A Meta-Ethnographic Review of Paid Staff and Volunteers Working together in Palliative Care

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Abstract

Paid staff and volunteers' experiences of working together to provide palliative care: a meta-ethnographic review

Context: Volunteers in palliative care settings are an essential part of care provision for patients and those important to them. Effective collaboration between volunteers and paid staff has been regarded as an important element of successful working, however, at times failures in coordination, information sharing and tensions within teams have been highlighted.

Objectives: To explore the views expressed by volunteers and paid staff about their experiences of working together in palliative care settings.

Methods: A systematic exploration of qualitative research using a meta-ethnographic approach. PsycINFO, CINAHL, Medline Complete and AMED databases were searched from inception to December 2021 for the concepts 'volunteers' and 'palliative care'. Repeated in-depth reading and appraisal of papers identified metaphors and concepts, providing new interpretations.

Results: Included papers (n=14) enabled the construction of five storylines:

1) "*we are the cake, and they are the cream*": understanding the volunteer role – separate, but part of a whole.

2) "…*we don't know what's wrong with people but sometimes we need to know*": access to information and importance of trust.

3) "*everybody looks out for each other*": access to paid staff and their support.

4) "*...we don't meddle in the medical*": boundaries.

5) *"it's the small things that the staff does for me that makes me feel good about my work*": sense of value and significance.

Conclusions: For effective working relationships between paid staff and volunteers, proactive engagement, recognition of each other's role and contribution, mutual sharing of information, and intentional interaction between both groups is needed.

Key message

This systematically constructed meta-ethnographic review identifies that successful teamwork between paid staff and volunteers requires consideration of what palliative care teams are and who they should include. Also, the importance of intentionally building relationships between volunteers and paid staff should not be taken for granted to prevent potential relationship problems.

Key words

Palliative care, volunteers, health personnel, collaboration, meta-ethnography

Running Title

Paid staff and volunteers working together.

Introduction:

There is a long history of volunteers working in palliative and end of life care; however, their role is continuously changing and evolving. Volunteers frequently become involved in providing practical and emotional support to patients and their families, also acting as an important link between them and the various healthcare teams (1, 2). However, the role of volunteers connected with palliative care is often challenging to quantify. Often volunteers are able to make a unique contribution due to their unpaid role, and in this way, they are often able to complement the work of paid staff (3). The involvement of volunteers in settings providing palliative care is regarded as a vital part of the care provided to patients and those important to them (1). However, the relationship of volunteers with other team members, including paid staff, providing palliative care has at times been reported to be challenging (4). Whilst collaboration between volunteers and paid staff team members has been highlighted as an important element of successful working, volunteers have commented that at times failures in coordination and tensions within teams may lead to them not being able make an effective contribution (5-7). Volunteers have reported that they felt they received insufficient information to prepare them for patient contact (8). Furthermore, the information volunteers deemed to be helpful to be able to successfully fulfil their role differed from what staff gave or thought necessary for them to know (9). Volunteers and paid staff have both suggested that greater opportunities for contact and integration between teams would be beneficial to improve their working relationship and understanding of each other’s needs (9).

Previous reviews looking at volunteers in palliative care settings have tended to focus on the role of volunteers and their experiences, with only elements of the findings discussing volunteer relationships with the wider healthcare team (10-12). However, no qualitative reviews had been found that specifically explored the way paid staff and volunteers work together when providing palliative care. This is an important contributing factor in the effectiveness and satisfaction of volunteers (9). Previous literature review recommendations have been for further research into improving communication and co-operation between paid staff and volunteers (12). A meta-ethnographic review is an appropriate method for exploring this phenomenon as this approach seeks to “derive substantive interpretations” that may be seen as a complete and standalone study (13). Consequently, the purpose of this meta-ethnographic review is to develop a deeper understanding of the views expressed by volunteers and paid staff about their experiences of working together in palliative care settings.

Methods:

This systematically constructed review follows the principles of meta-ethnography, and the methods are reported below according to the seven phases of meta-ethnography (14). This review is reported in line with the eMERGe guidelines on improving reporting in meta-ethnography (13-14).

