VOLUNTEER COORDINATORS IN BOSTON AREA HOSPITALS

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Reasons for The Study: Developments in Voluntarism

This report is the first step in exploring a group of related occupations which, for convenience, I am calling a Volunteer Establishment in the human services. The establishment consists of paid occupations which have as their main goals the recruitment, placement, coordination, etc. of volunteers; or which try to create policy for the use of volunteers; or which are supposed to advocate and advertise voluntary activity.

This Volunteer Establishment is of particular interest at present. Since 1969 voluntary activity has been undergoing some amount of expansion and reorganization, with an emphasis on the positive role of voluntarism in American life. The most recent upsurge in the promotion of voluntary activity came in the late 1960's from the Nixon administration and some wealthy private patrons, but a new departure was made at that time: voluntarism was given a nationally centralized and government controlled organizational base through the creation of two agencies, one public (Action), the other private (NCVA).

These new developments continue a tendency toward consolidation and rationalization in human service voluntary organizations which became vigorous early in the twentieth century with the consolidation of fundraising and centralization of allocative procedures in the Community Chest.

Nor is it entirely new for government to be involved in 'voluntary activity'. Some of the programs now included under the ACTION umbrella were begun before ACTION was created (although the most well-known of these, Peace Corps and VISTA have a dubious status as 'voluntary' activities, since the 'volunteers' in them are paid). The difference between past and present is the emphasis which the federal government has put upon centralization and rationalization of voluntary activity.

Standard advertisements are now used across the country to encourage voluntary activity. Voluntary Action Centers, long a feature of local urban life (under the rubric of "Volunteer Bureaus"), have been established anew by ACTION, or integrated into ACTION programs where possible. The allocation of volunteers is monitored, and can be controlled to some extent by the types of programs which ACTION establishes, and by ACTION's selection of particular projects in a program.

Attempts to change the scope and structure of voluntarism are bound to be met with resistance from those who feel that the new forms are threatening to them. Three main sources of resistance at this time are (1) certain labor unions, (2) some parts of the feminist movement, and (3) individuals long active as volunteers or paid members of the volunteer establishment who see their autonomy and status threatened.

It is not at all certain that the government effort is the beginning of any long-lasting change. The fact that the emphasis on voluntarism has been so strong, and so consistent for the last six years does, however, make the issue seem worth exploring. We might ask about the volunteer establishment:

- Who are the members of this occupational group, and what are their relations to one another?
- To what extent have the conditions mentioned above become salient in their thinking?
- Do they buy into the new effort toward national integration?
- What are their goals as voluntarists, and where have these goals come from?
- What forces in their settings help or hinder them in attaining those goals?
- In what direction are they really going?

These are the sorts of questions to be explored. The present study is a preliminary step: the assessment of one area of the Establishment, studied in a single metropolitan area.

Method

The main criterion in choosing a sample was to study a relatively homogeneous population, at least in terms of the organizations for which the respondents worked. Coordinators of hospital volunteer services seemed best suited for this purpose since (a) the necessities and realities of hospital organization are likely to impose similar role demands on hospital coordinators; (b) the use of volunteers in hospitals has a sufficiently long history that we could expect many hospital coordinators there to have been in the field for a long time and to be well versed in it; (c) health care has changed considerably in recent years and is still changing, so that we would hope to see some recognition of and reaction to these changes by the coordinators; (d) there are a large number of hospitals in the Boston area which we could reach in an hour's drive or less, and the names of most, if not all, of the volunteer coordinators are listed by the New England Association of Directors of Hospital Volunteer Services (NEADHVS).

Our sample was taken from the current NEADHVS list (with three updates). We selected from this list all hospitals within about a 15 mile radius of Boston, 46 entries in all. (There were fewer than 46 hospitals represented because a few hospitals listed more than one coordinator.) Letters soliciting participation were sent to all 46 coordinators, and soon were followed by phone calls requesting an interview. The two interviewers (Charles McCarthy and Fred Arnstein) did not contact all 46 because there was not enough time to interview each one of them. In total, 31 were contacted and two of these were so evasive as to be counted refusals (both were at the same hospital). Otherwise, the population was extremely receptive to the study. Thus the response rate, for those who were telephoned, was near perfect, and the sample represents 63% of all the coordinators listed in the greater Boston sample which we defined. We would therefore vouch for the representativeness of these results for the Boston area population. Of course, results might be different elsewhere.

Fifteen of the interviews were conducted by McCarthy, fourteen by Arnstein. They ranged in length from about one hour to over three hours, in most cases taking close to two hours. Many of the coordinators took time not just for the interview but to show the interviewers around their hospitals and to have coffee or lunch with them.

The two interviewers felt, by the end of their appointments, that they had gained a fair sense of which issues are generally pressing, and a sense of the personalities and concerns of a variety of respondents. As we proceeded from one interview to the next, we got the sense of how much there was to be said, of what statements would sound absurd, and we also got comments from many respondents about other coordinators -- whom we had already interviewed in some cases. Of course those comments are not a part of this report, but they were important to us in confirming that the ideas which many coordinators expressed in the interviews were the same ideas they expressed to other coordinators. Therefore, we feel fairly certain about stating that our respondents falsified very little, if at all. We also feel that, although some of our respondents may have been reluctant to talk about a few issues, on the whole they answered us truthfully -- each as she saw the truth.

