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Review Article

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

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Abstract

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.

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

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.

Introduction

There is a long history of volunteers working in palliative and end of life care; however, their role is

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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, 6, 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.[10,11,12] 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.[13] This review is reported in line with the eMERGe guidelines on improving reporting in meta-ethnography.[13,13]

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.[14] Within meta-ethnography this is achieved by translating, transferring concepts, metaphors and understanding across selected studies through a seven-step process (Table 1).[13]

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).

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 December 5th, 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

Table 1
An Overview of Research Process of Meta-Ethnography

Phase of Meta-Ethnography (Phases May Overlap and/or Run Parallel)	Purpose and Requirements of the Phase
Phase one: "getting started'	Identifying an area of exploration in which qualitative research can be employed to inform. This aims to find something which is worth studying through meta-ethnography.
Phase two: "deciding what is relevant to the initial interest"	Determining the studies relevant and of interest to the chosen area of exploration.
Phase three: "reading the studies"	In-depth reading and rereading of selected papers to begin identifying interpretive metaphors.
Phase four: "determining how the studies are related"	Studies must be put together by deciding the key metaphors, concepts by comparing, and contrasting them. Initial assumptions can begin to be made.
Phase five: "translating the studies into one another"	Translating studies whilst also maintaining the main concepts and metaphors of each paper.
Phase six: "synthesising translations"	The various translations are compared to determine if larger concepts can incorporate and encompass some of these separate translations.
Phase seven: "expressing the synthesis"	Express the translation and synthesis in an appropriate way to the identified audience.

Table 2
Population, Intervention, and Context of Interest

Population	Volunteer and paid staff providing palliative care to patients
Intervention	Collaboration/working together
Context	Any care settings providing palliative care to patients

building or limiting searches.[15] (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 (Table 3).

Search results were downloaded into Endnote X9, combined and deduplicated. 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 nonspecific 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.[16] 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.[17] 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).

Phase Three: Reading the Studies

Data Abstraction and Synthesis. The process of data abstraction followed Noblit and Hare's[13] guidelines for synthesizing qualitative data. The papers were repeatedly reread and the main components, comments and experiences from the different papers were compared aiming to ensure no relevant findings were missed or

Table 3
Inclusion and Exclusion Criteria

Inclusion	Exclusion
• Research exploring volunteers (considered for this review as a person who works for an organization without being paid) providing direct patient care (inclusive of physical care/verbal support/meal and drinks provision), in collaboration (working directly with or alongside) paid staff in palliative care settings. • Any care settings providing palliative care may include care provided to any patient (adult or child) with any formal terminal diagnosis (not limited to cancer). • Primary research employing any qualitative approach. • Research published in English language. • Published, peer-reviewed research.	• All quantitative research, including those with a combination of qualitative and quantitative research methods, as meta-ethnography only enables the inclusion of qualitative studies.[16] • Literature reviews (however, the reference lists may be used for "snowballing.") • Grey literature.

Table 4
Included Papers and CASP Score

Author, Year, and Country	Aim/s	Setting/Context/Service Description	Sample	Methodology and Method	Themes/Key Findings	CASP Score
Sangild stølen 2021 Denmark	To explore the challenges experienced in volunteer-professional care-giver cooperation in the general palliative care provided in nursing homes.	Looking at care provision in two nursing homes as part of general palliative care offered in Denmark.	Observations of volunteers ($n = 50$ −60) Interviews with volunteers ($n = 9$) Professional caregivers ($n = 13$)	Participant observations and interviews Sociological phenomenological approach	Symbolic indications of "them-and-us." Unspoken boundaries. Volunteers do the fun stuff. Meanings and actions regarding residents" best interests. Social activities support the wellbeing of the individual resident. Shielding the residents from excessive activity. The link, which was seen as the activity co-ordinator.	9
Vanderstichelen et al., 2020 Belgium	To describe volunteer roles across care settings through the perspective of those closely involved in the care of terminally ill people.	Participants were recruited from hospital, home, day care and live-in services	Volunteer ($n = 28$) Palliative care nurse ($n = 4$) Palliative care psychologists ($n = 6$) Family	Focus groups and individual interviews using a phenomenological epistemology.	Volunteers as "the other face of care," focus on psychological, social and existential care, and building relationships/ The liminal space of volunteers. Barriers to and facilitators of volunteer role performance.	10
Vanderstichelen et al., 2019 Belgium	To explore what constitutes volunteer-professional collaboration around palliative care	Palliative care volunteers in Belgium provide direct patient care. Their contribution comprises of a wide range of tasks, including practical and nursing tasks. Their main contribution is psychological, existential and signposting care tasks.	Volunteer ($n = 28$) Palliative care nurse ($n = 4$) Palliative care psychologist ($n = 6$) Family physician ($n = 12$)	Semi-structured focus groups and interviews a qualitative descriptive design with "grounded theory and phenomenological overtones"	Contact with professional caregivers. Support from healthcare professionals. Information sharing and coordination. Barriers to and facilitators of volunteer-professional collaboration.	9
Cloyes et al., 2017 USA	To describe how inmate volunteers learn hospice care through formal education and training, supervised practice, guidance from more experienced inmates and support from correctional staff.	The Louisiana State Penitentiary Prison Hospice Program (largest maximum-security prison in the US)	Observational data In-depth interviews with: Correctional officers ($n = 5$) Medical and hospice staff ($n = 14$) Inmate hospice volunteers ($n = 24$)	Ethnographic study including in-depth interviews and observational data	Learning to care: included formal training and education for prospective volunteers, practical experience at the bedside, formal and informal peer mentorship, interactions with medical and correctional staff.	5
Overgaard 2015 Denmark and Australia	To develop an understanding of the principles and conflicts that shape the division of labour (between volunteer and paid staff).	Two hospices—one located in Denmark and one in Australia	Volunteer co-ordinator (current and former) ($n = 3$) Hospice leader ($n = 1$) Nurse unit manager ($n = 2$) Social worker ($n = 1$) Diversional therapist ($n = 1$) Pastoral care manager ($n = 1$) Nurse ($n = 5$) Volunteers ($n = 26$) Kitchen staff ($n = 1$)	A comparative case study approach involving nonparticipant observation and unstructured interviews.	Within the Danish hospice the boundaries between volunteers and paid staff were discussed as a means of preventing volunteers from participating in direct care-giving. This was in contrast to the Australian hospice, in which direct personal patient care was "not off-limits to volunteers."	8

(*Continued*)