Phase one: selecting meta-ethnography and getting started

The aim of this study was to explore the views expressed by volunteers and paid staff about their experiences of working together in palliative care settings. Meta-ethnography was chosen as the method to enable a robust way of exploring these experiences and developing an understanding of this social phenomena (11). Meta-ethnography also enabled the researcher to retain the context and meaning of the original participant's and author's voices, which was deemed to be important in developing new understandings of this relationship (15). Within meta-ethnography this is achieved by translating, transferring concepts, metaphors and understanding across selected studies through a seven-step process (Table 1) (13).

<Insert Table 1 here>

Phase two: deciding what is relevant to the initial interest

Based on the aim of the study, the review question was constructed: How do volunteers and paid staff working in palliative care settings describe their experiences of working together?

The Literature review question was developed and guided by using PICo (**P**opulation, **I**ntervention, **Co**ntext) (Table 2).

<Insert Table 2 here>

Search strategy:

A search strategy was developed with the advice and guidance from a Lancaster University librarian who has specialist subject knowledge of health research. PsycINFO, CINAHL, Medline Complete and AMED (The Allied and Complementary Medicine Database) databases were searched since the beginning of the databases up to the 5th December 2021. These databases were selected to give a range of allied health and nursing perspectives, also the inclusion of databases that consider palliative and multidisciplinary approaches. Search terms such as 'volunteers' and 'palliative care' were developed with MeSH terms and other synonyms to capture potentially relevant papers for this review. The use of phrase searching was also used in the searches and words were truncated to ensure that variations of words were not excluded. Medical subject headings (MeSH) were modified according to each database which were used in combination with free-text search terms to build a comprehensive search approach. Database limiters were applied to only include academic journals, written in English language, and peer reviewed. Boolean operators (AND, OR) were used as they are beneficial in building or limiting searches (16). (Full details of the search strategy are found in Supplement 1).

Inclusion and exclusion criteria:

The inclusion and exclusion criteria were applied to the studies located (See Table 3).

<Insert Table 3 here>

Search results were downloaded into Endnote X9, combined and de-duplicated. Two reviewers (KO and MB) reviewed the first 500 titles and abstracts independently to ensure consistent and congruent application of the inclusion and exclusion criteria. KO then reviewed remaining titles, abstracts and subsequently full texts for inclusion or exclusion. Any disputes were checked with CW or YS and agreement reached on papers to include.

Quality Appraisal:

Included papers were appraised for quality using the Critical Appraisal Skills Programme (CASP) tool for qualitative research, which aids assessment of the quality of research across 10 relevant domains. This quality appraisal tool has been regarded as a non-specific tool for the varied range of qualitative research approaches, and as such may only be used to provide an uncomplete assessment of the quality of research (17). Furthermore, the value of using ‘checklists’ has been questioned in meta-ethnographic studies due to the risk that insightful studies would be excluded based on quality criteria (18). Consequently, the CASP scores generated were not used as a means of excluding papers, but to aid understanding of the strengths and weaknesses of each paper. A table of the of the main characteristics of the included papers was constructed, providing an overview of the research approaches, participants, location of research, and the author’s main findings and CASP scores (Table 4).

<Insert Table 4 around here>

Phase three: reading the studies:

Data abstraction and synthesis:

The process of data abstraction followed Noblit and Hare's (13) guidelines for synthesising qualitative data. The papers were repeatedly re-read and the main components, comments and experiences from the different papers were compared aiming to ensure no relevant findings were missed or ignored. Data were extracted and recorded from the papers, initially using mind maps and later a table of first and second order constructs for each paper was created, which then was amalgamated into a summary of all papers, showing how they relate and providing examples of the overarching concepts identified, using direct quotes to avoid misinterpretation. Data were extracted across the whole paper, including the methods and discussion sections of papers, rather than limited only to the findings (15), to avoid the loss of relevant conceptual data. This process was discussed and confirmed between KO and MB. KO and MB initially considered the papers independently before comparing emerging metaphors, concepts, and story lines to those created by KO and then discussed to ensure agreement (See Supplement 2).