It was clear at times that a respondent did not want to go into detail about an issue, but even in those cases we got a sense that the issue was there. Therefore, what follows is a blend of data and interpretations. We feel that the 'hard' data in themselves are inadequate and sometimes misleading because of the tendency of respondents to avoid difficult issues and because some respondents were better able than others to articulate issues. This report is a blend of quantitative data and our interpretations based on comments from the various respondents.

Types of Coordinators

On the whole we found that our respondents were highly concerned about the running of their individual programs, but very little concerned about, or even aware of, issues and trends which occupy the attention of those who are active in the 'field' of voluntarism on the national level. We learned this from the first question of the interview which asked:

> "What do you perceive to be the most significant issues in the voluntary sector of the human welfare services?"

and retained this impression through the remainder of the bulk of interviews.

Many respondents had to think awhile before beginning to answer the first question, and sometimes carried facial expressions that indicated to us that they were trying hard to think of <u>some</u> issue, not merely sorting through the issues that were already on their minds. In a few cases, co-ordinators simply could not identify any issues or trends. We probed and explained after asking question one, but sometimes got little in return beyond the local hospital program. For example, some coordinators stressed the benefit of volunteering to the volunteers; some talked about the details of running their programs.

On the other hand, a number of the coordinators did respond in terms of broader issues, such as labor unionism and its impact, or the concept of the paid volunteer. But we want to emphasize that in general the coordinators were locally oriented in comparison to any of the Volunteer Establishment personnel that one encounters in general placement agencies or in the larger national organizations.

As we interviewed a number of coordinators we began to notice that many of them seemed to

be one of two contrasting types. One type was the woman who is fairly well educated, and active in her field both inside and outside the hospital. This type of woman was more likely to be rather poised and self-confident, with clear and relatively broad ideas about the field. A second group seemed generally less well educated, only peripherally active in the professional associations or other voluntary agencies, and tended to be less selfconfident and, in fact, sometimes humble about their own programs or abilities. A few seemed to be so different from these two types that they were relatively 'lone wolves' in the sample. Nevertheless, the descriptive types do seem to say something important about the coordinators and the relations among them.

In order to see whether this distinction meant a great deal about the behavior of the co-ordinators, we constructed a new classification based on objective indicators.

The first two indices chosen were (1) awareness of broad social issues as indicated in the first question of the interview, and (2) amount of education. We find that the two characteristics are indeed related, as Table 1 indicates:

TABLE 1

Education	Awareness of broad social issues: Little	Some	Much
High School	5 (Local)	1 (Local)	0
Some College	2 (Local)	3 (?)	3 (?)
B.A. or B.S.	0	4 (?)	1 (Cosmopolitan)
Graduate Work	0	2 (Cosmopolitan)	3 (Cosmopolitan)

The cells of that table were then classified as Local or Cosmopolitan in orientation (Merton, 1957, 387-420).

In order to classify all respondents in to one of the two groups, we placed all those in the middle (?) who had organizational or volunteer affiliations outside the hospital in the Cosmopolitan camp, and those without such affiliations among the Locals. Organizational affiliation was used because it was central in our conception of the Cosmopolitan-Local distinction and because all but one of the Locals in Table 1 were lacking such affiliations, while four of the six Cosmopolitans in Table 1 for whom we have the information did have extra-hospital affiliations.

Thus, all the respondents except one (for whom educational data were lacking) could be classified as either Cosmopolitans or Locals on objective grounds. These categories corresponded rather closely to our initial impressions, as shown in Table 2.

TABLE 2

Comparison of Objective & Subjective Ratings

		Categories based on objective criteria: Cosmopolitan	Local
Categories based on general interviewer impressions	Cosmopolitan	6	3
	Local	2	11
	Other	3	4

It is clear from the interviews that there is a hierarchy and structure of sorts in the field. We have only some vague impressions, which could be followed up later. Certain Cosmopolitan coordinators are considered excellent by many of the Locals; however, not all Cosmopolitans seem equally trusted. For the Locals, who tend to be more traditional in their outlook and perhaps less self-confident about running their programs in ways the hospital administration will like, the more traditional among the Cosmopolitans are the more praised. These traditional Cosmopolitans are held up as models of excellence and helpfulness. At the same time, at least one non-traditional Cosmopolitan coordinator told us that some Local colleagues come to her for advice 'on the sly.' Certainly one interesting study that might be undertaken would examine the network of affiliations and advising that occurs among the various coordinators. Such a study was not part of this work.

The coordinator's setting

To understand our respondents, one must have some sense of the conditions in which they work and the demands placed on them. While there is wide variation in many aspects of the work, there are some important common themes also, and we discuss these first.