Table 4
Continued

Author, Year, and Country	Aim/s	Setting/Context/Service Description	Sample	Methodology and Method	Themes/Key Findings	CASP Score
Elliott & Umeh 2013 UK	To examine the psychological experiences of volunteer carers in a UK hospice.	Participants were from one UK hospice in the Northwest of England	Voluntary carers ($n = 9$)	Qualitative design Unstructured interview format. Data were analysed using a grounded theory protocol.	Motivation to volunteer, which included feeling that they were giving something back. Volunteering skills, including being aware and adhering to boundaries between their roles and those of paid staff. Psychological support and holistic care. Perceptions of the hospice. Performance hinderances, this theme included relationships between the paid staff and volunteers were occasionally a source of tension.	10
Field-Richards & Arthur 2012 UK	To explore the nurse—volunteer relationship in a day hospice.	One day care hospice in the East Midlands in England.	Day hospice volunteers ($n = 12$)	Underpinned by a qualitative interpretive approach Semi-structured interviews	Formalization, which included a structured induction, interview process and regulations. Division of labour. Working relationships, including those between volunteers and nurses.	9
Brown 2011 USA	To examine the coping techniques utilized by hospice volunteers.	Study participants were recruited by a letter invitation sent to 70 volunteer coordinators who were members of the western state Hospice and Palliative Care Association.	Hospice volunteers ($n = 15$)	A combination of Phenomenological and hermeneutic methods semistructured interviews	Volunteers used problem-focused coping, which included seeking advice from members of the hospice inter-disciplinary team. Emotion-focused coping, meaning making through appraisal and physical techniques. The most significant coping mechanism was talking with the volunteer coordinator.	10
McKee et al., 2010 Canada	To better understand the role of hospice volunteers in the rural context. Especially in what ways their contribution to end-of-life care is unique or irreplaceable.	North-western Ontario	Included hospice volunteers, Family members, members of the senior's club, Health professionals, a hospital administrator, members of the clergy, funeral director, police, and ambulance personnel.	"focused ethnography" 13 individual "loosely structured" interviews and 8 focus groups, field notes, photographs.	Volunteers have time to be there, "just sit" and time to listen. Time for a real relationship. Volunteers hold the dying person in community. Between friends and professionals: a unique circle of care.	9
Duggal et al. 2008 USA	To present the unique volunteer roles and experiences at the children's hospice and share ways that volunteers work to support the efforts of the clinical team.	Based at a hospice providing free of charge hospice care to children and their families living with life threatening illness.	Volunteer director ($n = 1$) Volunteers (not stated)	Descriptive design and interviews	Volunteer selection is important to ensuring a cohesive workforce. Training equips volunteers to work with confidence. It is important to ensure volunteer stability and satisfaction.	2

(*Continued*)

Table 4
Continued

Author, Year, and Country	Aim/s	Setting/Context/Service Description	Sample	Methodology and Method	Themes/Key Findings	CASP Score
Anderson & Öhlén 2005 Sweden	To obtain an understanding of what it means to be a hospice volunteer in a country without a tradition of hospice or palliative volunteer care services.	Three hospices in central and western parts of Sweden	Volunteers ($n = 10$)	Phenomenological hermeneutic approach Interviews	Why volunteers get involved in hospices, including their motives for becoming involved in hospices. Encountering the hospice, which included subthemes of “getting to know the atmosphere of the hospice,” “being assigned a constructive task’ and “longing for fellowship.” Encountering the patient, which included three subthemes of “wanting to understand the needs of the patient,” “imagining what fills the patient’s thoughts and time” and “retaining the encounter with the dying patient.”	9
Dein & Abbas 2005 UK	To establish the stresses that volunteers have to cope with in a hospice setting. To examine the ways that volunteers cope with these stresses. To examine the perceptions that volunteers have about the support provided by qualified staff at the hospice.	Volunteers from an 8-bedded in-patient unit and 10 day places.	Volunteers ($n = 17$)	Two focus groups. Data were analysed using thematic analysis. Groups were facilitated by a psychiatrist and two palliative care doctors.	Stressors included losing patients and dealing with disfigurement. Work was generally reported ass satisfying and stress-free. Coping strategies included keeping a distance from clients & religious faith. Support was generally perceived as adequate.	9
Sadler & Marty 1998 USA	To examine the turning points volunteers found important in their hospice training and volunteer experiences.	The study took place in a small hospice organization with 8 paid staff and approximately 40 volunteers.	Volunteers ($n = 17$)	Semi-structured interviews Turning point analysis	Pre-hospice turning points—personal events, such as personal experiences with death and dying. Interpersonal turning points—interpersonal events, including interaction with hospice staff. Group turning points—included small group interactions, structural support, recognition, and status and membership.	9
Paradis, Miller & Runnion 1987 USA	To explore the primary stressors experienced by volunteers providing direct patient care.	Data collected from 5 research sites in Kentucky and New York	Volunteers ($n = 17$)	In-depth interviews with four open-ended questions.	Volunteer stress found to be in four main areas—role ambiguity, status ambiguity, patients and families, and stress related to the volunteer’s personal circumstances.	4

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,[14] 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 (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 reread 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 (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 4575 papers were identified from the databases (CINAHL: 1882; PsycINFO: 1212; Medline: 1008; AMED: 473). Of these results, 1140 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 (Fig. 1).

Phase Six: Synthesizing Translations and 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[18] 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).

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 organization, with examples of this being enabled by senior management.[19,20] However, this relationship between

