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Hospice volunteer as patient advocate: A trait approach

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ABSTRACT

Objective: The purpose of this study is to examine traits of hospice volunteers that facilitate their success in this informal caregiving role, with the larger goal of alleviating the family caregiver burden and providing additional support to the hospice patient. To achieve this goal, a new scale was developed to tap into how hospice volunteers view their patient advocacy role.

Method: Participants were 136 trained hospice volunteers from the Midwest who had direct contact with hospice patients. Volunteers mailed anonymous surveys that included measures of argumentativeness, locus of control, attitudes toward patient advocacy, and key demographic items. A new scale was developed to measure patient advocacy by hospice volunteers called the Hospice Volunteer as Patient Advocate.

Results: Submitting this scale to exploratory factor analysis, two factors emerged: duty as patient advocate and support of patient rights. After performing a multiple regression analysis, results showed that female volunteers who were high in internal locus of control were more likely to perceive that volunteers have a duty as patient advocates. Younger volunteers with more years of volunteer experience, higher levels of internal locus of control, and lower external locus of control were more likely to support patient rights.

Significance of results: The findings of this study could be used to formalize hospice volunteers' role as patient advocates, thus better utilizing them as committed, caring communicators and improving patient-centered care at end-of-life.

KEYWORDS: Hospice volunteer, Patient advocate, Communication, Locus of control, Argumentativeness

INTRODUCTION

Deinstitutionalization, or caring for chronically ill and/or terminally ill patients in the home, is becoming an increasingly popular choice among American families. According to the U.S. Department of Health and Human Services' report on informal caregiving (1998, p. 5), over 50 million people per year provide care for a chronically ill, disabled or aged family member or friend during any given year in the home. The number individuals 65 years of age and older is expected to continue to grow at the rate of 2.3% per year but the number of family members available to care for them will only increase at a 0.8% rate (Mack et al., 2001). This trend continues despite the toll that caregiving can take on family members (Arno, 2006). One of the many duties that family caregivers perform for their loved ones is serving as a patient advocate. However, the stress of caring for a loved one who is dying can sometimes overshadow patient-centered care (Waldrop et al., 2005).Fortunately, hospice programs and volunteers step in at this point to provide respite and support for hospice patients and their families. The purpose of this study is to examine traits of hospice volunteers that facilitate their success in this informal caregiving role, with the larger goal of alleviating the family caregiver burden and providing additional support to the hospice patient. To achieve this goal, a new scale was developed to tap into how hospice volunteers view their patient advocacy role. Specifically, this

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study will investigate the role of two relevant communication traits (argumentativeness and locus of control) in hospice volunteers' attitudes toward patient rights and volunteers' duty as patient advocate. Both researchers have served as hospice volunteers.

Hospice volunteers are considered the 'backbone' of hospice care (Caldwell & Pearson Scott, 1994; Paradis & Usui, 1989), providing unique contributions to the palliative care movement (Guirguis-Younger et al., 2005). Due to rising health costs, hospice volunteers have become even more critical to maintaining the patient-centered philosophy of hospice care. In 2007, an estimated 400,000 active volunteers worked in hospices, of those 400,000, 58.7% assisted with direct patient care, typically devoting 45.1 annual hours, and providing 16 million total hours of annual service (National Hospice and Palliative Care Organization, 2009).

Hospice volunteers' roles range from providing direct services to the patient and family to providing administrative support, public relations, community education, respite for home caregivers, and gardening, and pragmatically, are "an important source of unpaid labor in hospices" (Dein, 2005). They offer social and emotional support through personal and team interactions with patients, families, physicians, nurses, religious and spiritual practitioners, staff, and other volunteers. Hospice volunteers are part of the hospice team providing a patient-centered focus to minimize patients' suffering as they progress through end-of life stages (Byock, 2000). This patient-centered focus is guided by patients' aims, choices, and needs, and necessitates "the ability to communicate effectively to be able to deliver care that is informed and directed by the patient" (Earp et al., 2008, p. 581).