Phase four: determining how the studies are related:

The papers and data extraction forms were repeatedly read and the main components, comments and experiences from the different papers were compared aiming to ensure no relevant findings were missed or ignored (example of initial data extraction form in Supplement 3 which were then further refined based on repeated reading of papers). The papers were assessed for reciprocal (where the accounts given are directly comparable) and refutational translation (where the accounts given are opposed to each other) across the studies. Furthermore, it was considered if there were lines of argument developing, which has been described as "a "whole" among a set of parts" (13).

Phase five: translating the studies into one another:

The original papers were re-read again to ensure comments had not been taken out of context. This aimed to "protect the particular, respect holism, and enable comparison" (13). In this way the study aimed to uphold the main concepts and metaphors from each paper during translation and comparison. Meta-ethnography aims to construct interpretations rather than provide an analysis (13). Concept mapping was used to aid this process to help visually represent the relationships between the different concepts (see Supplement 4). KO and MB discussed and confirmed this process.

Reflexivity:

Within meta-ethnography reflexivity is regarded as an important aspect of the research. This was acknowledged by Noblit and Hare (13), who stated that "the analyst is always translating studies into their own word view". Therefore, it is acknowledged that findings of the review are based on personal interpretations of the selected studies and as such subjectivity and personal understanding of the topic will have impacted on the interpretation of data. KO and MB both have a background as adult nurses and working in palliative care settings. Furthermore, the KO was employed as a nurse based on an in-patient hospice unit in England. Consequently, a reflective diary was kept aiding transparency.

Results:

Search outcome

A total of 4, 575 papers were identified from the databases (CINAHL: 1,882; PsycINFO: 1,212; Medline: 1,008; AMED: 473). Of these results, 1,140 duplicates were removed. This led to the inclusion of 14 papers in the final review (Table 4). A systematic approach was used to and recorded using an adapted version of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) diagram (see Figure 1).

<Insert Figure 1 here >

<Insert Table 4 here >

Phase six: synthesising translations & Phase seven: expressing the synthesis:

Characteristics of included studies:

Studies were published between 1987 and 2021 and were conducted in the United States of America (n=5), United Kingdom (n=3), Belgium (n=2), Denmark (n=1), Sweden (n=1), Canada (n=1), and one including both findings from Denmark and Australia. Study methods included interviews, often in combination with focus groups, field notes, and observations. Two studies included a combination of volunteers, paid staff, and family members as participants, five studies included volunteers and paid staff, however, seven of the included papers only included volunteer's perspectives. Settings included a nursing home which provided general palliative care, hospice in-patient settings, day hospices, the community setting, a children's hospice, and a prison.

This review intended to go beyond the findings of individual papers to create new overarching interpretations by translating concepts and metaphors into each other. Noblit (19) added that the selected studies need 'to be translated into each other as wholes—that is create analogies between and amongst a set storylines that encompass the whole', thus providing a fuller interpretation. Final consideration of the storylines was undertaken by KO and MB (Table 5).

<Insert table 5 around here>

Storyline one - "we are the cake, and they are the cream": understanding the volunteer role – separate, but part of a whole.

The first storyline illustrates the different ways volunteers and paid staff viewed the volunteer role, seeing it as distinct but also connected to paid staff. Volunteers often considered themselves integral to the team, using words such as '*we*' to indicate being part of the organisation, with examples of this being enabled by senior management (20, 21). However, this relationship between volunteer and organisation could also be perceived as 'them' and 'us', where they '*do not connect'* (22). This could create separation and misunderstandings between the volunteers and other team members.

At times paid staff considered volunteers as having a supplementary role. The care and support provided by volunteers was seen as extra to the essential contribution made by paid staff (23, 24). For some, it appeared that paid staff valued being distinct and different, with separate roles as much as volunteers did:

> *"We are the cake, and they are the cream. That is extremely important because they are not taking any piece of the cake. That is the difference between volunteers and professionals"* (23).

Often when this sense of separation was expressed, it was noted that paid staff and volunteers worked separately, both in location (sometimes in the same building but different areas) or separate tasks (22). It was not possible to characterise the type of setting this sense of separation took place, as both a hospice and a nursing home were involved (20). However, it is noted that both care settings, showing the most clear and distinct lines between paid staff and volunteers were in Denmark.