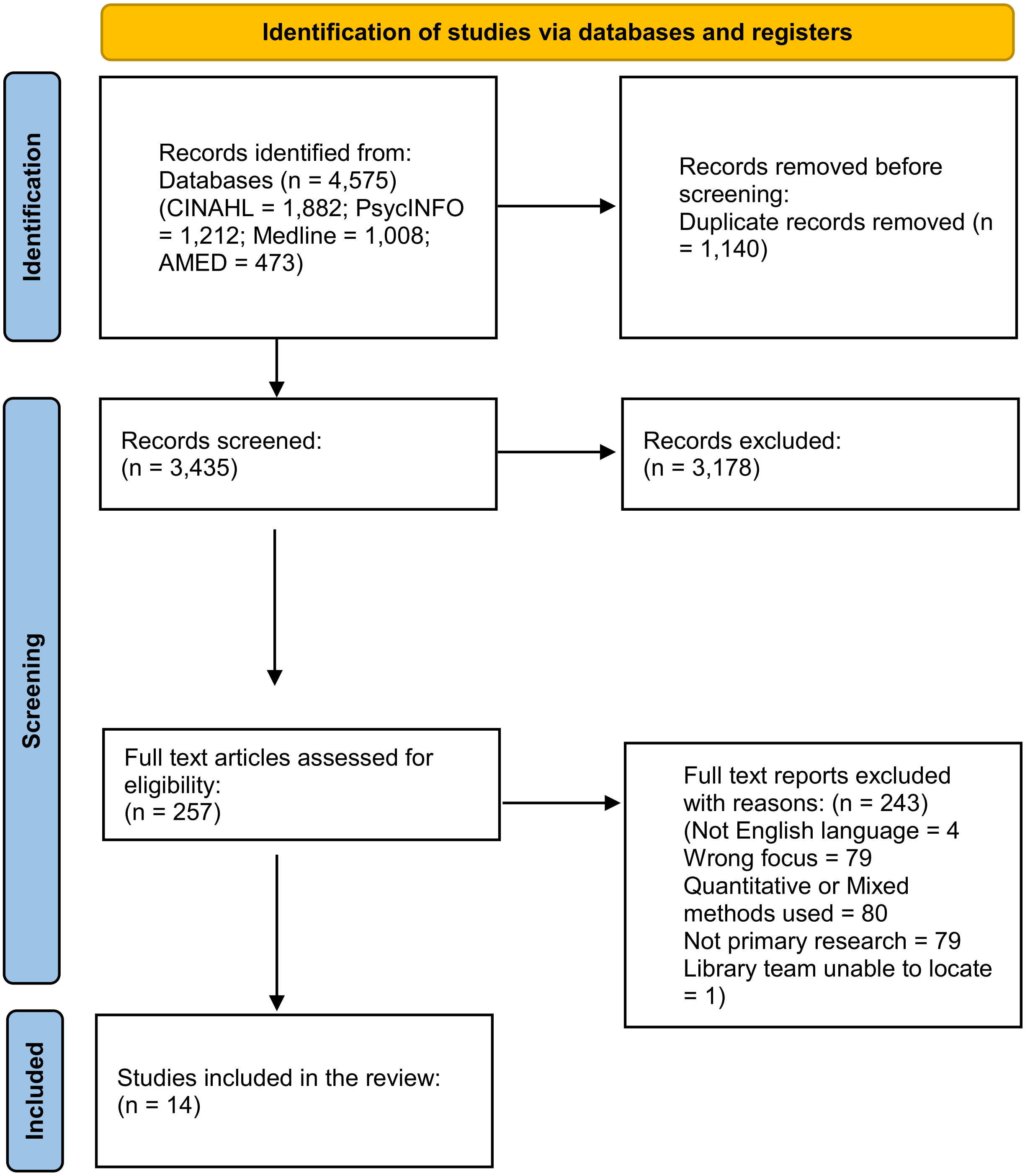

Fig. 1. Flow diagram of the review process. PRISMA 2020 flow diagram for new systematic reviews which included searches of databases and registers only. Available from: http://www.prisma-statement.org/documents/PRISMA_2020_flow_diagram_new_SRs_v1.docx. Accessed July 27, 2023.

volunteer and organization could also be perceived as "them" and "us," where they *"do not connect."*[21] 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.[22,23] 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".*[22]

Table 5
Storylines

Storyline 1	"*we are the cake and they are the cream*": understanding the volunteer role—separate, but part of a whole.
Storyline 2	"*. . .we don't know what's wrong with people but sometimes we need to know*": access to information and importance of trust.
Storyline 3	"*everybody looks out for each other*": access to, and valuing of, paid staff and their support.
Storyline 4	*"...we don't meddle in the medical":* physical and institutional boundaries.
Storyline 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.

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.[21] It was not possible to characterize the type of setting this sense of separation took place, as both a hospice and a nursing home were involved.[19] 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.[7,24–26, 27] Volunteers recognized 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".*[24]

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.[24,25] If volunteers felt uncertainty about the volunteer role, was believed to lead to a sense of insecurity.[28,29]

Although there was a generalized wish to be separate and different from each other, there was also a common feeling of mutual appreciation and regard.[6,23,24]

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.[7,21,27]

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:[4,21,22,27]

> *"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:[27]

> *". . . 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".*[27]

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.[21] 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.[28] At times this was extended to paid staff not sharing information about an individual's death:[21]

> *"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".*[21]

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.[23] A sense of mutual trust was a foundational element of effective teamwork between volunteers and paid staff.[24,26]

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 empathize and support volunteers emotionally.[20,25,26]

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".*[23]

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.[28] 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:[29,30]

> *"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".*[30]

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.[4,7,25,29]

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.[4,20,29] 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.[20,21]

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.[7,21,27] Whilst another referred to it as *"…we don't meddle in the medical."*[25] 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… ".*[25]

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."[28]

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. . . ".*[21]

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."[4,21]

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.[7,22]

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.[4,21,22]

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.[27] 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.[19,28] 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".*[19]

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 recognized by paid staff it led to disappointment, however there was general acceptance of the tasks assigned to them that were not to their preference.[7,28] 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.[7,28] 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".*[22]

However, volunteers with nonhealthcare backgrounds were encouraged to use their skills within the hospice.

Often there was a deep mutual regard and respect between volunteers and paid staff.[7,23,24] 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.[26]

Some volunteers felt ambiguity over volunteer status due to "organizational hierarchy" created uncertainty and "status conflict."[29] 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".*[27]

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 nonhierarchical approach to multidisciplinary working, valuing individual contributions, rather than status or qualifications.[30] However, not all appeared to agree, as some volunteers and paid staff questioned if volunteers were "qualified" for certain discussions.[4,19,29]

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;[31] 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 preregistration teaching.[32,33,34] 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.[35,36] 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 nonessential.

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 multidisciplinary (MDT) meetings.[38] 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.[37] Successful changes have been made to this relationship, seeking to eradicate the need for the "nurse-doctor game" within healthcare practice.[38] 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 organization 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."[39] Furthermore, it has been suggested that collaboration involves four key elements of coordination, cooperation, shared decision making and partnership.[39] 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.[40,41] However, Davies[40] 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."[42] Traeger and Alfes[43] 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.[44,45] 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.[12,46,47] 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.[48] Volunteering can build self-growth and wellbeing by building their sense of individual purpose.[49] 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.[47]

Recommendations

Recommendations for Practice

There is potential that joint education, including the ethos of palliative care and the organizational 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 multiprofessional 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.[50] 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 synthesize. 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.[51]

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 recognizing 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.