Most hospitals are large organizations where status distinctions are well-understood by staff and play an important part in their behavior. Within such a setting the concept of the volunteer is hard to accept. The volunteer is not specialist at anything, has no clear work or reference group, and is not governed by a definable set of sanctions. The volunteer can cause trouble without fear of losing her livelihood, or just as bad, can threaten to become so useful that a paid employee is in danger of being no longer needed by the hospital. Volunteers, like paid employees, come to the hospital for a variety of reasons, but unlike paid employees, the motivations of volunteers are not automatically channeled along lines of money and status rewards. (These problems tend to be somewhat different in the case of auxilliants, who will be discussed shortly.).

The role of the volunteer coordinator is equally problematic within the structure of the hospital. The coordinator is a sort of personnel manager who allocates unpaid labor in the hospital. Unlike the regular personnel manager, however, the coordinator must keep track of the doings and progress of each volunteer throughout the time the volunteer is active, which may be many years. The coordinator is constantly re-allocating her volunteers to new positions, partly because of the turnover in volunteers and partly because new positions for volunteers open up as paid staff sees a need for them. The coordinator also needs to create opportunities for volunteer service by convincing staff that the volunteers will be useful to them, unlike the regular personnel officer who merely allocates applicants to predefined positions.

Therefore the volunteer coordinator is in contact with many parts of the hospital on a daily basis. She, like the volunteers, has no formally defined reference group even when she is called a department head. She is free to give help or make trouble for any of the regular status groups within the institution, and so tends to be mistrusted until she proves herself in action over a long period of time. Even then, she faces the conflict between her need to keep the volunteers happy and her need to satisfy the departments where volunteers are placed. This conflict can occur, for example, when a volunteer arrives on her appointed day but there is no work which is really appropriate for her. Shall the coordinator take the chance of putting the volunteer in an assignment where she may not perform well in order to keep her allegiance for the future?

Although the volunteers' status in the hospital is ambiguous, it is also very low. This fact was expressed to us by enough coordinators that we feel it must be fairly pervasive in hospitals, although there are surely exceptions as well. As one coordinator said, "They think of us like they think of the toilet. You don't think about it at all until you need it." Or as several others put it, "We are at the bottom of the totem pole !"

The volunteer coordinator is therefore in the position of having to try to appear to like and want to please all parties, including her volunteers. She has very little power over anybody, so she must rely on the traditional techniques of isolated low status individuals who attempt to influence others: ingratiation, flattery, loyalty, working hard to be useful, and subtle, friendly manipulation. Most coordinators see themselves as running programs which the hospital administration will insist represent administration needs and policy. The coordinator, for all her involvement in 'professional' associations, has only very weak independent professional standards which can be invoked in fighting the hospital.

Volunteer programs at most hospitals have, in the abstract, considerable potential for expansion and change simply because there are no very clear guides as to what a volunteer program should be. However, when the hospital administration is traditional and clear in its demands, the chance for innovation is small. The coordinator must then either go along unwillingly with administration policy (because she is so easily replaced if she causes trouble) or else she must identify sufficiently with administration policy that she can operate comfortably within her constraints.

Many hospitals, on the other hand, are not so rigid about the co-ordinator's role. In such cases, coordinators can expand and upgrade the quality of volunteer services by getting to know the various other hospital staff, suggesting new programs, and slowly proving that their volunteers are capable and reliable.

Auxiliary, Coordinator and Hospital

A deeper understanding of the coordinators' role and status require a look at the women's auxiliary, or its equivalents. Several of our respondents explained to us that the auxiliaries at many hospitals were in the past, and sometimes still are, composed of doctors' wives and other fairly wealthy women who served their own interests through auxilliant activity by advancing their husbands' careers or satisfying their own needs for involvement in activity outside the home, while they kept the hospital in touch with a wealthy segment of the population who were able to donate or raise money for gifts to the hospital. Until recently (perhaps the last twenty years and less), the auxilliary actually was the volunteer corps, or at least had control over it. The activities of these auxilliary volunteers, however, were usually closely circumscribed both by what they were willing to do and by the fears of hospital staff that they might be troublesome if they attempted to do more.

The auxilliants were both tolerated and pampered by hospital administrators, who saw them as sometimes meddling and troublesome, but also as sources of money and other support. In time, as hospitals grew larger and more complex, and as volunteers from outside the auxilliary have become both willing and anxious to take on more responsibilities, it became necessary to find regular coordinators for auxilliary/volunteer services. The first volunteer coordinators were thus auxilliary members, and the first coordinators from outside the hospitals were considered, in many cases, only administrative assistants for auxilliary activities.

However, just as volunteers are not subject to the same standard sanctions as paid workers, so coordinators drawn from the auxilliary were not as useful or tractable to hospital administrators as paid coordinators whose primary loyalty did not lie with the auxilliary. Besides, as the scope of voluntary service expanded and began to include some tasks which were distasteful to higher status ladies, the auxilliants themselves often did not want to be full time coordinators. For these reasons, it has become widespread practice for volunteer coordinators to be recruited from outside the ranks of the auxilliary.