Hospice volunteers have traits that make them uniquely qualified to provide patient-centered care to their patients. For example, Egbert and Parrott (2003) found that hospice volunteers differed from hospital volunteers in that whereas hospital volunteers were more likely to provide instrumental support, hospice volunteers were more likely to provide emotional and personal support. In a related vein, Mitchell and Shuff (1995) administered Myer-Briggs Type Indicator tests to hospice volunteers. Their results indicated higher levels of extraversion and a preference for using intuition as a way of gathering information; these results were also consistent with previous research (Paradis & Usui, 1987). Thus, the "typical" hospice volunteer is likely to be a social, caring, and empathetic communicator who works to build a trusting relationship with the hospice patient.

Serving as a hospice volunteer is not without its challenges. After analyzing transcripts of 17 focus groups of hospice volunteers, Dein (2005) reported the stresses to hospice volunteers included losing patients and dealing with the physical disfigurement of patients, but those volunteers generally viewed their work as satisfying. Volunteers also reported coping with stress by perceiving death as a natural process, seeking support from other volunteers, and finding solace in religious faith (Dein, 2005). Conversely, volunteers gain satisfaction thorough giving their free time for important causes, achieving self-fulfillment and personal growth, and learning about life and death (Claxton-Oldfield et al., 2004; Field & Johnson, 1993; Sadler & Marty, 1998).

In addition to these unique qualities, hospice volunteers inhabit an unusual position within the interpersonal network of hospice patients. Volunteers are neither hospice professionals nor naturally-occurring friends, yet they often bridge the gap between these two roles. This unique position may be a result of ambiguous relational and role boundaries that separate volunteers from the paid, emotionally-detached component of staff, administration, and health professionals (Fox, 2006). Hospice volunteers often become friends and confidantes because it may, at times, be easier for hospice patients to discuss their fears or uncertainties with a non-professional, committed volunteer. However, due to this unique social and organizational position, hospice volunteers have the potential to fulfill an additional role that could greatly benefit hospice patients and their families — that of patient advocate. The hospice volunteers' position complements the traditional advocacy role of nurses in supporting the compassionate processes of accommodation and adaptation to end-of-life issues.

Hospice Volunteer as Advocate

Patient advocacy is motivated by three main goals: patient-centered care, dependable medical systems, and greater patient participation (Earp et al., 2008). A nurse serving as a patient advocate helps the patient handle the healthcare experience by providing information to support and promote the patient's decisions (Mallik, 1997a). However, some research has indicated that nurses often perceive that organizational inequalities in professional status, power, and work roles make it difficult for them to have the authority to question either the medical profession or health care systems (Hewitt, 2002). Hospice volunteers, with their unique supportive skills, could provide an untapped communication channel for both patients and hospice nurses.

It may be difficult to conceptualize what communication skills or traits can equip hospice volunteers best when undertaking the role of patient advocate.

From a legal standpoint, the term *advocate* is "one who pleads the cause of another" (Oxford English Dictionary, 1989). In the clinical setting, patient advocacy has emerged as a popular philosophy in nursing literature, "a buzzword that has been linked with concepts of morality, ethics, autonomy and patient empowerment" (Hewitt, 2002, p. 439). Considerations of these and other definitions of advocacy lead to the idea that an advocate should be not only empathic, but one who actively communicates on behalf of another person and protects the person's rights and personal control. One who communicates on behalf of another should be able to argue credibly and persuasively argue in appropriate contexts with those in authority. To do so, a person must have a strong sense of personal empowerment. Thus, two traits that might be related to this picture of an advocate are argumentativeness and locus of control.