Volunteer's distinctiveness was perceived positively, enabling them to overlap the worlds of paid staff and patients in way described as a '*unique hybrid'*, and where volunteers could be the '*eyes and ears'* of paid staff (7, 25-28). Volunteers recognised this different function to paid staff, enabling them to perform different roles because they were not paid staff:

> *"The nurses, they go into the home and it's like, 'Okay, I [the nurse] got to get this done and I've got to get that done...' It's very task-oriented... [But] I've seen [volunteers] just being there, that is what they do: they are being there; they sit, they listen"* (25).

Both volunteers and nurses noted the importance of 'being there' as a role of the volunteer that separates them from paid staff. In this way they saw the difference between "being", which was linked with volunteers and "doing" which was associated with nursing staff. However, at times volunteers also found expressing their unique role challenging with formal care providers, instead referring to the tasks they performed to give credibility to what they did. This may have contributed to the lack of understanding from paid staff about their role (25, 26). If volunteers felt uncertainty about the volunteer role, was believed to lead to a sense of insecurity (29, 30).

Although there was a generalised wish to be separate and different from each other, there was also a common feeling of mutual appreciation and regard (6, 24, 25).

Storyline two - "…sometimes we need to know": access to information and importance of trust.

This second storyline shows how paid staff and volunteers discussed information sharing and how for volunteers this was also connected to feeling trustworthy. Knowing what information could be shared was challenging for both volunteers and paid staff. Volunteers perceived that paid staff did not always share important information which they required to work effectively (7, 22, 28).

Those that had volunteered for a longer period felt that they previously knew more about patients, but this changed due to an increased need for patient privacy and confidentiality. Ambiguity around confidentiality agreements or the perceived level of seriousness that volunteers took regarding patient confidentiality limited the information paid staff were willing to share. Volunteers found that this strict approach to confidentiality made it difficult to perform their roles safely (4, 22, 23, 28):

> *"So, I [wasn't] meant to give her digestive biscuits but I didn't know that…we don't know what's wrong with people but sometimes we need to know"* (7).

Some volunteers felt that the lack of information sharing was because they were not deemed trustworthy, despite signing confidentiality agreements (28):

> *"… obviously the nurses stick to the confidentiality and unfortunately volunteers aren't told and yet we have to take the confidentiality thing very seriously but we're not trusted with that, which is odd really as you're trusted so far with patients"* (28).

Some paid staff did not feel it was important for volunteers to be informed about the details of patient's illness because this did not impact their ability to work effectively. Paid staff also tried to prevent any 'wrongdoing' by sharing more information than they should (22). However, this caused disappointment for volunteers, as they were interested in the people they met. The lack of information about patients led to volunteers misunderstanding the paid staff's rationale for their actions towards patients (29). At times this was extended to paid staff not sharing information about an individual's death (22):

> *"if someone dies, they can't tell you. Then you happen to find out accidently. When you are in the house a lot, this is strange (...) You know the resident"* (22).

Becoming a volunteer often involved learning to trust not only others, but also to trust themselves and the importance of being trustworthy. The setting that the importance of being trustworthy was particularly noted was in a prison setting, where prisoner volunteers work with paid palliative care teams to support prisoners approaching the end of life (24). A sense of mutual trust was a foundational element of effective teamwork between volunteers and paid staff (25, 27).

Storyline three - "everybody looks out for each other": access to paid staff and their support.

The third storyline focuses on the views relating to value volunteers placed on different types of support received from paid staff.

Support offered to volunteers by paid staff was seen as either functional or emotional. Some volunteers sought assistance and advice from a variety of paid hospice workers including social workers, nurses, and clergy. Functional support was perceived as drawing on the experiences of paid staff about difficult situations, compared to emotional support, which focused on processing difficult experiences encountered. Some volunteers preferred to discuss their experiences with fellow volunteers. It was thought that those with similar perspectives were in a better position to empathise and support volunteers emotionally (21, 26, 27).

Other volunteers felt that they wanted greater social connection with staff, which would increase a sense of belonging to the team:

> *"You have a close relationship with the nurses, a one-on-one interaction, which you may not experience in other healthcare settings…everybody looks out for each other"* (24).