Now the 'typical' coordinator (in hospitals with an affluent auxilliary) plays something of a liaison role between the auxilliary and the hospital. From the point of view of administration, the role of the coordinator seems to be to keep auxilliants feeling that they have an important role in the hospital so that they will continue to give money and support, but at the same time to keep them under control and out of the administrator's hair by fielding some of their complaints and educating them as to what the hospital really is all about. The coordinator also allocates auxilliants to assignments where they will do no harm (like the hospital giftshop), though in this she is supported by the auxilliants themselves, who have traditionally run such services. The 'typical' coordinator in the hospital with a less powerful auxilliary plays these roles with less feeling of tension or conflict. She is more oten very much in tune with the auxilliary, and sees it as her ally.

Our data, unfortunately, do not deal systematically with many of these issues, but we do have some information worth noting. Of the twenty-eight hospitals we saw, only three did not have an auxilliary or its equivalent. (In some cases, community organizations which are not called auxilliaries serve essentially the same function. We were conservative in making this judgement in our counting). The auxilliary is therefore a very pervasive institution. The auxilliaries generally were restricted to particular areas of voluntary activity, notably running gift shops and coffee shops and raising money, with a variety of other activities depending on the hospital. In some hospitals where the auxilliaries were officially volunteer organizations, they did very little in the way of regular hospital volunteering. In a smaller number of hospitals this was not true, and auxilliants did account for a sizable proportion of the volunteer staff. We saw many cases where a small number of auxilliants had given thousands of hours of volunteer time over the course of many years, but in the course of that time had developed their own baliwicks, particularly gift shops, in which they spent all their volunteer time, leaving other volunteer tasks to non-auxilliants.

In most hospitals, the auxilliary and volunteer office work very closely together, and all auxilliary volunteers are channeled through the paid coordinator. On the other hand, six hospitals had the auxilliary and paid coordinator entirely separated. In some of the latter cases we heard comments like, "I was told to stay strictly away from the auxilliary." In two other hospitals, the coordinators said they served an explicitly liaison role between auxilliary and the hospital.

We did not ask people about their feelings toward the auxilliary, but feelings often came out in the conversation. Most often, the feelings expressed were positive (13), and somewhat less often we heard about conflict, tension or trouble either presently or in the past (8). One coordinator, in a hospital without an auxilliary, said that she had been warned full well that it would be a great mistake for her to try to create an auxilliary. It would only cause her trouble.

In some cases coordinators had mixed feelings about the auxilliary. One respondent, who for the most part had negative comments to make about her own and other auxilliaries, nevertheless said that auxilliaries were necessary as a way for the hospital to maintain relations with the community. In fact, she said, if they had not already been there, it would be necessary to create them.

Thus there appears to be a spectrum of coordinator/auxilliary relations, including cases where the auxilliary does not exist, cases where it is on cordial terms with the coordinator, and cases where there is tension. It does seem that the trend is toward more power in the hands of the coordinator and a more specialized and weaker role for the auxilliary. Some of the coordinators in our sample have experienced aspects of this transition during their years on the job.

Where a volunteer coordinator finds herself at odds with the auxilliary, she must maintain a facade of friendliness. Otherwise, with very few exceptions, she could not keep her job. Again and again we encountered statements like "The main thing is not to rock the boat." Or-- again in the nautical metaphor-- "The first thing they told me when I came here was Don't Make Waves."

The Coordinator as Public Relations Officer

Even where there is no auxilliary, there are generally other groups in the community on whom the hospital relies for support, such as religious organizations for religious hospitals, or veterans groups for veterans hospitals. The hospital also finds itself needing often to address the entire surrounding community in order to secure support for its programs, and for expansion. In all these cases, the volunteer coordinator functions as a liaison between hospital administration and community groups, just as she did with the auxilliary.

The coordinator's role as general public relations and public education staff was elaborated to us by many respondents in some detail for their particular hospital. Some systematic data are also available which indicate that the issue is important, and shows that coordinators often have different priorities for their jobs than they think their administrations have.

We gave each coordinator a list of possible goals of her volunteer program and asked her to rank these goals, first as she perceived them to be held by the hospital administration, and then as she herself felt about them. The goals listed were:

a. Helping the sick by providing voluntary services.
b. Recruiting health professionals by involving people in volunteer experiences which may influence their career choice.
c. Helping the volunteers find meaning and satisfaction through their volunteer experience.
d. Achieving social change or reform.
e. Maintaining good relations with the community.
f. Other goals.

Table 3 summarizes the rankings.

Table 3 shows that the first three goals, which have to do with patient care, volunteer satisfaction and health personnel, are relatively highly ranked by the coordinators, and the coordinators feel that administration agrees with them for the most part.

The goal which shows the most interesting difference is (e.) 'Maintaining Good Relations with the Community.' Six respondents thought administration would give this goal highest priority, but no coordinators gave it such a high ranking themselves. Eight respondents thought administration would give it second highest priority, but only four would give it such a high ranking themselves. On the other extreme, eight of our coordinators put community relations in fourth place as a goal for themselves, but only two felt that administration would rank it so low.

