant staff had to work extra hours to fill those roles/gaps. But the main thing we felt was a sense of loss in the hospice. The corridors seemed quieter and we had lost a bit of what makes the hospice special. As a whole we missed volunteer support and personally I missed those little chats with volunteers about their lives. The hospice without volunteers felt different. Volunteers have started to return to the hospice and the shops and we have realised how much those volunteers have missed us and they have said it has impacted their mental health and well-being.

My office is above Day Hospice and I miss the sound of laughter and chatter that I used to hear through the floorboards, which would often prompt me to pop down and say hello to the staff and volunteers.

We have lost quite a few volunteers who were probably thinking of retiring and this has just moved that decision forward. We will be forever grateful for the time they have given us. We have got quite a few new volunteers who have either been furloughed or made redundant and whilst this is really good we know these are only temporary as these people need to return to work at some point.

Life without volunteers was unimaginable and we always said we cannot do what we do without them but we have been forced to adapt and look at new ways to recruit and support out volunteers and we are forever grateful for the ones who have been able to return and look forward to the day we welcome more back – whenever that may be.

Some of these responses reinforce findings of the thesis including the symbiotic support of volunteers and staff, the social and emotional benefits of volunteering and the value of 'being there' and everyday conversations. However, they also signal the challenges ahead in rebuilding a volunteer workforce after the pandemic. Certain groups have been particularly vulnerable to the effects of Covid 19, including older age groups and those with chronic health problems; many health care settings have been places where the effects of the virus have been particularly aggressive. Consequently, hospices may find some volunteers reluctant to return and those who do return may be required to adopt new and different working practices in line with safety guidelines. Even the simple act of being with someone may be something that needs to be thought about, all of which opens up the possibility of future research into The Landscape of Hospice Volunteering after Covid.



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Appendix 1: Descriptors of Volunteer roles based at the hospice (adapted from Volunteer Information Pack on the hospice website)

Volunteer role	Role description
Admin Support	Working with Day Hospice; Finance; HR; Fundraising; Retail and Volunteering Teams General office duties, telephone calls, projects and ad-hoc tasks. Must be IT competent and helpful if confident on the telephone.
Chaplain's assistants	Working with the Chaplaincy team The overall purpose of the Chaplaincy Department is to give support to patients and their families to offer them a listening ear and to make appropriate and sensitive pastoral responses. The time and resources of the Chaplain's Assistants are available to people of any faith or none.
Complementary Therapists	Working with the Complementary Therapy team Qualified and insured therapists to help with aromatherapy, massage and reflexology.
Counsellors	Working with the Counselling team Qualified, with a minimum of a Diploma/Level 5 or degree in counselling studies, and who can give two or more hours per week, offering counselling to our patients and their relatives. Experience of palliative care/bereavement work is an advantage but not essential.
Day Hospice helper	Working with Day Hospice staff Volunteers are required to talk to patients and help with activities/games. Volunteers may also help patients with craft activities.
Day Hospice Hospitality	Working with Day Hospice staff Make refreshments for patients, help set up the tables for lunch and clear up afterwards.
Day Hospice drivers	Drive patients to Day Hospice and take them home again, using their own car.
Volunteer gardeners	Help maintain gardens, especially vegetable and herb garden and the pots and tubs on the terrace.
Hospice Biographer	Working with Chaplaincy team Recording patient's life stories to pass onto loved ones. You will be given 2 days training by the Hospice Biographer Charity. Minimum commitment required is one day a fortnight for 12 months.
Housekeeping support	Working with the Housekeeping team Light duties including making drinks, changing water, talking to patients, caring for the flower displays, keeping the ward kitchen stocked and surfaces clean.
Inpatient Unit support	Working with the Inpatient team Supporting the nursing staff with ad-hoc tasks i.e. testing the nurses call system; water temperature etc.
Receptionist	Receptionists are needed to work on a rota (one shift per week) during weekdays, weekends or evenings. Good interpersonal, computer and telephone skills are essential, and as the reception desk is the first port of call for most people visiting the Hospice, a warm and welcoming manner is required. You are the front face of Fernbank Hospice so a happy, friendly disposition is essential.
Tea trolley volunteers	Working in the Inpatient Unit Serve refreshments to patients and their visitors every afternoon and wash up afterwards. This will be for about an hour, depending on the number of patients and guests. You will be given basic food hygiene training.