Argumentativeness

Aptly, argumentativeness is defined as "a generally stable trait which predisposes individuals in communication situations to advocate positions on controversial issues" (Infante & Rancer, 1982, p. 72). Argumentativeness could be a useful trait for those volunteers who represent their patients' opinions, beliefs, and attitudes to other parties. Previous research has indicated that individuals who are argumentative are often more credible leaders in group problem-solving discussions and are perceived more positively by subordinates (Infante & Rancer, 1996). Infante and Rancer (1993) tested individuals' frequency of engaging in advocacy and refutation interactions. They defined advocacy as "when you state your position on a controversial issue and then defend your position when it is attacked by other individuals" and refutation as "when you attack the positions that other people take on controversial issues" (p. 419). Results of this study indicated that highly argumentative individuals engaged in more advocacy and rebuttal interactions than those individuals with moderate or low argumentative levels. Thus, we hypothesize that:

H1: Hospice volunteers high in argumentativeness will be more likely to report that the role of hospice volunteer is to serve as patient advocate.

Locus of Control

Another variable of interest related to patient advocacy is the amount of control an individual perceives he or she has over life circumstances. Specifically, locus of control (LOC) is the amount and type of control individuals believe they have over their own behavior. Rubin (1993) suggested that LOC relates to interpersonal motivation; individuals with external LOC believe that powerful others control their lives and are motivated by an inclusion motive to communicate with others. Individuals with internal LOC believe they have control over their environment and tend to be motivated to communicate by a control motive; they desire communication because they can use it to advance their own agendas. Brenders (1989) reviewed research on LOC in health communication and found that internal LOC is linked to coping with life stress and illness. Individuals with internal LOC were more assertive, proactive, and autonomous in interpersonal situations, and perceived the value of health communication information to assist them in maintaining control of choices. These conclusions would support the following hypotheses:

H2: Hospice volunteers high in internal LOC will be more likely to report that the role of hospice volunteer is to serve as patient advocate.

H3: Hospice volunteers high in external LOC will be less likely to report that the role of hospice volunteer is to serve as patient advocate.

METHOD

Participants

This research study was approved by the Kent State University Institutional Review Board. A total of 380 sealed survey envelopes were hand-delivered to the participating hospice volunteer coordinators. The volunteer coordinators were asked to label and mail the sealed, postage-paid survey contents to their hospice volunteers who had direct patient contact. Seven surveys were returned to the researchers with incorrect addresses and one incomplete survey was returned. Thus the corrected total number of circulated surveys sent to hospice volunteers as 372. Of the distributed surveys, 155 completed surveys were returned, making the return rate of completed surveys 41.7%.

Although the researchers asked the hospice volunteer coordinators to include only hospice volunteers with direct patient contact in the pool of study participants, 14 reported no direct patient contact, five did not report their patient contact status, and 136 reported they did have direct patient contact. The participants with patient contact who returned completed surveys ($n = 136$) were hospice volunteers in the Midwest (110 female, 25 male and 1 who did not report his/her biological sex). The ages of the respondents ranged from 19 to 84 years ($M = 60.34$, $SD = 12.92$). Regarding racial/ethnic background, 109 were Caucasian, two were Asian/Pacific Islander, one was Hispanic, one identified himself/herself as Other, and one did not report his/her ethnicity. With regard to marital status, 93 were married, 16 were single or never married, 14 were widowed, 12 were divorced, and one did not report his/her marital status. Respondents reported an average of 4.49 years of volunteering ($SD = 4.37$) that ranged from < 4 months to >18 years (four participants did not report their volunteer years), an average of 9.59 hours per month of volunteering ($SD = 11.01$) that ranged from one hour per month to 100 hours per month (17 participants did not report their volunteer hours).