The table reflects the feeling of many coordinators that the hospital is primarily or largely interested in the volunteer program for its usefulness in keeping good relations with various constituencies in the community, while they are only peripherally interested in the actual functioning of volunteers in the hospital. On the other hand the coordinators themselves are concerned with precisely that which administration does not care so much about: the day to day tasks performed by volunteers and their impact on patient and volunteer alike.

Success in this setting is measured by the degree to which the coordinator can create a program which is attractive to both volunteers and hospital. In hospitals where volunteers are allowed a wide choice of tasks and where many of these tasks are intrinsically rewarding, success is most likely. In a few hospitals we visited we had the impression that the entire organization was run by

TABLE 3

Goals for the volunteer programs as volunteer coordinators rank them and as they believe their hospital administrations rank them.

Perceived Rankings of Administrators: High 1	2	3	4	Low 5	Mean		Mean	Coordinators' own rankings: High 1	2	3	4	Low 5
18	4	1	1		1.4	a. Helping sick	1.3	20	7	1		
1	2	10	7		3.2	b. Recruiting	2.7	4	2	9	3	1
1	10	6	4	2	2.8	c. Helping vols.	2.2	6	11	3	2	1
	1	1	3	6	4.3	d. Social Change	3.6		3	2	2	4
6	8	7	2		2.2	e. Community Rel.	3.2		4	8	8	
	2					f. Other				1	2	1
	N = 26						N = 27					

volunteers, who seemed to be everywhere, doing everything, in their coral-colored smocks. In such hospitals, volunteers have become so accepted and important a part of hospital operations that they would not likely be dispensed with, and the volunteer coordinator can count on support from the hospital for at least some new programs.

In other hospitals one sees few volunteers. The problem is not always just in administration policies and coordinator ingenuity, however. In hospitals for the chronically ill and the aged, volunteers are more difficult to recruit because the conditions are more depressing and the range of opportunities is smaller. Yet even in some such hospitals, it appeared to us that volunteers were doing a considerable amount for the institution.

Some personal characteristics of the respondents

During the course of the interviews we several times encountered women who told us that "we are all pretty similar in this field" and others who told us just the opposite, "you won't find two of us alike". We began the study thinking that co-ordinators would be similar-- as indeed they are in some ways-- but found that the differences among them are as striking as the similarities.

There is no common training or socialization for the volunteer coordinator. She may be recruited from virtually any background. We did not collect systematic data on the previous occupations of our coordinators, but we learned enough to know that they come through a diverse collection of former pursuits and motivations. Some worked at the hospitals where they now coordinate, but in other capacities, and many of these women did not seek the volunteer position but were asked to take it when the job opened up. Some women said they frankly were not sure they wanted the job, but after some hesitation decided to try it. Of course, for most of the women we interviewed, the job has worked out fairly well for them or they would no longer be there. We did not try to interview any former volunteer coordinators.

Some women did actively seek employment in volunteer or related fields, and happened upon jobs as they opened. Others were not really looking for volunteer-related jobs, or any job, but knew a hospital administrator or were recommended to an administrator. Again, these women were sought out. Many of our respondents had long and wide experience with various aspects of voluntary activity, while others had none before their present jobs. If one could draw a picture of the 'average' volunteer coordinator, she would be a woman who had been more sought after by the hospital than she was seeking the job, and who had not considered taking such a job before although she did have some experience in voluntary activity. But many coordinators deviated from this 'average'.

Educational backgrounds are similarly diverse. The twenty-eight women who gave us information about their education were distributed this way:

Amount of education	
High school diploma or less	6
Some college	10
Undergraduate college degree	6
Graduate Work	6

In their ages, however, the women are much more similar to one another. Of the respondents we interviewed, only two were under forty years of age. All the rest ranged between 40 and 65 years old, with a mean age of 52 years. We are not sure why there are so few younger women in the occupation. One possibility is that the age structure of the occupation reflects life-cycle situations and hiring practices. Mature but not elderly women are perhaps most likely to have the time to do full time coordinating, have the experience and contacts that often help get these jobs, and know a good deal about interacting with people. But there appears to be a bias against hiring women over the age of fifty. A scatter plot of age against years at the job (not reproduced here) shows that all coordinators over 50 in our sample have been at their present jobs at least four years. All those over 55 have been there at least 7 years. No coordinators over 50 were hired recently.

We asked the women whether they had any future career plans. The majority (20) of them replied that they did not. Among those who did were a few who saw definite goals for themselves after retirement. This suggests that for most of the women, being a coordinator is not part of a career pattern which is planned in advance. Certainly there are no clear directions to go after being a volunteer coordinator except perhaps personnel work.

Professional Self-Images

One question asked each respondent whether she considered herself to be a professional. More (18) of our respondents did consider themselves professional in their jobs than did not (11). A few of those who didn't consider themselves professional in the jobs said that their non-job activities, like membership or officership in professional associations, was a more professional activity. Although Cosmopolitan respondents tended to call themselves professional more often than did Locals, the difference was not significant.