Volunteers desired fellowship with paid staff, which was one of the reasons for volunteering. Volunteering was not only about functional working with patients, but also about feeling connected to a wider team consisting of other volunteers and paid staff. When this need for fellowship was not met it could create feelings of rejection (29). Some paid staff said they were readily available for volunteers to speak to, suggesting volunteers were given permission to engage with paid staff. However, despite this offer being made some volunteers felt awkward disturbing nursing staff, implying that further reassurance of the working relationship may have been needed for some volunteers (30, 31):

> *"Also, the day hospice nurses. They are always there and say repeatedly that 'we are here, if there are any problems please come and speak to us'. We have a very good relationship"* (31).

Volunteers found working with, or in the presence of, paid staff was reassuring. However, some volunteers reported having difficulty contacting paid staff. Infrequency of working together due to shift patterns was seen as a barrier to effective communication which was felt could lead to confusion and misunderstandings. Volunteers expressed concern that this may cause important information about patient care to be lost, putting excessive pressure and responsibility on the volunteers (4, 7, 26, 30).

The role of a volunteer coordinator facilitated communication when there was limited contact between paid staff and volunteers. In addition to seeking support from paid staff, volunteers referred to volunteer coordinators for problem solving and advice. This was often felt to be an important relationship for volunteers (4, 21, 30). However, some of the paid staff felt that the role of the co-ordinator could create a 'third-person' and become a barrier to joint co-operation and development of mutual understanding. Consequently, whilst coordinators were seen as an important part of aiding volunteers to solve problems, it was perceived that they should also encourage volunteers to make use of the interdisciplinary team when needed (21, 22).

Storyline four - "...we don't meddle in the medical": boundaries.

This storyline considers the perception that boundaries could be physical, institutional and at times unspoken.

At times there were perceptions of boundaries that kept volunteers outside the 'professional domain', including multidisciplinary team meetings. This was 'valued' by some volunteers, as they wished to respect the boundaries (7, 22, 28). Whilst another referred to it as *"...we don't meddle in the medical"* (26). Volunteers were aware that they should not 'cross the line', although these boundaries were never strictly defined and at times exceptions occurred:

> *"… you're busy in the kitchen with who knows what, but you hear the nurse that, er, someone is anxious, er, wishes for someone to be near, wishes – you drop everything..."* (26).

Consequently, when requested by paid staff, volunteers appeared to function in a different domain than their volunteer tasked role. It was thought that when volunteers felt uncertainty about their boundaries, volunteers may be afraid that they would accidently stray into the 'domain of the nurses' (29).

Volunteers used the expression *'stepping on toes'* of paid staff regarding invisible and unspoken boundaries:

> *"There are lots of practical things I'd like to talk a little bit more about, like the boundaries between what a volunteer can do and what the professional caregivers do – to have a better understanding of the nature of their professional work (…) I'm afraid of stepping on someone's toes…"* (22).

However, within another context, it appears paid staff were also concerned this could happen with volunteers. This was overcome through supervision, which was used to evaluate volunteer's strengths and weaknesses in a positive way, 'without stepping on toes' (4, 22).

Shifting boundaries, driven by an increased sense of formality through policy and restrictions, impacted on working relationships between paid and volunteer. However, change was often seen as a positive by some volunteers, appreciating an increased structure, which were clearly explained and defined (7, 23).

Some volunteers were not permitted to enter patient rooms, creating physical boundaries. Volunteers described feeling they had crossed an 'institutional boundary' although this was unspoken, it represented a physical area specifically for paid staff. Lack of interaction from paid staff caused volunteers uncertainty of being welcomed into the physical space. However, some paid staff believed that if volunteers were not working in the same areas that they miss the opportunity to get to know each other. This suggests that there may have been misunderstanding between the two groups. Volunteers felt that having a shared physical space would make a 'big difference' to working relationships (4, 22, 23).

Storyline five - "it's the small things that the staff does for me that makes me feel good about my work": sense of value and significance.

The final storyline illustrates the sense of significance and value felt by volunteers as part of a wider hierarchical structure

Feeling appreciation from paid staff helped volunteers to see their own role as significant and worthwhile (28). When appreciation was lacking volunteers felt unimportant and unnoticed. The desire for recognition varied amongst volunteers, some valuing formal recognition through newsletters and special volunteer events (20, 29). However, others felt that formal recognition in this way was not necessary, preferring more informal recognition:

> *"it's the small things that the staff does for me that makes me feel good about my work"* (20).

