Contributions to Patient Satisfaction: A New Role for Hospital Volunteers

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INTRODUCTION

Traditionally, hospital patients have communicated with medical professionals and hospital personnel directly or through such "linking persons" as family members or friends. For some patients, however, this process does not always work. A hospital is an organizationally-complex and technologically-sophisticated environment which can be confusing even to those who have extensive experience with it. The difference between a patient's everyday life and his or her status as a patient in a hospital can lead to a feeling of helplessness regarding medical and non-medical problems alike. The thesis of this paper is that volunteers can make a contribution toward alleviating this feeling and that the contribution volunteers can make is substantially different from the services of health care professionals.

Various hospital professionals are concerned with patient satisfaction and communication mechanisms. Social workers and pastoral counselors as well as, more recently, patient advocates or ombudsmen are involved (e.g. Adcroft; Hospitals). Also, hospital administrators and medical personnel have become increasingly concerned about patient satisfaction. No doubt the advent of the malpractice suit is one reason, and hospitals are naturally concerned about their reputation in the community. Perhaps most important, there is a growing recognition in medical literature of the role of the patient him or herself in preventing and recovering from illness, (e.g. Reeder; Sehnert; Haug and Lavin).

The patient sometimes needs help in pursuing an active role in his or her treatment process. Empirical studies have shown that health consumers often are dominated by the opinions of health providers even in situations where the consumers are given the role of expert, as in community health planning committees (Parkum and Parkum). The family member can frequently be of help to the patient because he or she knows the details of the patient's situation. The patient advocate or other helping professional can sometimes help because he or she is specially trained to perform this role. The limits on the professional's role are that he or she, by definition, is instrumentally oriented, task specific, emotionally neutral, and limited in time allocation. The patient advocate in particular is meant to deal mainly with the exceptional case rather than cater to patient problems which appear routinely and are not due to shortcomings or shortcircuits in the hospital organization.

The patient advocate and other helping professionals also have potential conflict of interest problems as hospital employees. With patients

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coming and going, loyalties and ties are likely to be formed with other hospital employees, and this may eventually render the professional less effective. Even if this is not the case, the helping professional will not have the time to discover and attend to tasks which require detailed acquaintanceship with a patient, such as emotional support or assistance with a patient's private matters left unresolved because of the hospitalization. These are left to family members or friends. Sometimes a patient does not have such helpers, and this is where the volunteer can assume a new role.

Volunteers have been used in hospitals for many years, but traditionally hospitals have been reluctant to involve "non-professionals" directly in patient care-related assignments. A break with this tradition has taken place in maternity wards where progressive hospitals have given the father-to-be (or sometimes another helper of the woman's choice) a recognized role in recent years, with considerable success. Volunteers can make similar contributions throughout the hospital if properly recognized and utilized. The results of this study demonstrate the need for such new volunteer roles.

METHODOLOGY

A random sample of 32 adult patients was taken from four surgery floors of a medical school-related hospital specializing in tertiary care[1] in the southeastern United States. Nurses as well as the family member or friend who was most involved with the patient were also interviewed. Family or friends whom the patients identified as being most helpful to them during their hospitalization are here referred to as "linking persons." Surgery floors were selected because it was felt that surgery patients would display most of the problems of hospital patients in general and would not uniformly display characteristics unique to any given medical condition. During a typical period almost half the patients in the hospital were surgery patients. Both pastoral care services and a patient representative were available to these patients.

The patients were interviewed twice: first at the beginning of hospitalization, usually prior to surgery, and again toward the end of their stay. Nurses and linking persons were each interviewed once for each patient during the latter period. Four different semi-structured interview schedules were used. The 125 interviews were conducted by three trained interviewers. All data-gathering was completed within a three-week period.

RESULTS

While questions were asked on a variety of subjects, the responses were most interesting relative to three variables: needs; socio-economic status; and sex.

Patient Needs

Since information was gathered from patients both early and later during their hospital stay, from nurses, and from family members acting as a link between the patient and the hospital, a spectrum of perspectives was obtained. The nurses, for example, felt that 47% of the sampled patients had special needs or problems. The nature of these problems was, according to the nurses, non-medical in 67% and medical in 33% of the cases. Family members, on the other hand, recognized only special needs and problems in 31% of the patient population. About one-fifth of the patients were not able to identify a family member or friend who could speak for them and almost as many, 16%, said they needed an additional helper acting as a friend or family member. Other questions to patients, linking people, and nurses, indicated needs for assistance beyond what the hospital provided in the case of 50% of the sampled patients.