Procedures

Telephone contact was made with seven hospice volunteer coordinators in the Midwest to request their cooperation with the study. Six of the hospice programs were public facilities that offered both home care and a hospice care facility; one was a private service offering home care only. After they agreed to participate, each hospice volunteer coordinator then received packets that each contained a letter to prospective participants, a copy of the survey, and a self-addressed stamped envelope (addressed to the researchers). A total of 380 sealed survey envelopes were delivered to participating hospice volunteer coordinators. The volunteer coordinators were asked to affix labels addressed to their hospice volunteers and mail the pre-stamped envelopes. Participants were informed that the hospice program for which they volunteered was distributing the surveys on behalf of the researchers and that participation was anonymous and voluntary. Passive participant consent was provided when participants filled out and mailed the completed survey.

Instruments

Participants completed measures of volunteers' patient advocacy, argumentativeness, locus of control, and several demographic items.

Hospice Volunteer as Patient Advocate (HVPA)

The HVPA scale was adapted from Ingram's existing Patient Advocacy Scale (PAS) (1998), which assessed how nurses act as patient advocates. PAS is a 50-item, 5-point Likert-type instrument with response options ranging from "strongly disagree" to "strongly agree". For this project, the researchers excluded questions that were specifically related to nursing and instead focused on questions related to patient rights, advocacy, volunteer duty, truthfulness with patients, and pursuing political change to improve patient care. The resulting scale included 25 items designed for hospice volunteers. As the scale was developed specifically for this study, the 25 items were subjected to exploratory factor analysis. Although there were eight Eigenvalues greater than one, the visual scree procedure suggested a four-factor solution, accounting for 49.52% of the total variance. However, upon consideration of the resulting four latent factors in this sample, the fourth factor was determined to be nonsensical, and third factor had poor reliability (Cronbach's alpha = .51). Thus, for this exploratory study, only two factors were retained (Table 1). The two factors were named "Patient Rights" (Cronbach's alpha = .88) and "Volunteer Duty" (Cronbach's alpha = .79) and each included six items.

Argumentativeness

The Argumentativeness Scale (Infante & Rancer, 1982) is a 20-item two-dimensional self-report instrument that measures tendency to approach arguments (ARGap) and avoid arguments (ARGav). The five response options range from "almost never

Table 1. *Final Factor Solution*

Item	Factor 1 Patient Rights	Factor 2 Volunteer Duty
Patients have a right to know their diagnosis.	.86	.11
Patients have a right to know their own prognosis.	.83	−.01
Patients have a right to be told if they are going to die.	.79	.01
The cultural orientation of the patient should be respected even when it conflicts with my own values.	.70	.09
Patients have the right to make their own choices.	.62	.28
Patients should be able to refuse care.	.62	.11
	Reliability = .88	
Volunteers should assist patients to complain where necessary.	.12	.76
Patient advocacy is fundamental to the role of the volunteer.	−.01	.74
Acting as a patient advocate is a rewarding experience for the volunteer.	.03	.72
Volunteers have a duty to campaign for better health care for all.	.07	.70
Volunteers should speak up for patients who cannot do so themselves.	.14	.65
Volunteers should pursue political change to improve patient care.	.10	.52
	Reliability = .79	

true" to "almost always true." Previous reliability coefficients ranged from .86 to .91 for ARGap and .82 to .86 for ARGav items (Infante & Rancer, 1982; Infante, 1987; Rancer et al., 1985; 1992). Similar to these studies, reliability for the current study fell within acceptable ranges (Cronbach's alpha = .87 for ARGap; Cronbach's alpha =.84 for ARGav).

Locus of Control

Levenson's (1973) multidimensional Locus of Control (LOC) instrument is a 24-item 5-point Likert instrument (with responses ranging from "strongly disagree" to "strongly agree"). Levenson's scale modified Rotter's (1966) LOC instrument, as Rotter's LOC examined how individuals perceived *only* internal and external control. Levenson (1973) reported that the internal consistency estimates were only moderately high, Kuder-Richardson coefficient alpha was .67 for the internal scale, .82 for the powerful others, and .79 for the chance scale. Levenson's (1973) LOC scale was used because it expanded on the internal and external control to include luck, chance, and fate (separate from external control). Lindbloom and Faw (1982) concluded that the factor structure for Levenson's 24-item instrument was reliable and supported the multidimensional nature of locus of control. Reliabilities for this current study were internal LOC (Cronbach's alpha = .69), external LOC (Cronbach's alpha = .74), and chance LOC (Cronbach's alpha = .78).