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Supplement 1. Search Strategy

Search Terms Used in AMED

Sequence	Search Terms	Limiters	Results
S3	S1 & S2	Peer Reviewed Journal, English	473
S2	Volunteers OR TI (volunteer* OR voluntary OR unpaid) OR AB (volunteer* OR voluntary OR unpaid)	None	6993
S1	"Palliative Care" OR "Assisted Suicide" OR "Euthanasia" OR "Terminally Ill Patients" OR "Hospice" OR "Bereavement" OR "Grief" OR "Respite Care") OR TI (Palliat* OR Terminal* OR bereave* OR endstage OR "end stage" OR "advanced stage" OR "last stage" OR "late stage" OR "final stage" OR dying OR "end of life" Or end-of-life OR hospice OR "supportive care" OR (death N5 (grief OR mourn* OR loss))) OR AB (Palliat* OR Terminal* OR bereave* OR endstage OR "end stage" OR "advanced stage" OR "last stage" OR "late stage" OR "final stage" OR dying OR "end of life" Or end-of-life OR hospice OR "supportive care" OR (death N5 (grief OR mourn* OR loss))	None	22,322

Search Terms Used in PsychInfo

Sequence	Search Terms	Limiters	Results
S3	S2 and S2	Peer Reviewed Journal, English	1212
S2	DE "Volunteers" OR TI (volunteer* OR voluntary OR unpaid) OR AB (volunteer* OR voluntary OR unpaid)		70,095
S1	DE "Palliative Care" OR DE "Assisted Suicide" OR DE "Euthanasia" OR DE "Terminally Ill Patients" OR DE "Hospice" OR DE "Bereavement" OR DE "Grief" OR DE "Respite Care") OR TI (Palliat* OR Terminal* OR bereave* OR endstage OR "end stage" OR "advanced stage" OR "last stage" OR "late stage" OR "final stage" OR dying OR "end of life" Or end-of-life OR hospice OR OR "supportive care" OR (death N5 (grief OR mourn* OR loss))) OR AB (Palliat* OR Terminal* OR bereave* OR endstage OR "end stage" OR "advanced stage" OR "last stage" OR "late stage" OR "final stage" OR dying OR "end of life" Or end-of-life OR hospice OR "supportive care" OR (death N5 (grief OR mourn* OR loss))		80,046

Search Terms Used in CINAHL

Sequence	Search Terms	Limiters	Results
S3	S1 and S2	English Language; Peer Reviewed	1882
S2	(MH "Volunteer Experiences") OR (MH "Volunteer Workers")) OR TI (volunteer* OR voluntary OR unpaid) OR AB (volunteer* OR voluntary OR unpaid	None	76,487
S1	(MH “Hospice and Palliative Nursing”) OR (MH “Palliative Medicine”) OR (MH “Palliative Care”) OR (MH “Hospice and Palliative Nurses Association”) OR (MH “Terminal Care”) OR (MH “Hospice Care”)) OR TI (Palliat* OR Terminal* OR bereave* OR endstage OR “end stage” OR “advanced stage” OR “last stage” OR “late stage” OR “final stage” OR dying OR “end of life” Or end-of-life OR hospice OR “supportive care” OR (death N5 (grief OR mourn* OR loss))) OR AB (Palliat* OR Terminal* OR bereave* OR endstage OR “end stage” OR “advanced stage” OR “last stage” OR “late stage” OR “final stage” OR dying OR “end of life” Or end-of-life OR hospice OR “supportive care” OR (death N5 (grief OR mourn* OR loss))	None	149,402

Search terms used in MEDLINE Complete

Sequence	Search terms	limiters	Results
S4	S1 & S2 & S3	English Language; Scholarly (Peer Reviewed) Journals	1008
S3	(MH "Qualitative Research+") OR TI (experience OR interview* OR qualitative OR experience* OR “semi-structured” OR semistructured OR unstructured) OR AB (experience OR interview* OR qualitative OR experience* OR “semi-structured” OR semistructured OR unstructured)	None	1069
S2	(MH "Volunteers+") OR (MH "Hospital Volunteers") OR TI (volunteer* OR voluntary OR unpaid) OR AB (volunteer* OR voluntary OR unpaid)	None	297,492
S1	(MH "Palliative Care") OR (MH "Palliative Medicine") OR (MH "Hospice and Palliative Care Nursing") OR (MH "Hospices")) OR (Palliat* OR Terminal* OR bereave* OR endstage OR "end stage" OR "advanced stage" OR "last stage" OR "late stage" OR "final stage" OR `dying OR "end of life" Or end-of-life OR hospice OR "supportive care" OR (death N5 (grief OR mourn* OR loss)) OR (Palliat* OR Terminal* OR bereave* OR endstage OR "end stage" OR "advanced stage" OR "last stage" OR "late stage" OR "final stage" OR dying OR "end of life" Or end-of-life OR hospice OR "supportive care" OR (death N5 (grief OR mourn* OR loss)	None	856,435

Supplement 2. Summary of First and Second Order Constructs for Each Paper, and the Storylines Identified

Example of Participant quotes (First order constructs) indicated in italics
Example of Primary author interpretation (Second order constructs) indicated in normal text

Papers in Order of Date (Newest to Oldest)	Understanding of the Role . . . Them and Us/ We/Separate but Part of Whole	Hierarchy/ Power/ Recognition/ Feeling “Qualified”	Access to Information/ Trust	Access to Staff/Support/ Role of the Volunteer Coordinator	Boundaries
Stølen (2021)	“*We can do better. I feel we sometimes look at [the volunteers] as “them” and then there’s “us”. We do our work and focus on that, but we do not connect it to the volunteers’ work. They’re a great part of what we can offer*” *(care assistant)* The analysis identified phenomena encapsulating features of meanings derived from interactions between volunteers and professional caregivers that communicated a “them- and- us” understanding. This made cooperating on care activities for residents more challenging for both groups	*I’m afraid of stepping on someone’s toes. I do not want my work to come at the cost of professional resources... (volunteer)*	“*They can ask me about things I’m not allowed to tell them about. It is about confidentiality. Then you try to find a way, so the resident does not lose their dignity*” *(care assistant).* The professional obligation of confidentiality was a strong symbol for volunteers and professional caregivers alike, communicating their differing knowledge, roles, and authority, as well as the protection of the residents’ personal integrity. Knowing what information could be given to volunteers was not always easy.	*(About coordinators)* “*It’s a barrier when we don’t arrange encounters between volunteers and professional caregivers (...) It isn’t enough for the activity coordinator to have third- person contact to the volunteers. If they are not on the ward, we do not get to know each other. It is about trust. It is about developing a mutual understanding.*” *(Care assistant)* For professional caregivers, the activity coordinator role communicated priorities about the primary contact and responsibility for volunteers and cooperating with them about offered social care activities. Some professional caregivers felt that this role could be a barrier to daily cooperation and mutual under-standing.	*...I want to respect the boundaries’ (volunteer)* . . . When volunteers went to the ward to pick up a resident to participate in an activity or deliver a resident to their room afterward, they reported feeling that they crossed an institutional boundary, which they understood as entering the professional caregivers’ domain. In this space, they felt uncertain about whether they unknowingly crossed pre- established and unspoken boundaries.