Appendix 2: Volunteer Statistics as recorded on Hospice Database August 2020

Number of registered volunteers	July 2020	Aug 2020
Total number of volunteers	708	714
Number on main database	632	638
Shop volunteers	391	411
One off events volunteers	76	76
Number of starters	1	13
Number of leavers	18	9
% turnover	2.8%	2.0%

Gender	
Male	149
Female	489

Age	
14-17	38
18-30	40
31-40	20
41-50	42
51-60	77
61-70	135
71-80	129
81+	18
Blank	139

Ethnic / Cultural background	
Asian Bangladeshi	0
Asian British	1
Asian Chinese	0
Asian Indian	0
Asian Pakistani	6
Asian other	1
Black African	1
Black British	0
Black Caribbean	0
Black other	2
Mixed other	0
Mixed White & Asian	1
Mixed white & Black African	0
Mixed white & Black British	1
Mixed white & Black Caribbean	0
Other ethnic group	1
Prefer not to say	1
White British	156
White English	242
White Irish	4

White other	4
White Scottish	3
White Welsh	0
Blank	206

Marital Status	
Civil partnership	4
Divorced	6
Joint Household	11
Married	132
Other	1
Prefer not to say	4
Separated	2
Single	96
Widowed	40
Blank	341

Sexual Orientation	
Bisexual	8
Heterosexual	215
Homosexual	3
Lesbian	1
Transsexual	0
Prefer not to say	15
Blank	396

Religion	
Buddhist	2
Christian	166
Hindu	0
Jewish	0
Muslim	6
Rastafarian	0
Sikh	0
None	76
Other religion	1
Prefer not to say	14
Blank	372

Disability / Limitations	
Yes	16
No	581
Blank	41
PEEPS required	3

Appendix 3: Record of fieldwork

This is a record of scheduled activities involving data collection.
In addition to these organised events, I visited the site to attend trustee meetings every fortnight and these provided opportunities before or after the sessions for me to 'hang around' to do participant observation, particularly of volunteer activity. The times are approximated for the purposes of this record but provide an overview of the time spent in the field.

Date	Activity	Time spent in hours	Cumulative hours
03/06/14	Board meeting (project outline and consent)	2.0	
11/06/14	Meeting with LG / CB and Income generation meeting	2.0	4.0
25 /06/14	Receptionist team meeting	1.5	5.5
02/07/14	Care quality Sub-committee meeting	1.5	7.0
09/07/14	Income generation meeting	1.5	8.5
29/07/14	Board meeting	2.0	10.5
31/07/14	Shadowing session	3.0	13.5
03/09/14	Care quality Sub-committee meeting	1.0	14.5
03/09/14	Shadowing session	2.5	17.0
10/09/14	Income generation meeting	2.0	19.0
3/10/14	Interview PS	1.0	20.0
8/10/14	Income generation meeting	2.0	22.0
6/11/14	Interview SW	1.0	23.0
11/3/15	Interview JF	1.0	24.0
17/2/15	Visit DH Shadowing	4.0	28.0
17/02/15	Interview T	1.0	29.0
18/12/15	DH volunteer meeting	2.0	31.0
10/06/15	Meeting SMT vols	1.0	32.0
7/07/15	IPU visit	1.0	33.0
22/07/15	LSP 1 session	2.0	35.0

29/07/15	Meeting	3.0	38.0
16/09/15	LSP 2	2.0	40.0
30/09/15	Interview	1.0	41.0
1/10/15	Interview	1.0	42.0
10/12/15	Interview	1.0	43.0
15/12/15	Meeting	2.0	45.0
17/12/15	Interview	1.0	46.0
2/03/16	Interview	1.0	47.0
2/03/16	Interview	1.0	48.0
2/03/16	Interview	1.0	49.0
18/06/16	Interview	1.0	50.0
30/9/16	Interview	1.0	51.0
3/11/16	Interview	1.0	52.0
24/11/16	Interview	1.0	53.0
10/12/16	Meeting	2.0	54.0
14/12/16	ISG Meeting	2.0	55.0
16/12/16	Interview	1.0	56.0
31/1/17	Meeting	2.0	58.0
8/2/17	ISG Meeting	2.0	60.0
22/03/17	Meeting	2.0	62.0
	Induction training	2.0	64.0
14/6/17	Meeting	2.0	66.0
20/06/17	Study day	6.0	72.0

14/09/17	LSP 3 session	2.0	74.0
9/10/17	Interview	1.0	75.0
6/06/17	Interview	1.0	76.0 \
17/07/17	Interview	1.0	77.0
17/07/17	Interview	1.0	78.0
19/10/18	Interview	1.0	79.0
21/10/18	Interview	1.0	80.0
6/11/18	Interview	1.0	81.0

Appendix 4: Information sheet for participants

University of Huddersfield

"The Workplace Learning Experiences of Volunteers in a Hospice."