However, even among those who claimed to be professional there was a range of conclusiveness about the matter. Some were very definite: they would say 'Absolutely' or

'Definitely' when asked if they were a professional. Others hesitated, or said 'Yes, I guess so' and similar less clear things. Furthermore, among those who claimed not to be professionals, there were a range of attitudes. Some claimed that they themselves were not professionals but that other people in the field were. (These were Local respondents referring to Cosmopolitans.) Others said that nobody in the occupation was a real professional. And some expressed that interesting idea that being a non-professional was an important part of the job because "Being a non-professional, I don't intimidate my volunteers" as one women put it. Evidently there is a feeling in the hospital that professionals do have power and are intimidating to others of lower status. Most of the volunteer coordinators we saw found themselves often taking an interest in the personal affairs of the volunteers, out of necessity in order to keep the volunteers working well, and out of interest and compassion to help them over their personal difficulties.

Hospital volunteer coordinating is not a profession by the usual criteria. Coordinators do not possess a body of common skills and training which renders them expert in well-defined procedures and enables them to claim that they are the best judges of each other. They have no equivalent of 'private practice' through which they can maintain autonomy; instead, they are bureaucratic functionaries whose special job is the maintainance of relations between the hospital and its clients (patients) on the one hand, and its patrons (the auxilliary and other community forces) on the other. As soon as she ceases to be supported by her employing hospital, the coordinator is no longer a coordinator. Her status has very little autonomous component. And because she is so constrained, she has little independent say about who may volunteer and what these volunteers may and must do. In this last respect, however, some coordinators have tried most successfully to make their jobs 'professional' -- control can exist to some degree over the volunteer program depending on the availability of alternative volunteer options within a hospital, the attitude of administration, and the ability of the particular coordinator to create and impose standards.

When asked what qualities about them or their job make them feel they were professionals, most respondents answered in terms of personal qualities like outgoingness, compassion, sensitivity, or organizational ability. The qualities listed were not always the same, probably because different coordinators see their jobs in somewhat different terms. For some, the person contact is extremely important. These coordinators are extremely interested in watching, helping and even supervising the development of their volunteers. For others, patient care is most important, and the coordinators who feel this way voiced concern throughout the interviews that hospital care, and medical care generally, must be improved, and that it is imperative to have good volunteer programs to fill the gaps. For still other coordinators, the running of the program and the education of staff and community seem the most important priorities. These different types, and other, emerge from the interviews.

A volunteer coordinator must be able to handle masses of detail at the same time being warm to the various people she contacts. For the running of a successful program, there is no doubt that considerable personal ability is required, but this in itself does not make one a professional. It seems quite clear that many co-ordinators are using the word about themselves in hopes that the claim will make it so. In fact, judging from their status at most hospitals, the claim does not help very much.

Hospital Coordinators and other Placement Agencies

We asked whether volunteer placement agencies or other organizations outside the hospitals were helpful in providing volunteers. Only three hospitals seemed to rely heavily on outside agencies, and two of these were hospital of a special nature, one located in the center of the metropolitan area, accessible to university students and other potential volunteers who came through outside programs. A second hospital was for chronic patients and relied heavily on RSVP.

Most coordinators said they got no help (9) or almost none (11) from outside agencies. Many of these said that the Voluntary Action Center in Boston was not helpful in providing volunteers even though the hospitals were there. The same was said, with less frequency, for other agencies, including ACTION and the Civic Center and Clearinghouse. For the most part, these comments implied that <u>the outside agencies simply were not geared to attracting appropriate volunteers for the hospitals</u>, and that the main avenue for recruiting new volunteers was through word-of-mouth enthusiasm shown by current volunteers or patients. Most (21) of the coordinators did very little or no active recruiting; four said they did recruit. However, there is a hazy line between recruitment and public education, and many of the coordinators who do not explicitly recruit nevertheless speak to various civic and community groups when they can.

Relations with hospital staff and other problems

We have emphasized that the coordinator's job entails a great deal of interaction with many different staff in the hospital, and this interaction succeeds or fails largely on the basis of the coordinator's personal qualities of friendliness, persuasiveness and helpfulness to other staff. Several sections of our

questionnaire asked respondents how they felt about aspects of the hospital and its staff in relation to the volunteer program.

One series of items asked respondents first to rate their own attitudes toward voluntary activity in the hospital, according to the scale:

1. Extremely valuable
2. Definitely valuable
3. Somewhat valuable
4. Of small value
5. Of approximately no value
6. Of negative value.

Then they rated the feelings of other groups in the hospital toward voluntary activity. Of course these ratings were the coordinators' perceptions and so may not reflect how the other groups really feel, but they do reflect the coordinators' feelings of trust and ease in working at their hospitals. The mean scores are presented in Table 4 in declining rank order of favorable attitude.