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Vanderstichelen, Cohen, Van Wesemael, Deliens, and Chambaere (2020)	Volunteers were found to represent an “other,” more approachable “face of care” and to occupy a liminal space between and overlapping the professional and the family domains.			“*I think the problem for us is also, with us the nurses work- two nurses work, er, 2 days in the week, one works 3 days. Er, the occupational therapist, er, er, Monday, Wednesday and the week after on Wednesday, Friday. So, it’s a constant change of people. A lot has to be done and settled in between. And then I think that the communication, I feel, falls short. . .*” *(volunteer)* *Lack of support and coordination for the volunteers* impeded their role of “being there” and the development of the relationship with the dying person. . . However, when support and coordination were present, participants indicated they facilitated volunteer role performance.	“*The point is that we don’t meddle in the medical. . .*” *(volunteer)* Professional care givers indicated that volunteers should not cross the line when providing psychological guidance. However, these boundaries were never strictly defined.
Vanderstichelen, Cohen, Van Wesemael, Deliens, and Chambaere (2019)	Our study shows that volunteers and nurses assume complementary roles, work together cooperatively	“*You have a tandem bike. The nurse is at the front and the volunteer is at the back because you’re responsible for this together and together you brief each other.*” *(volunteer)* Patients and family carers described the volunteer-nurse relationships as hierarchical, suggesting that volunteers are there to support nurses and that health care professionals provide directions to volunteers Family physicians were unclear about whether volunteers are allowed to take part in illness trajectory discussions with patients and whether they were qualified for this.	“*What I have issues with sometimes, but I don’t have that much experience with palliative volunteers, but I think that maybe it applies to volunteering in general - regarding professional confidentiality, I have issues with it. I once met a volunteer who really came into my practice: “Oh and that patient,” you see. And I was like whoah, whoah. I don’t have to tell you all of this. (.) No, regarding professional confidentiality, I sometimes think - Because you can be a palliative volunteer and be involved, but if you start*	“*Just your functioning in the group, what you think is good, what you think is bad, what they think should be improved. That sounds very, very harsh now, right? But it’s brought in a very soft manner and always ends (laughs) on a positive note. (.) But it gives you the chance, I think, to talk openly for once without someone else present, without stepping on toes*” *(volunteer)* Participants described two types of support that health care professionals offered volunteers while working together: functional support and emotional support.	

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			spreading that around to everyone, then I think .. I think it's tough. We're so strictly bound to that, but they're not. At least I think not, legally?" . . . "*They are in principle. (. . .) They don't always take it that seriously, yeah*" *(Family physicians)* volunteer-nurse collaboration was characterized by mutual information-sharing about the patient's condition and its development		
Cloyes et al. (2017)	The inmate hospice volunteer role represents a unique hybrid between the roles of hospice volunteers, nurse assistants and family caregivers found outside the prison in community-based hospice programs.	"*[b]e a resource to them. When they ask questions, answer the questions; give them the best answer that you can; and do the research that you need to do in order to give them that. They're going to suck [the information] up like a sponge. And then they'll be able to use it in the future. They want this to work.*" *(nurse)* Volunteers described how an ongoing willingness to learn from their patients and each other was essential to being a "good" volunteer. . . This ethic of continuous learning is valued; good volunteers continue to educate themselves and each other as they gain more experience. "They get a very, very close relationship or rapport with the [patients]. . . That's why we really respect whenever they say something's wrong with one of the patients, they see those declining health issues." (nurse)	The work of becoming a volunteer involves learning to trust; being able to trust not only others, but also trusting oneself and being trustworthy. This sense of trust is foundational to the teamwork and sense of stewardship described by inmates and staff, and to how they represent the hospice program to inmates outside the unit.	Despite the availability of grief counselling offered by the hospice social worker, every volunteer interviewed stated that they preferred to discuss their experiences with their mentors and fellow volunteers.	LSP nurses also stressed the importance of interacting with volunteers in a professional manner, maintaining appropriate boundaries while also recognizing the value of volunteers as the front-line members of the hospice care team.

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Overgaard (2015)	“*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.*” *(Hospice Leader, Denmark)* the volunteers at the Australian hospice perform work that overlaps with that of nurses and social workers in particular	Danish professionals have effectively managed to maintain a monopoly over care-giving, which has resulted in a successful professionalisation project	“*A volunteer came up to me after dinner and asked, “How old is that patient?” It may seem like an innocent question,(...) but we are not allowed [to tell].*” *(Nurse, Denmark)* The strict approach to confidentiality sometimes made it difficult for the volunteers to perform their roles.		*“And it’s the certainty that there is a razor-sharp line between being a professional and being a volunteer. The volunteers must of course not in any way interfere in the care.” (Hospice Leader, Denmark)* Boundaries between volunteers and staff at the Danish hospice were created and articulated primarily as a means to prevent volunteers from participating in any direct care-giving
Elliott and Umeh (2013)	Participants also believed that volunteers may sometimes bridge the gap between the patient and the nursing staff, acting almost as a “go between,” thereby providing another form of psychological support to the patient	“*She said basically the hospice would grind to a halt without the volunteers. . .and I think that’s made it worthwhile*” *(volunteer)* “*And you’ve got to make sure that [you] speak to the staff, not do something off your own bat, that’s the thing*” *(volunteer)* Feeling appreciated by the paid staff not only facilitated good relationships between the volunteers and paid staff, but also helped the volunteers to regard their role within the hospice as valuable.	*“We used to know more about the patients but it was intruding on their privacy and so. . .it’s a question of need-to-know, and we don’t always know what we need to know” (volunteer)* The lack of patient information provided to volunteers also seemed to promote the feeling among some of the participants that they were untrustworthy despite having signed a confidentiality agreement.	Some participants mentioned having good relationships with other volunteers and the paid staff as essential for team working. This was considered an important asset for a good volunteer.	It is important that hospice volunteers are aware of and adhere to the boundaries between their roles and those of the paid staff.
Field-Richards and Arthur (2012)	“*Maybe they felt a bit kind of threatened if you like, I don’t know why they would because I mean we’re not professional and you know we’re not nurses. . .I mean we’re only here to help you know. . .we’re not looking to take their jobs off them*” *(Volunteer)* there was consensus among volunteers that the current flexible and informal status of their role augmented the quality of nursing care provided	“*the nurses treat us with great respect and they’re very glad of us and you know we’re glad of them. . .they’re wonderful with us*” *(volunteer)* The nature of relationships between volunteers and nurses within the hospice was variable. Those reporting positive relationships with nurses felt that they worked well as a team, were appreciated, and were well supported in their role.	“*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*” *(volunteer)* There was a perception among volunteers that staff did not always communicate important information required to work effectively within the broadening sphere of hospice volunteering.		There was a perception among volunteers that these boundaries were shifting in response to increasing formality and a changing interface between paid and unpaid work. These changes impacted directly on working relationships.
		Volunteer coordinators should immediately notify volunteers regarding the death of a patient. In addition, providing information	“*That is my main coping skill is to talk with out with my volunteer coordinator. When those things happen (stressful experiences) I try to get*		