This suggests that whilst volunteer preference on how recognition is received is individual, the desire for it in some form from paid staff was more widely expressed (7).

Recognition by paid staff of volunteer's individual interests, abilities and skills influenced their experience of volunteering and sense of value. Volunteers saw their role as unique and that their contribution should be guided by their personal strengths. When this was not recognised by paid staff it led to disappointment, however there was general acceptance of the tasks assigned to them that were not to their preference (7, 29). Volunteers felt that it was important to carry out tasks to the best of their ability, but at times paid staff did not appear to see the value their personal contribution, such as baking (7, 29). At times volunteers that had a healthcare professional background were regarded with apprehension:

> *"Hang your uniforms outside. You simply cannot bring your old job in here"* (23).

However, volunteers with non-healthcare backgrounds were encouraged to use their skills within the hospice.

Often there was a deep mutual regard and respect between volunteers and paid staff (7, 24, 25). Respect was also given to volunteers by paid staff due to the level of knowledge they had about the patients and how they were feeling. Volunteers saw that being regarded as 'good volunteers' was linked to their continued willingness to learn about patients and from others. Suggesting that gaining respect was connected to demonstrations of commitment from volunteers (27).

Some volunteers felt ambiguity over volunteer status due to 'organisational hierarchy' created uncertainty and 'status conflict' (30). However, some volunteers were aware of a sense of hierarchy:

> *"you've got to make sure that [you] speak to the staff, not do something off your own bat"* (28).

This suggests that they were required to seek permission from paid staff before acting. The metaphor of a tandem bike was used to describe the working relationship suggesting a closeness and connection between paid staff and volunteers for effective collaborative working. However, the paid staff member remains the lead in the relationship at the front of the bike with the volunteer at the back (4).

A high level of satisfaction from volunteers to the wider principles of the hospice movement was attributed to a non-hierarchical approach to multidisciplinary working, valuing individual contributions, rather than status or qualifications (31). However, not all appeared to agree, as some volunteers and paid staff questioned if volunteers were 'qualified' for certain discussions (4, 20, 30).

Discussion

The aim of this meta-ethnographic review was to explore the views expressed by volunteers and paid staff about their experiences of working together in palliative care settings. Challenges for volunteers, paid staff and settings providing palliative care when seeking to work together were highlighted in this review. The overarching concept throughout all five story lines identified was of team and team working between volunteers and paid staff, which was evident with the use of the term 'we' to describe their relationship. Teamwork can be seen threaded through three main issues identified; 1) redefining what palliative care teams are and who they should include, 2) the impact of power and hierarchy on teams, and 3) the importance of intentionally building relationships between volunteers and paid staff.

The desire from volunteers to work as part of a team with paid staff was evident within several of the storylines and seen by volunteers wanting to be connected in a meaningful and purposeful way. The importance of teamworking is often seen as a key element of effective palliative care (32); however, teamworking is often limited to those regarded as 'healthcare professionals' or paid staff. Within healthcare, the term 'interprofessional team working' is often used and advocated and included as a core element of pre-registration teaching (33-35). This concept encourages healthcare professionals to view other professionals as having an equally valid contribution to make to patient care and to work collaboratively. It has been further suggested that trans-professional working, which seeks to transcend individual disciplines to form more integrated and cohesive teams would enable team members to develop greater knowledge and understanding of each other's roles and responsibilities (36, 37). However, this positive model still does not necessarily seem to fully remove barriers to fully include relationships between paid staff and volunteers. Consequently, many volunteers may still be seen as outside of the core team within a palliative care setting. This separation links with the metaphor used in storyline one of "we are the cake, and they are the cream", seeing healthcare professionals and paid staff as essential and volunteers as non-essential.