TABLE 4

Group	Attitude toward Volunteers (Mean Score)
Volunteer coordinators	1.46
Patients	1.65
Patients' families	2.04
Hospital Administrators	2.19
Nurses	2.30
Therapists	2.71
M.D.'s	2.85

Another set of questions asked respondents whether they had any conflicts with other hospital staff. The majority of coordinators (17/29) claimed there were no conflicts. Perhaps this question deserves to be treated as cautiously as any, since it touched on sensitive ground for the respondents. We can therefore take the positive replies (12) as a minimum estimate of the number who actually experienced conflict. A second question asked whether there were any other main problems which the coordinator faced in carrying out her program. Here, the responses indicated that more (19/29) respondents did have important problems.

A listing of the different 'problems' and 'conflicts' mentioned shows that sometimes there is overlap between these categories. The most commonly mentioned (9) conflict or problem is lack of acceptance of volunteers by other hospital staff. This was phrased sometimes as staff feeling threatened, sometimes as staff being uneducated about the use of volunteers, sometimes as a complaint that the staff had a non-accepting attitude.

Along similar lines, four respondents complained that the hospital administrations were indifferent to volunteer programs and would not provide the recognition and other support that a program needs to be entirely successful. One respondent complained that her hospital would not accept a particular program which was threatening to the status-quo there. And three respondents complained about problems with the auxilliary when asked these questions (several other complained elsewhere in the interview).

Three respondents complained about their low pay. And several other problems also had to do with money: lack of money for new programs, for more paid staff in the volunteer office, and for transportation for volunteers. The related problem of office space was mentioned by three respondents. And two respondents said they had difficulty because their hospitals are located in dangerous city neighborhoods where volunteers rightly fear to travel.

The quality of the volunteers was mentioned as a problem by six respondents. The particular qualities the respondents were seeking differed among them: one needed more minority people, but a more common problem was finding volunteers who were reliable and committed to helpful interaction with patients. This seemed to be a problem particularly in chronic hospitals, and among younger volunteers.

Volunteers and Unions

In addition to the importance of educating hospital staff to the potential uses of volunteers, particularly now that volunteers are willing to do a larger variety of tasks than they once were, respondents also were keenly aware of the threat to job security posed by a volunteer corps. Many of our respondents mentioned this issue in the first question, where we asked them to define whatever issues they saw as important. There, and elsewhere, they mentioned unions and trouble with unions, either in the past, presently, or anticipated. Often, coordinators claimed that in fact volunteers do not take the place of paid employees but only supplement them. This does appear to be true in the sense that a coordinator would not risk offending paid staff by proposing that a volunteer do a job which was already done by an employee. One gets the impression that the coordinators have been through some difficult times on the issue and are treading carefully at this time.

On the other hand, it is clear that volunteers perform a great many tasks which might be paid if there were money available, or if the hospital decided to allocate its budget that way. Table 5 summarizes the activities of volunteers in the hospitals we saw. Let us consider first those activities which are least likely to be paid.

TABLE 5

Activities of volunteers as reported by coordinators

Below are listed various areas of responsibility which volunteers may have.

a. Which of these services are performed by volunteers in your institution? (check all those applicable).

b. Which two of these services consume the most volunteer time? (Write 1 for the most time consuming and 2 for second most.)

c. Are there any areas where you feel that the volunteer provides a unique or significantly important service to this institution? (Check all those applicable.)

a	b	c	
27	22	21	One-to-one interaction with patients (reading or talking to patients, playing cards, etc.)
13	6	6	Organizing and facilitating group activities for patients (recreation, drama, etc.)
13	4	8	Taking an advocate role (calling the attention of hospital staff to patient problems, etc.)
21	11	9	Providing shopkeeping services
27	7	7	Bookkeeping and other office functions
8	0	4	Policy-making and advisory functions
11	7	8	Other...

Table presented here is same format as original question sheet. Numbers indicate how many coordinators responded positively in each cell.

The table shows that most of the hospitals use volunteers in one-to-one interaction with patients. This is said (by the coordinators) to be the most essential function of volunteers as far as they are concerned: the direct care of patients, the humanizing of the hospital. Not only did our respondents mostly claim that their volunteers interacted directly with patients, but most of those also said that this activity took up a large proportion of the total volunteer time, and also felt that it was a significantly important service to the hospital. This is the kind of service for which the most compelling arguments can be made that payment is not appropriate or necessary.

Interacting with groups of patients was listed in only about half the hospitals, and was considered very important in only half of those. Another activity happens with a similar frequency: the volunteer taking an advocate role vis-a-vis the patient. A still smaller number of hospitals listed policy-making and advisory functions as part of their volunteer operation.

So much for the activities which are least likely to be paid. Three other types of activity are also listed with some frequency which would ordinarily be paid. Bookkeeping and other office functions is listed at nearly all the hospitals, and shopkeeping at two thirds. 'Other' activities, which are listed at eleven hospitals, usually mean non-interactive chores like running errands and rolling bandages. All these potentially paid activities consume a large proportion of volunteer time at seven or more of the hospitals.