Liz Dixon, School of Education and Professional Development, University of Huddersfield

Participant Information Sheet

I am a Senior Lecturer at the University of Huddersfield currently undertaking research for a PhD at the university. I am also a trustee at Fernbank hospice.

What is the research about and what are its potential benefits?

My research aims to identify the contribution volunteers make to a hospice and to enhance understanding of the relationships between paid staff and volunteers. It will inform the policy and practice of using volunteers at Fernbank and help to build the research capacity at the hospice.

Why have I been asked to take part?

Given your involvement as a volunteer or a paid member of staff at Fernbank, your perspective and experiences will be a valuable input to create a better understanding of what volunteering in a hospice involves.

What will I be asked to do?

There are different activities you **might** like to take part in:

1. As the researcher, I will be spending time observing and speaking informally to volunteers and paid staff in the hospice. One way you can participate in the research would be to agree to me spending some time with you 'shadowing' one of your volunteer sessions at Fern Bank. This will give me an opportunity to see you in your volunteer role, discuss it with you and to better understand your role in context.
2. You can take part in an audio-recorded interview. The interviews will be face-to-face lasting approximately one hour. During the interview you will be invited to talk to me about your experiences of being a volunteer, or working with volunteers, at Fern Bank and to share your ideas about the potential benefits, problems and challenges involved in volunteering in a hospice. The interviews will take place at the hospice at a time convenient for you.
3. Finally, you might like to take part in a group session with other volunteers and/or staff. At these sessions participants will be asked to make models using Lego to represent aspects of their experience of volunteering and share their ideas with others in the group. This is intended to be a novel way of sharing ideas and getting a better shared understanding of volunteering at the hospice. These sessions will be recorded on video and digital camera and will last approximately 2 hours.

Do I have to take part?

Participation is completely voluntary and there is no obligation to do so. You can take part in just one or two of the activities if you prefer. If you do decide to take part, you will be asked to sign a consent form, but please note that you will still be free to withdraw at any time and without giving a reason.

What will you do with the findings from the research?

The research is primarily for a PhD qualification which I am undertaking at the University of Huddersfield.

Aspects of the research and its findings may be subsequently published in academic journals, presented at conferences and used for teaching purposes. A summary of the research will also be given to the hospice.

Will I be personally identified in the research?

All participants will be given a false name and this will be used in any written publications, conference presentations or reports. Anything that you say in the interviews/ group sessions that could identify you personally will not be used.

Will the information I provide be confidential?

Yes. This will only be seen by myself, my research supervisors and a transcriber at the University. However, if you should describe events which could be of significant concern, for example workplace harassment or abuse, I may feel obliged to report this to the relevant authorities inside or outside of the University.

No person other than myself, my research supervisors and a transcriber will have access to data. All paper documents will be anonymised and will be kept in a locked filing cabinet and computer files will be password protected.

Has permission been obtained for the research to be undertaken at Fernbank?

Yes, the Directors at the hospice have been fully informed as to the nature and purpose of the research study and given permission in writing for the research to be conducted at Fernbank Hospice. The Board reserves the right to withdraw this permission at any time.

Will taking part have any disadvantages for me?

I do not foresee any disadvantages for those taking part. There is a slight possibility that discussion of experiences as a volunteer may elicit strong or even distressing feelings for some respondents, and you may wish to access support available to you if this is the case:

- any confidential counselling service available to you at the hospice
- support from a friend, colleague or family member.

What should I do if I have any questions?

I will be happy to answer any queries you may have, both before and after taking part in the research.

What do I need to do next if I would like to be involved?

If you would like to be involved in one or all of the events described above, you will need to read and complete a consent form and provide me with your contact details. I will then get in touch with you to discuss arrangements for your participation.

Contact details:

Liz Dixon
Senior Lecturer
School of Education and Professional Development
University of Huddersfield
Email l.dixon@hud.ac.uk

Supervisor:

Professor Helen Colley
h.colley@hud.ac.uk
Dr Kevin Orr
k.orr@hud.ac.uk

Appendix 5: Information poster for the research project

Research : Volunteers at Fernbank



The research project

I am a Senior Lecturer at the University of Huddersfield currently undertaking research for a PhD at the university. I am also a Director at Fernbank hospice.

I am carrying out my research with volunteers and staff at the hospice.