The boundaries of interprofessional teams within palliative care should be challenged to consider the unique and valid contribution volunteers make when included as integral members of the team. However, how to make this meaningful and preventing their inclusion being only a token or goodwill gesture would need consideration within each palliative care setting. Teams meet and work for different purposes, for example, to discuss patient care, to discuss staffing issues, or to discuss the running of the setting. Therefore, consideration and identification of which meetings and teams would be appropriate for different groups of volunteers and paid staff to be involved in to enable their contributions to be meaningful and mutually beneficial. Volunteers were often regarded as an additional element of care and as such absent from multi-disciplinary (MDT) meetings (39). They encouraged more joined-up thinking and volunteer inclusion in MDT meetings to give space for constructive conversations. Transparent communication of which meetings different volunteer groups would be included in would reduce the concern of stepping on each other's toes due to unspoken boundaries.

Recognition of a hierarchical and power imbalance between paid staff and volunteers was evident. Within healthcare there have been historical imbalances of power, notably between doctors and nurses. There has a long-standing perspective that nursing was an oppressed role and nurses were subservient to doctors (38). Successful changes have been made to this relationship, seeking to eradicate the need for the 'nurse-doctor game' within healthcare practice (39). However, whilst improvements are evident in relationships between healthcare professionals, throughout the storylines it was seen that volunteers perceived they had a lower status in the organisation than paid staff. Volunteers may experience feelings of subordination, leading to an opinion that they were controlled in their volunteering roles by paid staff (7).

Throughout the storylines, the words 'working together' was seen as significant, which appeared to be different from collaboration. Although the term collaboration is often used in research, the definition of what this means is not always clear. Collaboration maybe seen as 'an integration of activities and knowledge that requires a partnership of shared authority and responsibility' (40). Furthermore, it has been suggested that collaboration involves four key elements of coordination, cooperation, shared decision making and partnership (40). Most elements associated with this definition of collaboration were not frequently seen within the storylines, despite volunteers and paid staff being in the same working environment. Often within healthcare research the terms 'teamwork', 'working together' and 'collaboration' are used interchangeably (41, 42). However, Davies (41) found that there are clear distinctions between the phrases 'working together' and 'working alongside' others, showing that simply working in the same location does not necessarily equate to collaboration.

The metaphor of the tandem bike, with the paid staff up-front, directing, and leading, with the volunteer behind following, implied a power imbalance and volunteers had less control. Volunteer empowerment is a key aspect in encouraging volunteer engagement, building an increased sense of control over their contribution within the setting. Highlighting that paid staff, of all levels, play an essential role in volunteers feeling empowered and an important part of the team. This may be achieved by volunteers and paid staff building shared goals and including volunteers in decision making processes. Within the Netherlands a hospice initiative includes a paid coordinator with oversight of large numbers of volunteers who receive training to carry out much of the patient care needed. Volunteers appear to be empowered to carry out care, make independent decisions. On occasion that something goes wrong it is regarded as ‘a situation to learn from’ (43). Traeger and Alfes (44) suggests that volunteer empowerment can be aided by them having the skills, knowledge, and ability to carry out tasks effectively through training and development. Therefore, joint training for volunteers and paid staff during induction on relevant topics, such as the values and structure of the organisation, moving and handling and core principles of palliative care may help to reduce the sense of power imbalance.

Throughout the storylines, it was evidently important for volunteers and paid staff to intentionally build positive and meaningful relationships. Increasing social interaction between paid staff and volunteers was seen to be a constructive way of improving working relationships and further building a sense of fellowship that was deemed to be important to some volunteers. Over the last few years, COVID-19 restricted many volunteers ability to have face-to-face contact in palliative care settings, leading to reduced social interaction and changed the way communication with patients, paid staff and other volunteers occurred (45, 46). This change to an important aspect of volunteer’s reason for volunteering in palliative care should be considered by palliative care settings to ensure volunteers feel the sense of community and camaraderie they felt was important within this review. Palliative care settings going through times of change or growth can reduce the sense of intimacy within these settings, which can negatively impact on the experience of volunteers (12). Therefore, as demands for palliative care services increase and settings expand, there should be consideration for how a sense of fellowship and belonging can still be fostered.