Patients were asked if there was ever a time during their hospital stay

when they needed help and could not get it. While most had not had this problem, 25% had had difficulties. These people had generally not been assisted by helping professionals working in the hospital. Only 19% of all patients had been contacted by pastoral counselors, and these patients were not necessarily those with special needs. The patient representative had only helped in one case, and support by social workers was also not in evidence.

The nature of the tasks provided by linking persons was primarily emotional support and visitation and sometimes assistance with household duties. In a few cases, family members helped out by dealing with medical and hospital issues concerning the patients. More of these cases were cited by family members than by hospital personnel. Specific examples included cases in which patients were unable to obtain needed information from hospital staff. One such patient could not get the attention of the medical personnel when necessary. The personnel felt the issue had been resolved because they had explained what the patient had to do, in this case filling out several forms. The patient still did not understand and was at a loss about what to do and very upset. This particular patient, a lower class black male, did not have a linking person, and he was not being helped.

In other cases, a linking person or a hospital employee helped resolve the problem. Sometimes the help consisted of obtaining information for the patient and sometimes it was a question of arguing on behalf of the patient, bringing specifics about the patient's situation to the attention of the relevant hospital employees.

Socio-Economic Status

Patients with higher socio-economic (SES) characteristics were more confident in their ability to obtain information from the hospital staff. Those with more than average contact with nurses had higher SES in 75% of the cases, and patients with lower SES more frequently than others said that they had not had the chance to ask all the questions they would like about their condition or hospitalization. Probably as a result of the more frequent contact between higher SES patients and nurses, the nurses were more aware of the situation of these patients, including if they had family members or others helping them. The higher SES patients also had other advantages, notably more family members available and assistance from these linking persons which went beyond just emotional support and visitation. Lower SES patients more frequently obtained their help from lower-ranked employees. For example, the families of higher SES patients more often mentioned physicians as the person on the hospital staff who helped the most.

Sex Differences

While the sex of patients was related to the sex of the linking person helping them (with men having almost exclusively female helpers and only 60% of the women patients having female helpers), the more interesting observations concerned the relative effectiveness of the sexes in the linking role. While effectiveness could not be measured directly within the confines of the study, patient statements are illuminating. Eighty percent of the patients who had male linking helpers said that they had had a chance to ask all their questions about their hospitalization compared with 58% of the patients with female helpers. Similar differences were found in reference to the survey question on whether patients felt they could get their questions answered.

Women helpers on the other hand were more often present in the hospital and they were found in general to be more active, aware and involved in the linking role than were men. This may account for the finding that women said that they provided emotional help and visitation to the patient while the men more often

mentioned specific or practical tasks such as household management.

IMPLICATIONS FOR VOLUNTEER UTILIZATION AND TRAINING

That about half the patients have special needs and problems and that hospital helping professions are indicated in this study to be rather ineffective in meeting these needs are not in themselves indications that volunteers could be helpful. However, the finding that family and sometimes friends perform a role which is much appreciated by the patients, albeit sometimes unrecognized by the hospital staff, along with the observation that 16% of the patients needed an additional helper acting as a friend does suggest a potential role for volunteers. It requires a more definitive study to determine how accurately this percentage reflects a need throughout the entire patient population. However, 16% in a hospital of the size investigated would amount to 88 patients at any given time, a sizeable number of people. If these people have the same needs as patients who rely on family members or friends, and this study indicates that they do, then the help needed (emotional support and visitation, assistance with household tasks, and occasional support in dealing with the hospital bureaucracy, either directly or through patient advocate or similar services) is ideally suited to volunteers.

Patient satisfaction with and utilization of hospital services are likely to be related to the ease with which patients communicate with their care givers. Trained volunteers can help in this regard, as well as in cases where a linking family member or friend cannot assist or even be identified. These will frequently be patients in the lower SES category and sometimes patients whose spouses cannot take time off from work or patients who do not have a relative on whom to depend.

The training of volunteers might include knowledge about hospital services and, depending in part on the characteristics of the volunteer such as gender and previous experience, assertiveness training. Also pertinent would be training in relating to different categories of hospital employees as well as to patients with different SES characteristics.

The volunteer can provide what the helping professional cannot: time and attention to personal circumstances beyond those related to professional patient care and the disease picture. Volunteers are in this respect untapped resources, and they could make a considerable contribution to making hospital visits less traumatic to patients, while simultaneously easing the burden on the hospital professionals.

FOOTNOTES

[1]Public health terminology distinguishes among primary care, the physician's office and other care facilities designed to be the patient's first point of contact with medical professionals; secondary care, provided by hospitals and other care units without very specialized and advanced services; and tertiary care, the highest level of care designed primarily for patients who cannot obtain adequate care at the primary or secondary level. The main implication for this study is that many patients are from out-of-town and may be assumed to have non-medical problems above and beyond those of local patients.

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