Finally, we computed two stepwise linear regression equations: one for patient rights and one for volunteer duty. To control for individual differences, volunteers' demographics were entered in the first step (age, gender, years of experience as a hospice volunteer, and number of hours per month devoted to hospice volunteer work). In the second step, all three LOC variables were entered, and argumentativeness was entered in the final step.

RESULTS

The primary goal of this research was to investigate how two traits of hospice volunteers might influence their role as patient advocates. A secondary goal was to develop an instrument to capture quantitatively how patient advocacy was viewed by this volunteer population. A measure of hospice patient as patient advocate (HVPA) was developed following the lead of two previous exploratory studies in nursing (Hatfield, 1991; Ingram, 1998). Results of the current study's exploratory factor analysis revealed two viable factors: patient rights and volunteer duty (Table 1).

To achieve the primary goal of this study, these two dependent variables (patient rights and volunteer duty) were investigated for their relationship to LOC (internal, external, and chance) and argumentativeness. Results revealed that age, the number of years experience as a hospice volunteer, and having a higher internal and lower external LOC predicted volunteers' support for patient rights (Table 2). Demographic variables alone explained 9.1% of the variance in hospice volunteers' perceptions of patient rights (adjusted R^2). After adding LOC variables in step two, 23.16% (*adjusted* R^2) of the variance was explained (R^2 Change = 14.06; $p < .01$). The addition of argumentativeness did not significantly improve the model predicting hospice volunteers' perceptions of patient rights (R^2 Change < .01; $p = .43$).

With regard to perceptions of volunteer duty, only having a higher internal LOC was a significant predictor (Table 2). Demographic variables explained less than one percent of the variance in hospice volunteers' perceptions of volunteer duty. However with the addition of the LOC variables, 26% (adjusted R^2) of the variance was explained (R^2 Change = .29; $p < .01$). As with patient rights, argumentativeness did not significantly predict hospice volunteers' perceptions of volunteer duty (R^2 Change= .02; $p = .17$). A complete bivariate correlation matrix is shown in Table 3.

DISCUSSION

More and more patients are being encouraged to take ownership and responsibility for their own health

Table 2. *Regressing patient rights and volunteer duty on volunteer demographics, locus of control, and aggressiveness variables: Summary of the final results*

Predictor	Patient Rights Final β	Volunteer Duty Final β
Step 1		
Age	−.31**	.06
Gender	−.08	−.21 (p = .057)
Volunteer Years	.23*	.02
Volunteer Hours	.12	−.03
Step 2		
Internal Locus of Control	−.24*	−.42***
External Locus of Control	.38*	−.19
Chance Locus of Control	−.08	−.08
Step 3		
Argumentativeness	.09	.16

Note: All betas are final betas on the last step of the regression.
* $p<.05$, ** $p < .01$, *** $p < .001$.

Table 3. *Bivariate correlations for patient advocacy and subscales*

Subscale	1	2	3	4	5	6	7	8	9
1. Patient Rights	4.51 (.53)	.26**	−.24**	.22*	.24**	−.04	.05	.05	−.08
2. Volunteer Duty		3.70 (.66)	−.37**	−.12	−.04	.15	.06	.08	.12
3. Internal Locus of Control			2.38 (.51)	−.03	−.16	−.23*	.10	.04	.05
4. External Locus of Control				3.78 (.48)	.74**	−.16	.08	−.01	−.03
5. Chance Locus of Control					3.68 (.54)	−.09	−.08	.01	.09
6. Argumentativeness						−3.94 (11.02)	−.21*	.11	−.17
7. Volunteer Years							4.50 (4.38)	.14	.36**
8. Volunteer Hours								9.60 (11.01)	.09
9. Age									60.34 (12.93)