Therefore even though the coordinators are careful to stress that they do not threaten paid workers, it is also clear that they provide services to the hospital which would otherwise have to be paid for or foregone. A number of coordinators emphasized to us that they are really saving their hospitals thousands of dollars each year by providing volunteer services. Logically, the two issues are separable: the services provided save money but without threatening existing jobs. However, the reality of the situation at some hospitals seems to be that the coordinator is actually on the side of the administration against organized labor. Not all coordinators wish to be in that place, but it is our impression that most of them tend to see the unions as troublesome.

Furthermore, in a pinch, administrators would call on volunteers to be scabs, and to this we do not think most coordinators would object. The potential for conflict in this area is certainly present.

Conclusions and Implications

This study began with the postulation of a Volunteer Establishment, defined in terms of certain occupational roles. We proceeded to explore the details of this 'Establishment' by studying one of its parts: hospital volunteer coordinators.

Certainly one conclusion we can draw here is that hospital coordinators do not have many links to members of the Establishment, aside from their own hospital peers. For models they look to the more conspicuously successful among themselves. For concrete help they rely mainly on the public constituencies who support their hospitals, not on volunteer placement agencies, with very few exceptions. Although some of them do have opinions about ACTION, most find it and other national volunteer-promotion organizations pretty much irrelevant to their work. The vigorous debates and speculations which are part of NCVA, or which one may find at conventions of the American Association of Directors of Volunteer Services, or the Association of Voluntary Action Scholars, concerning the meaning, philosophy and direction of voluntarism as a whole are conspicuously absent from the personal agendas of the bulk of the coordinators, except as these issues become salient through the hospital work experience itself.

Let us suppose for a moment that the same insularity was typical of other major institutional areas as well -- areas such as education, welfare, and mental health. If such were the case, then we would be dealing not so much with an 'Establishment' as with an occupational category stratified into two parts. One of these, the larger part, would be doing the work of coordinating volunteers in their everyday activities. The second part, more visible to the public, would be typified most by those who staff the organizations which deal at a secondary level with volunteers, organizations which in fact can abstract themselves more easily from the everyday requirements of specific volunteer situations, and deal instead with the general phenomenon of volunt<u>arism</u>.

There is no doubt that neither model -- the well-integrated 'Establishment' or the two-part occupational group -- represents the reality, which is somewhere between. Further study of the nature of the links within this structure ought to be worthwhile because in fact there is little known about the degree of penetration which the national organizations have upon attitudes and programs in the nation as a whole, the types and sources of resistance to national influence, or, to put the whole matter a different way, the sources of the various philosophies and practices which together make voluntarism what it is.

All this is suggested by way of a worthwhile topic for study. What I am certainly not suggesting here is that one or another volunteer approach is superior and that we need to figure out how to sell this approach to the heathen.

From a practical point of view, at any rate, one should not expect very rapid change among hospital volunteer coordinators. Given the network of associations which we have found and the pressures of hospital coordinators' jobs, the most effective source of training and innovation at this point would seem to be from within the ranks of the coordinators themselves. Certainly, training which suggested grandiose or startling innovations would be unacceptable for most hospital coordinators, because most hospitals would not be ready to accept them.

Finally, the question remains to what extent the present state of affairs is satisfactory. The answers will depend to some extent on the interests of the party who asks. Our study suggests that, from the patient's point of view, volunteers are both useful and wasted. If we assume that a patient gets the most benefit from direct contact with volunteers (and to judge from coordinators' comments, this is a fair assumption), then a good deal of volunteer time is wasted. Volunteers, as we have seen, are used in a variety of positions for which direct patient contact is not present or is routinized. Ideally, a hospital would pay to have these jobs done, leaving volunteers free to associate with patients on a primary level. However, there is an important exception: some volunteers are not able or willing to interact effectively with patients. To what extent does this factor account for the proportion of volunteer time spent away from patients? We would like to know, but we did not set out to examine the problem and have no data that bear on it.

From the point of view of hospital administrations, our data suggests that the volunteer services are running smoothly and satisfactorally. The length of tenure of our respondents tends to support this conclusion, as does the general tone of their responses. They are loyal and dedicated to their hospitals, in spite of any frictions or problems that may occur. The data, however, cannot fully support this view, because there are some hospitals in which volunteers services are present very little or at all. We made no attempt in this study to discover how many such hospitals there were or to explore their experiences with volunteers. Our data are also less than satisfactory because we did not interview the administrators themselves. It is possible that they would like to see better trained coordinators in some cases. Nonetheless we strongly suspect that, by and large, administrators are happy with the coordinators.

There is no way from these data of determining the adequacy of the coordinators from the point of view of the volunteers themselves. During the course of our visits to hospitals, we encountered volunteers and spoke with them briefly. They sometimes praised and sometimes condemned their coordinators. Because the coordinator's role involves a high degree of personal discretion at the level of interaction with volunteers, the personal qualities of the coordinator will be of tremendous importance in creating a satisfactory situation for the volunteer.

From the point of view of the coordinators themselves, we have the impression of general satisfaction with their jobs and relatively little felt need to pursue extra training or expand horizons beyond that which is already offered in the context of the hospital coordinator associations.