As part of my research, I will be spending time observing and speaking informally to volunteers and paid staff in the hospice. Today I will be spending some time 'shadowing' volunteer sessions at Fernbank. This will give me an opportunity to find out more about volunteers' role and the contribution they make to the hospice.

Taking part in the project

Participation is completely voluntary and there is no obligation to do so. If you would like to know more about the project, there is an information leaflet available on reception. If you would prefer not to be involved, please feel free talk to me at the hospice about any questions or concerns. Alternatively, my contact details are:

Liz Dixon
Senior Lecturer
School of Education and Professional Development
University of Huddersfield
Email l.dixon@hud.ac.uk

Trustees at the hospice have been fully informed as to the nature and purpose of the research study and given their permission in writing for the research to be conducted at Fernbank Hospice.

Appendix 6: Consent form

UNIVERSITY OF HUDDERSFIELD

"The Workplace Learning Experiences of Volunteers in a Hospice."

Liz Dixon, School of Education and Professional Development, University of Huddersfield

Consent form

	Please tick
I have been fully informed of the nature and aims of the research and consent to taking part in it.	
I understand that I have the right to withdraw from the research at any time without giving a reason, and a right to withdraw my data if I wish up to one month after the event.	
I give permission to be quoted (by use of a pseudonym) and understand that direct quotes from my interviews/group sessions may be used in future publications and conference presentations and for teaching / training purposes.	
I understand that the interview and group sessions will be recorded and that the recordings and images will be kept in secure conditions at the University of Huddersfield.	
I understand that no person other than the researcher, her supervisors and transcriber will have access to the recordings.	
I understand that my identity will be protected by the use of a pseudonym and that no information that could lead to my being identified will be used.	

Name of participant .....

Signature .....

Date .....

Name of researcher .....

Signature .....

Date .....

Two copies of this consent form should be completed. One copy to be retained by the participant and one copy to be retained by the researcher.

Appendix 7: Interview Schedule

Thank you for taking part.
Check consent

- Would you like to start by telling me how you came to be volunteer at Fernbank?
- What had you done previously?
- Could you describe the work you do and your role as a volunteer?
- Have you had any training or support in your role?
- How did you learn to do the roles that you have at the hospice?
- Your roles involve working with paid staff at the hospice. Can you tell me how that works? Are there any challenges/problems?
- What do you think are the differences between people how volunteer and those in paid roles at the hospice?
- I imagine being at Fernbank could be emotional at times for volunteers and staff. Have you had any experience of that – difficult situations, relationships, friendships.
- Was there any support available to you?
- What do you get from volunteering?
- What do you think volunteers bring to the hospice?
- Do you see any ways for developing the way volunteers are used at Fernbank?
- What do you think are the challenges volunteers might fact in their role?
- Could you describe what Fernbank would be like without the volunteers?
- Anything more you would like to talk about?

Appendix 8: Planning notes - Hospice Lego session with staff

Welcome

Introductions (Labels) and housekeeping

Audio recorder

Label models

Take photos

Purpose of the session:

- Purpose of the research with reference to Participant Information Sheet
- Explain 'informed consent' – complete 2 copies of consent form
    - (Explain research protocols including informed consent, video recording, photos, use at conferences, anonymity)
- Introduce the principles and techniques of metaphorical modelling

Lego:
Opportunity to play first
Skills Building: Confidence, dexterity, breaking and re-building, getting your eye in!

SKILLS BUILD

1**. Tower building contest** - highest without falling – do the tilt test – ***need tape measure***

2 **Choose 10- 15 pieces from the box :** Build a creature from available pieces (5 minutes)

3. **Other Lego examples to reinforce the concept of metaphor**

Elephant – a headteacher of a school
Air head figure with bubble – a teacher
Other examples to discuss - Web, ladder, net, ghost, crocodile, window

4. **Modify the creature made in 2** – Friday night / Monday morning
    - Share models with the group.

5. **Applying metaphor to a model** (optional extension activity)

    - Select any 15 pieces of your choice.
    - Clear all other pieces away.
    - Free build – don't try to make anything specific
    - Given a choice of 4 words – describe your build as a metaphor of the word on the card

Using the full LEGO sets :

- Build something which represents your current role at the hospice

- Build something which represents a hospice volunteer
- Build something which represents the role of hospice volunteers
- Build something which represents challenges with volunteers
- Working with volunteers - could be you or more generally
- Working in a Hospice without volunteers

REMINDERS

- Tape measure
- Camera
- Reorders
- Script
- Labels
- Tower building certificate