Note: Means and Standard Deviations are reported on the diagonal.
** Correlation is significant at the 0.01 level (2-tailed).
* Correlation is significant at the 0.05 level (2-tailed).

care (Wright et al., 2007). For hospice patients, who are often frail or otherwise unable to clearly represent themselves, having a patient advocate has become an essential part of navigating the complex United States health care system. As patient advocates, family members know the patient well, but may not fully comprehend the health care system and its terminology. On the other hand, health care providers understand the health care system much more, but may know little about the patient. Hospice volunteers could serve as innovative, alternative patient advocates due to their unique roles in patient's lives: serving simultaneously as members of the patient's personal network and of the professional hospice team. This study makes an important first step toward a better understanding of the concept of volunteer advocacy so that researchers and clinicians can help foster these types of relationships.

Toward this end, the HVPA was adapted using items from Hatfield (1991) and Ingram (1998). The current HVPA was initially a four-factor structure obtained through exploratory factor analysis; however only the first two latent factors showed acceptable validity and reliability. Thus, the HVPA contained two subscales (patient rights and volunteer duty), each with six items.

In addition to examining the latent constructs of patient rights and volunteer duty through the development of the HVPA, this study looked at the relationship of these variables to volunteers' locus of control (internal, external, and chance) and levels of argumentativeness. After controlling for relevant demographic variables (age, gender, number of years spent volunteering, and number of hours per month spent volunteering), results showed that external (powerful others such as doctors, staff, and patient' relatives) and internal LOC (personal control to advance one's own agenda) were related to volunteers' perceptions of patient rights and volunteer duty. Specifically, volunteers' perception of the importance of patient rights was positively related with having a higher internal LOC and a lower external LOC. Volunteers' perceptions of their duty as patient advocates was positively related to their internal LOC. In other research, an internal locus of control has been associated with other positive communication outcomes, such as the increased use of reasoning (Canary et al., 1986), decreased use of coercion strategies to influence or persuade (Brenders, 1987), and overall success in interpersonal interactions (Avtgis & Rancer, 2006).

After controlling for relevant demographic variables and LOC, argumentativeness was not found to be a significant predictor of either patient rights or volunteer duty. Previous research indicated that argumentativeness was linked to advocacy (Avtgis & Rancer, 1997); however the results of this study did not support this relationship for this context. One possible reason for these results may be that the word "argument" seems counter to the goal of providing supportive and compassionate care. The majority of this sample was comprised of female volunteers, and it may be that the term "argument" had a negative connotation, and thus was not measuring the positive communication construct of argumentativeness as defined by Infante and Rancer (1982). It may be that with this study's population, other trait scales, such as assertiveness (Lorr & More, 1980; Martin & Anderson, 1996; Rathus, 1973), willingness to communicate (McCroskey & Richmond, 1987), or interpersonal communication competence (Rubin & Martin, 1994), could be used to tease out the component of patient advocacy that indicates how volunteers persuade, support, or assert their hospice patients' rights or concerns.

Implications

A recent study found that one reason people might decline to have a hospice volunteer in their home is the concern that volunteers do not receive enough training (Claxton-Oldfield et al., 2009). Traditionally hospice volunteer training has focused on empathetic, altercentric (concern with, interest in, and attentive to a conversational partner), supportive, and accommodating communication (Hall & Marshall, 1996). Volunteers may not currently view their role as one of actively interceding for their patients' rights. This perception might explain why the present study found that argumentativeness was not highly related to advocacy among hospice volunteers. To equip hospice volunteers for the role of patient advocate, hospice volunteer training programs may need to incorporate communication skills such as assertiveness, nonverbal communication, and persuasion. Recent research revealed a link between LOC and communication skills training, "physicians with an 'internal' LOC demonstrate communication skills acquisition to a greater degree than those with an 'external' LOC" (Libert et al., 2007, p. 560). Recognition of the LOC link could enhance communication training, to help hospice volunteers become more aware of utilizing their 'internal' LOC to advocate for their patients by learning to control and enhance competent interpersonal communication. These skills could create more competent communicators who could reason effectively with staff, professionals, other volunteers, patients' family, and, ultimately, patients. The training would include sensitivity to patients' cultural traditions, personal values, family circumstances, and lifestyles. The importance of both patient rights and volunteer duty distinguishes hospice volunteers as viable candidates for formal communication training focused on person-centered support, sharing information, responding to emotions, assisting with decision-making, managing uncertainty, and enabling patient self-management (Epstein & Street, 2007).