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		about funeral services and allowing volunteers to participate in such grief-related rituals may provide a sense of closure and emotional comfort.	*more information. If the information is something I don't want to hear, I again, talk it out and that to me has usually been the best way to deal with the stress that I feel from these experiences that I have.*" In addition to seeking assistance from the volunteer coordinator, participants sought assistance and advice from a variety of hospice workers including social workers, nurses, and clergy. One participant said she used the interdisciplinary team for assistance		
McKee, Kelley, Guirguis-Younger, MacLean, and Nadin (2010)	"*The nurses, they go into the home and it's like,* "*Okay, I 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.*" *(nurse)* It was a significant theme in these interviews that volunteers found it difficult to describe their work in a way that they felt has credibility with formal providers of care, and they were not sure if their role was understood by formal providers.		They know how to relay the needs of the dying and their family members in a way that nurses trust ("They are like our eyes and ears"; "They are very observant and they help us"), and they know how to interpret and manage the formal system in a way that families trust		
Duggal, Farah, Straatman, Freeman, and Dickson (2008)	The hospice has a large pool of active volunteers with diverse talents, skills, and abilities that supplement the work of the professional staff	"*At Canuck Place Children's Hospice, I am respected, even though I am a younger member of the team.*" *(volunteer)* The morning family volunteer works under the supervision of the school teacher. The study suggests that hospice volunteers benefit from personal growth, as well as improved self-esteem and self-worth from their interactions with patients and staff		"*You have a close relationship with the nurses, a one-on-one interaction, which you may not experience in other healthcare settings*" *(volunteer)* forming stronger relationships between staff and volunteers so volunteers feel engaged as part of the overall team.	Evidence must be provided throughout the interview of the following examples of qualities and attributes: Self-awareness and ability to set personal limits and boundaries

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Andersson and Ohlen (2005)	Being assigned a constructive task. Volunteers contributed by performing a variety of tasks that were additional to or an enhancement of the work performed by the regular staff, including the inter-professional healthcare team. How positive the experience of being a volunteer was largely depended on how the staff and the volunteer mutually succeeded in identifying suitable tasks and if the volunteer was given clear guidelines on how to perform the tasks. Simply coming to a ward without having a defined task can be experienced as a burden.	*She described feeling not important,* “*because nobody takes any notice what I think about the situation*” *(volunteer)* One volunteer related how uncertain she felt about whether staff noticed that she was there or not. Positive encounters with the hospice are closely related to personal growth.	“*That’s right. You don’t have to know that. But all the time those questions are there in the sick person and within me. I wonder what is wrong with him or her. It may be someone you see a lot, others you never see. I haven’t felt OK to ask either, since somehow, we have got to know that we don’t need to know what’s up with people. I have been careful not to ask. It’s as if it’s none of my business*” *(volunteer)* The volunteers from another hospice recounted how staff clearly told them that it was not that important for the volunteers to know what sickness the patients were afflicted with because the volunteer could still do a good job.	The social contact with the hospice, the security of being familiar with staff, and the opportunity of contributing something to compensate for the support that their own relative had been given, were important reasons.	Volunteers may feel uncertainty about what is expected of them and they are afraid to “cross over into the domain of the nurses.”
Dein and Abbas (2005)	Several pointed out how their roles were different from or complementary to those of professional staff and they perceived little competition between the groups.	Much of this satisfaction might derive from the ideology of the hospice movement which involves three core ideas: . . . the delivery of such care by nonhierarchical multidisciplinary teams which values the skills and contributions of individual team members rather than their status or qualifications in our study volunteers generally reported feeling valued and morale was perceived to be high in the hospice generally. A number of factors might relate to this high level of satisfaction and morale: . . . positive feedback from professional staff	In relation to this there is a need for volunteers who will be working with patients to be given more information about the disease processes they will encounter and the issues of disfigurement that they will encounter in their jobs. Specifically, they should be taught the basic presentations of cancer, the common treatment modalities, cure versus palliation and alternative therapies. However, issues of confidentiality prohibit volunteers having direct access to patients’ medical records.	“*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.*” *(volunteer)* Generally, volunteers reported good working relationships with professional staff	One source of stress derives from “boundary conflicts” - tensions between paid staff and volunteers over the work done by volunteers and the information (often deemed confidential) about patients that they wanted. . .

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Papers in Order of Date (Newest to Oldest)	Understanding of the Role . . . Them and Us/ We/Separate but Part of Whole	Hierarchy/ Power/ Recognition/ Feeling "Qualified"	Access to Information/ Trust	Access to Staff/Support/ Role of the Volunteer Coordinator	Boundaries
Sadler and Marty (1998)	The use of the pronoun "we" when referring to hospice was common among all those interviewed.	"*As a member of the team I feel that my reports are just as important as any of the other members. I can honestly say that no team member carries any more weight than anyone else. Each member has his or her area of expertise and then it is put on the table and we make a decision based on that information.*" *(volunteer)* the executive director, despite her hierarchical role in the organization, made the volunteers feel like an important part of the organization. "*it's the small things that the staff does for me that makes me feel good about my work*" *(volunteer)* . . . In short, while people expressed different levels of desire for recognition, many of the volunteers admitted that the informal and formal recognition they received was an important part of their desire to be volunteers. " *.. as long as hospice allows me to grow and helps me to understand myself as an individual, I will continue my relationship with the organization.*" *(volunteer)* it is important to make sure that volunteers attending team meetings arc made to feel comfortable, given advice on how to contribute to the meetings, and made to feel as much of an "expert" as the others at the meeting.		"*Although (the coordinator and director] do a good job of setting us up for the realities of volunteering, I think they should spend some time with us at the end of training and discuss our needs. I think it would be very beneficial to me and to other volunteers if we could sit down one-to-one with (them] and discuss how we can meet both hospice's needs as well as my needs.*" *(volunteer)* All of the interpersonal turning points emphasized the importance of interacting with hospice staff, volunteers, patients, and patients' families. Of these, the most important turning point, mentioned by all 17 volunteers, was the quality of interaction they had with hospice staff during training. In this study, the two main people involved regularly in training were the training coordinator and the executive director.	

