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ESSAY/PERSONAL REFLECTIONS

Professionalization of hospice volunteer practices: What are the implications?

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Volunteers are increasingly considered as core members of interdisciplinary palliative care teams, and thus no longer “informal providers.” The definitive trend towards formalizing the role of hospice volunteers is indicated not only by national work to develop best practices (Ferris et al., 2002), but also by efforts of the Canadian Council on Health Services Accreditation to develop quality indicators for accrediting volunteer agencies. This movement emerged from a need to coordinate, define and standardize the role of volunteers in palliative care settings, as well as to manage organizational resources and maintain standards of excellence. The purpose of this forum is to highlight the possible impact of this development on the nature of volunteer contribution to end-of-life care.

We acknowledge that there are many good reasons for formalizing the role of volunteers and implementing accreditation criteria. For hospice volunteer organizations, having a well-defined mandate and standards for quality improves their credibility with health care organizations, health care professionals, as well as funders. Undoubtedly, a clearly defined scope of practice thus improves volunteer accountability and visibility in the health care system. Having “best practices” means that expectations of volunteers are clearly understood by others, and explicit standards will delineate the nature and boundaries of the volunteer role with clients and families. In addition, accreditation of volunteer organizations may enhance funding opportunities because it provides a means to encourage and demonstrate consistent high quality care delivered by volunteers.

Designing and implementing a framework of best practices is expected to introduce great advantages for the management and administration of volunteer programs. For example, volunteer coordinators can benefit by having a model to guide volunteer practice. A framework of best practices and core competencies can assist in the recruitment of new volunteers, training and the application of training standards, the supervision of volunteers, and dealing with issues of liability and ethics.

While it is clear that developing volunteer best practices as basis for accreditation will benefit the organizations and health care system, it is less clear how this might change the experience of the volunteers themselves, and the experiences of clients and families. Implicit in the effort towards defining and formalizing volunteer practices and accreditation is to standardize behavior, role, and expectations. How will this trend to professionalize the role of hospice volunteers impact their work? Will volunteers find their work more or less satisfying? Will having a professional framework facilitate or be a barrier to recruitment of new volunteers? Will families value their relationships with volunteers more or less than before? These and other questions need to be carefully examined, and the answers incorporated in the work of accreditation initiatives.

Volunteer contributions are unique and must have a privileged status in palliative care. Volunteers have been a crucial part of the palliative care movement and have been, in some ways, the most steadfast element in end-of-life care. The accreditation movement actually serves to acknowledge the primary rather than ancillary role of the volunteer in palliative care. However, caution must be observed

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in safeguarding the most important element in the volunteer experience: the relationship of the volunteer and the dying individual.

This relationship between volunteers and those with whom they work remains somewhat of a mystery. Volunteers provide a great deal more than instrumental help; their presence becomes part of an individual's dying journey, a crucial existential, spiritual, and developmental time. There is an extensive literature focused on the motivation of volunteers to take part in the rather difficult admission to mortality and its inevitability (e.g., Morrow-Hawell et al., 1999; Payne, 2002; Webster & Kristjanson, 2002). Volunteers share their time and presence with dying strangers (Stoddard, 1992), yet, many aspects of the volunteer experience remain unknown.

It can be argued, that like some other intimate relationships throughout life, there is mutuality between the volunteer and the dying individual, in which healing, growth, and recognition of common humanity can occur. Palliative care volunteers know that they do something that professional providers often do not. They are keenly aware that they have a distinctive connection with the dying person, and making this connection is fundamentally the reason and reward of their experience. Volunteers describe their experience as deeply rewarding; they report that these enriching encounters with dying others sustain them through dealing with the difficulties of loss and death. In other words, volunteers gain personal meaning, fulfillment, maturity, growth, improved helping skills, and a sense of efficacy from their volunteer work (Morrow-Hawell et al., 1999; Payne, 2001, 2002; Webster & Kristjanson, 2002). While it is important to introduce guidelines and standards, it is crucial to allow and protect the human process.

There is no doubt that advances in science and palliative medicine have brought remarkable benefits to end-of-life care (e.g., pain management). It has been suggested, however, that science has transformed death into a "technical" experience rather than a time of transformation, reconciliation, and peaceful closure (Hawthorne & Yurkovich, 2003). 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. Volunteers belong to a long lineage of social action and natural helping. There is a huge reservoir of tacit, even subversive, knowledge embodied within the practice of volunteers, which needs to be protected. Through volunteers, the community extends its natural helping to end-of-life care, and offers sympathetic understanding of the dying process through lived experiences and cultural diversity (McKinnon, 2002; Payne, 2002); and in this way the community along with the dying individual become the unit of treatment.

While the motivation for the development best practices and accreditation is to improve the quality of care, these authors raise a caution. Volunteers who see themselves as natural helpers may find the trend to professionalization less compatible with their expectations and interests. Many of the strengths hospice volunteers bring to their work include their commitment to the primacy of their relationships with others, and relate to their personal experiences as caregivers and their desire to give back to the community. It is possible that the greater the formalization of the volunteer role, the less likely it is that volunteers can offer clients what they need most. In fact, as health care professionals become increasing focused on the medical aspects of care (Hawthorne & Yurkovich, 2003), there is increasing need for volunteers to fill the void in the area of human relationship and shared human experience.

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