The storylines show that a sense of recognition was important for volunteers to feel valued by paid staff, which is also echoed in other studies (12, 47, 48). The findings of this review highlight the importance of acknowledging volunteers’ individual contribution, which was linked to their sense of personal worth. Maslow’s theory of human motivation views that for individuals to reach their potential they first need to feel they belong and find their place in a group, followed by meeting their esteem needs. This includes feeling a sense of esteem, attention, and recognition from other (49). Volunteering can build self-growth and wellbeing by building their sense of individual purpose (50).

Therefore, for volunteers to reach their potential in their work as part of a palliative care team they need to feel acknowledged and appreciated by the wider team. Effective communication, successful utilization of volunteers and having joint social events between paid staff and volunteers may be effective ways of improving volunteer retention and satisfaction (48).

Recommendations

- Recommendations for practice

There is potential that joint education, including the ethos of palliative care and the organisational values would develop a mutual sense of belonging to one team with a clear vison and intent. The inclusion of volunteers in team meetings should be considered to improve information sharing, enable volunteers to make a unique and valid contribution, also foster a sense of empowerment. The way volunteers are to be included in meetings would need to include transparency in communication verbally and written, such as during initial induction training and written job descriptions for both volunteers and paid staff to prevent misunderstandings.

Furthermore, encouraging volunteers and paid staff to be in each other's presence more, both during work and socially may encourage improved relationships, this may include simple initiatives, such as a shared room for breaks. Successful working between paid staff and volunteers should not be taken for granted to prevent potential problems and breakdown in their relationships.

- Recommendations for policy

Policy and guidelines regarding palliative and end of life care are often aimed specifically at health and social care professionals. The recommendations often include the benefit of multi-professional working; however, this may exclude the contribution of volunteers. Consequently, including volunteers in relevant aspects of policy on how they can contribute to effective palliative care through working with paid staff may be useful. Volunteer inclusion in national policy and guidelines may also support individual palliative care settings navigating some of the challenges discussed throughout the storylines, enabling them to filter this into local guidelines.

- Recommendations for future research

There were still problems with the working relationships between paid staff and volunteers highlighted in the review, such as power imbalances, ineffective communication, unclear boundaries, and not seeing volunteers as fully integrated members of the team. Therefore, further primary research seeking to further build an understanding of the working relationships between paid staff and volunteers and make improvements is recommended. Volunteer empowerment was raised as an area for consideration, which links with the aims of participatory action research. Action research can be used to encourage groups to feel empowered by enabling the participants to control and take ownership of the direction and focus of the research (51). Therefore, participatory action research, exploring the relationships between paid staff and volunteers in a palliative care setting is recommended.

The papers that met the inclusion criteria originated in only seven high-income, Western countries. Whilst the culture and context of volunteering and healthcare provision across these countries has differences, it may be that similar findings would not be identified if there had been a broader range of research from other contexts available to synthesise. Research is recommended across a range of cultures and contexts to explore the relationship further between volunteers and paid staff.

Strengths and Limitations

Only qualitative studies were included in the review, it may be that some studies using quantitative or mixed methods may be of value in understanding volunteer – staff relationships. However, the methodological approach adopted in this study enabled an in-depth exploration of the phenomena of interest. Meta-ethnography is an iterative and interpretive approach; therefore, the world view of the authors would have influenced the findings of this review. Whilst our world view may not necessarily be a limitation of the research, this should be considered by readers. However, through following the eMERGe reporting guidance, we have sought to provide transparent reporting to improve the robustness of the review (52).

Studies included in the final review are all Western-centric cultural background, and whilst variations due to country of origin have been found, the inclusion of other cultures may have included a different insight and valuable perspective to the discussion. Therefore, future research considering a wider cultural context maybe beneficial.

Conclusion

The findings of this meta-ethnographic review show that whilst recognising individual roles and purposes within a palliative care setting, being part of one collective team is important for both volunteers and paid staff to work together effectively. This encourages a sense of belonging, camaraderie, and common purpose. The discussion has also explored that Collaboration goes beyond 'working alongside' others or ‘working together’ by implying active cooperation and joint efforts towards shared goals. It was also highlighted that paid staff are key in empowering volunteers through building shared goals and including volunteers in decision making. Finally, for successful working relationships between paid staff and volunteers, proactive engagement and interaction between both groups is needed.

Disclosures and Conflicts of Interest

All authors have no conflicts of interests to declare.

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