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Paradis, Miller, and Runnion (1987)	Role ambiguity refers to conflicting obligations and responsibilities experienced by volunteers. For example, is the volunteer a patient advocate, a staff advocate, or both? Can a volunteer assume direct care responsibilities for a patient, or is that solely within the purview of staff?	Although volunteers felt comfortable working with staff, they were often unsure of their status in the organizational hierarchy They felt that staff should give them more feedback about the quality of their work.	Eight noted that they wanted more information from staff and expected greater staff-initiated communication with them.	The staff most directly in contact with the volunteers were the volunteer coordinator, nurse, and social worker. When asked to name the staff with whom they worked, most volunteers named a nurse.	

Supplement 3. Example of Initial Data Extraction Form for One Included Paper

Overgaard (2015) The boundaries of care work: a comparative study of professionals and volunteers in Denmark and Australia

Themes	Participant Quotes (First Order Constructs)	Primary Author Interpretations (Second Order Constructs)
Boundaries/ stepping on toes	"And it's the certainty that there is a razor-sharp line between being a professional and being a volunteer. The volunteers must of course not in any way interfere in the care." (Hospice Leader, Denmark) "And there was no clear-cut delineation of what they could and couldn't do. So, they might be feeding patients. Do they know how to assess [if patients] can or cannot swallow?" (Nurse Unit Manager, Australia)	Boundaries between volunteers and staff at the Danish hospice were created and articulated primarily as a means to prevent volunteers from participating in any direct caregiving Observational data revealed that volunteers at the Danish hospice were allocated practical, labour-intensive type jobs. Anything that involved direct care was off-limits to the volunteers; until recently, volunteers were not even allowed to enter the rooms of the patients
Understanding of the role . . . them and us/we/ separate but part of whole	"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." (Hospice Leader, Denmark)	(Australian) The use of volunteers was not understood to pose a risk to paid staff positions the volunteers at the Australian hospice perform work that overlaps with that of nurses and social workers in particular
Access to information/trust	"A volunteer came up to me after dinner and asked, "How old is that patient?" It may seem like an innocent question, (...) but we are not allowed [to tell]." (Nurse, Denmark) "There are times when we have raised concerns that a new patient has arrived and we, as hosts, haven't been informed that the person is almost blind or deaf." (Volunteer, Denmark)	The Danish hospice took a rather strict approach to confidentiality, which consisted of two layers: one between the paid staff and volunteers, and another between the volunteers and the outside world The strict approach to confidentiality sometimes made it difficult for the volunteers to perform their roles. Although confidentiality might be understood as a means of protecting care receivers, it might also be understood to protect paid staff from interference by volunteers. (Australian) The resignation and a change in management saw the volunteers' engagement significantly restricted to include less autonomous roles and required volunteers to work under supervision. Yet, at the time of data collection, volunteers were still trusted with extensive responsibilities and volunteers shared many job functions with the nursing staff and social workers, including work that required high levels of competency.