Incorporating communication skills related to patient advocacy could increase volunteers' latitude and autonomy to improve social support for patients. The result could be more assertive, competent, and committed volunteers. The hospice philosophy, protocols, and individual policies would need to accommodate this new volunteer role, by including the relevant privacy issues that are legally and ethically required when communicating about sensitive health issues. Each hospice organization would need to support and clarify this innovative, boundary-spanning volunteer role carefully with its own governing body, board of directors, and volunteers. The outcome could foster a stronger role identity for the volunteers as part of the hospice care team. Hospice organizations could also benefit by creating a new patient communication support channel, thus improving patient empowerment about their end-of-life decisions.

Limitations and Future Directions

There may be some limitations in this study's sample that are related to the population as a whole. The current study's sample was predominantly older ($M =$ 60.34 years), Caucasian, and female, which is consistent with previous research about hospice volunteers (Egbert & Parrott, 2003). It is an ongoing challenge for volunteer-dependent organizations to recruit diverse volunteer candidates. Hospice patients and their families are far more diverse than the fairly homogeneous group of volunteers who serve them (Roessler et al., 1999). In addition to the demographic information collected in this study, future research might include level of education and other relevant socio-economic (SES) variables such as income level. Collecting SES data could help researchers understand additional factors that influence patient advocacy and provide clues to any linkages.

The *Patient Bill of Rights*, adopted by the U.S. Advisory Commission on Consumer Protection and Quality in the Health Care Industry in 1988 (National Institutes of Health), the Hospice Association of America (2008) developed the *Hospice Patients' Bill of Rights* in 2005, and the *Pain Care Bill of Rights* (American Pain Foundation), although not required by law, are all generally accepted and practiced by United States hospices. This strong emphasis on individual rights and autonomy is important in understanding the patient advocacy movement in United States health care that continues to be fueled by rapid advances in medical technology, suspicion of medical advice, and the emerging business model of the patient as a consumer (Mallik, 1997b). This study suggested that hospice volunteers already exhibit strong beliefs about the rights of patients and currently may be practicing patient advocacy in an informal capacity. The next step might be to recognize and formalize their role as patient advocates and move the volunteer from a peripheral position in the hospice patient's network to a role as a more fully integrated member of the multi-disciplinary hospice team. Hewitt (2002) argued that nurses are not the only patient-centered agents in contact with patients. Likewise, Guirguis-Younger et al. (2005) suggested that the hospice volunteers' presence provides more than just instrumental help during the patient's dying experience; it also fills a void and creates "crucial existential, spiritual, and developmental time" (p. 114).

This study represents a first step toward creating an instrument to measure hospice volunteers' tendency to advocate on behalf of patients and their families. Patient advocacy and communication competence are multifaceted constructs. Future research needs to look at whether the subscales of the HVPA can be reproduced in related populations where patient advocates are needed. The researchers intend to refine the current HVPA measure to extend the identification of the critical variables related to the communication action of patient advocacy. Toward this end, additional factors such as volunteers' spirituality, religiosity, concern for better health care for all, and truthfulness may need to be examined. These concepts could provide a volunteer advocacy model that fits into the larger hospice ethos of holistic, compassionate, patient-centered communication.

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