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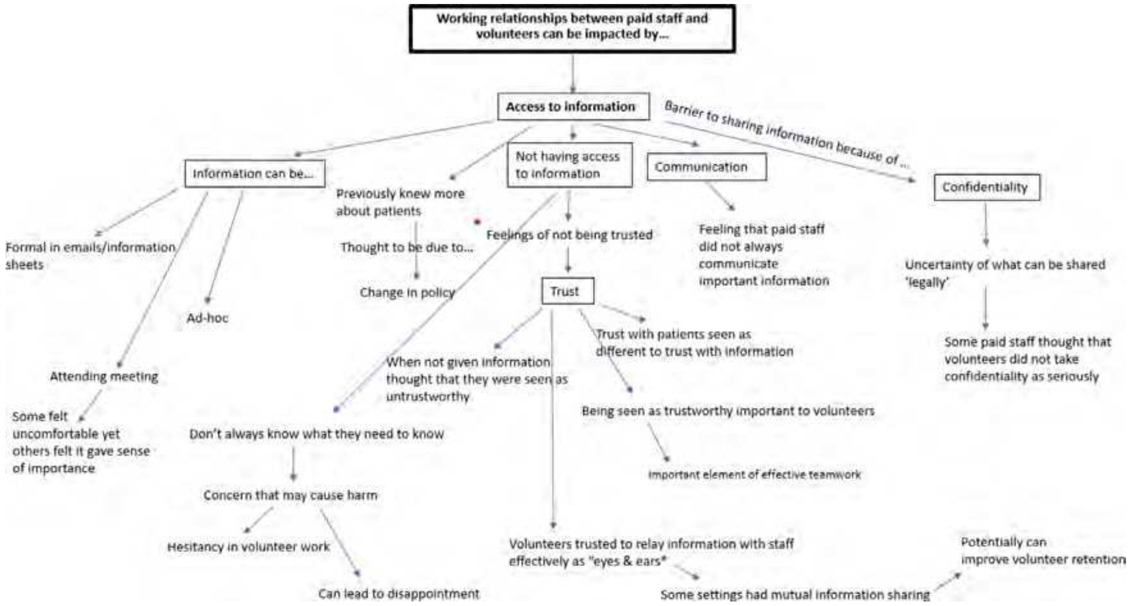
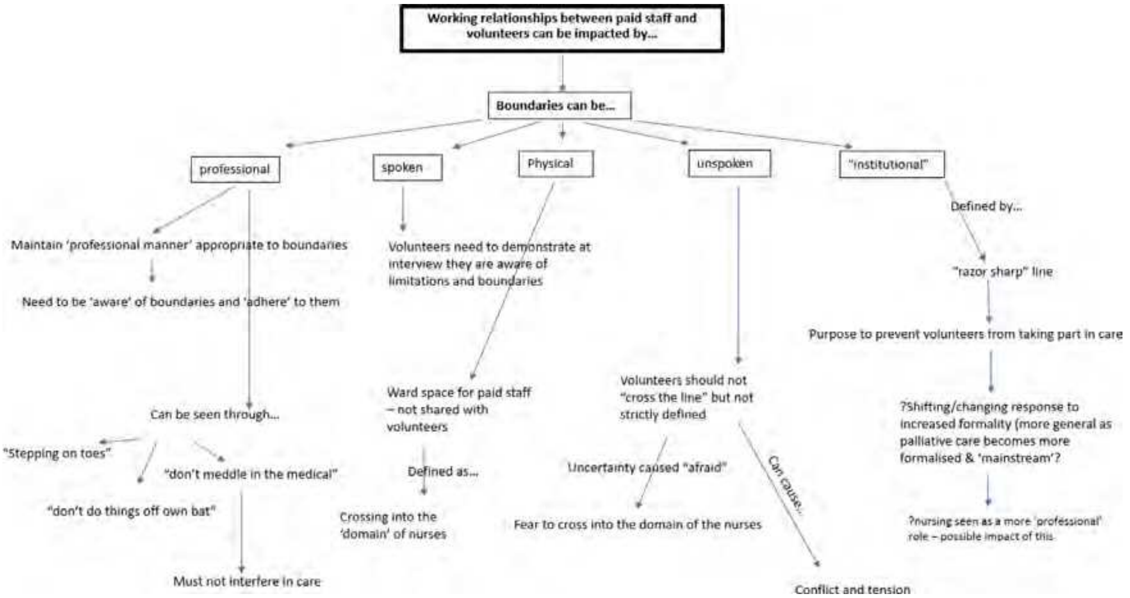
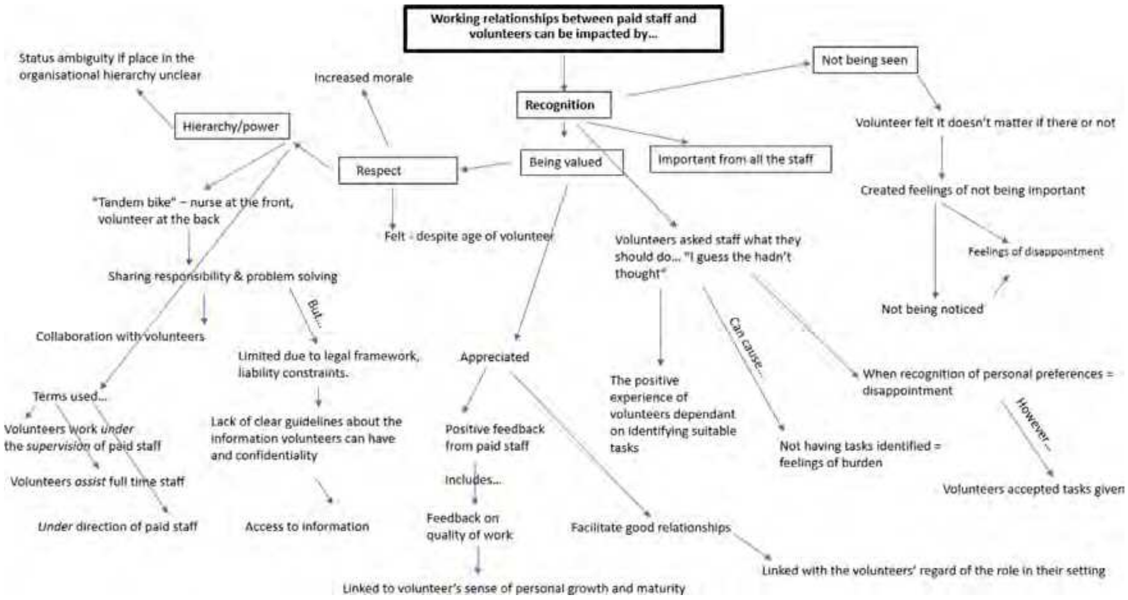
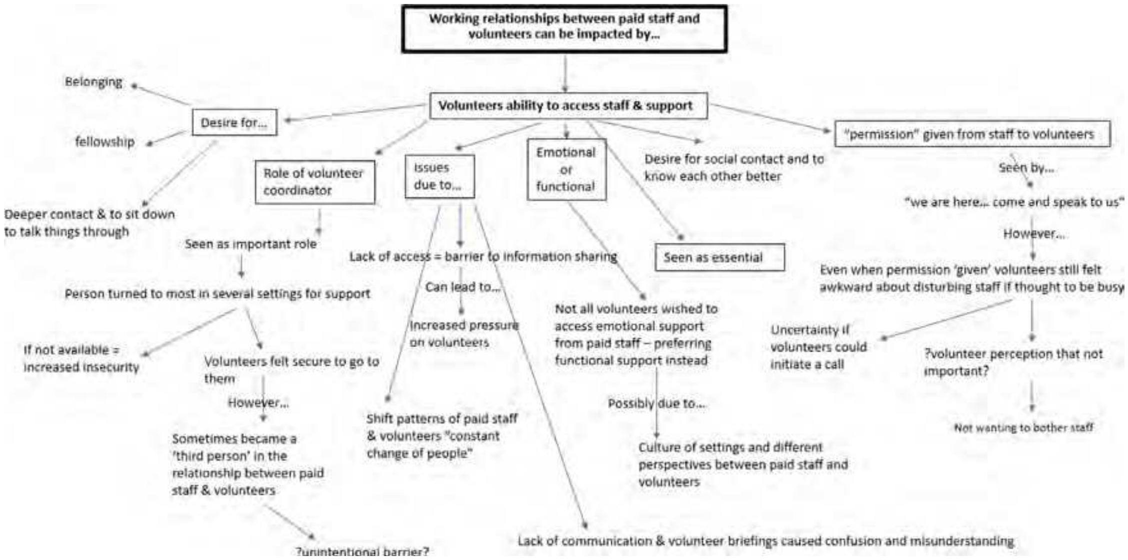
Themes	Participant Quotes (First Order Constructs)	Primary Author Interpretations (Second Order Constructs)
		At the Australian hospice, the concern for confidentiality was addressed in the same way with staff and volunteers, i.e., through education and monitoring. This approach to confidentiality reflected the general hospice culture of volunteers being trusted like other staff.
Hierarchy/ power		Danish professionals have effectively managed to maintain a monopoly over caregiving, which has resulted in a successful professionalisation project

Supplement 4. Concept Maps for Each Stary Line






Working relationships between paid staff and volunteers can be impacted by...
Recognition
Not being seen
Volunteer felt it doesn't matter if there or not
Created feelings of not being important
Feelings of disappointment
Not being noticed
Important from all the staff
Being valued
Respect
Increased morale
Hierarchy/power
Status ambiguity if place in the organisational hierarchy unclear
"Tandem bike" – nurse at the front, volunteer at the back
Sharing responsibility & problem solving
Collaboration with volunteers
But...
Limited due to legal framework, liability constraints.
Lack of clear guidelines about the information volunteers can have and confidentiality
Access to information
Terms used...
Volunteers work under the supervision of paid staff
Volunteers assist full time staff
Under direction of paid staff
Felt - despite age of volunteer
Appreciated
Positive feedback from paid staff
Includes...
Feedback on quality of work
Linked to volunteer's sense of personal growth and maturity
Facilitate good relationships
Linked with the volunteers' regard of the role in their setting
Volunteers asked staff what they should do... "I guess the hadn't thought"
The positive experience of volunteers dependant on identifying suitable tasks
Can cause...
Not having tasks identified = feelings of burden
When recognition of personal preferences = disappointment
However...
Volunteers accepted tasks given


Working relationships between paid staff and volunteers can be impacted by...
Volunteers ability to access staff & support
Desire for...
Belonging
fellowship
Deeper contact & to sit down to talk things through
Role of volunteer coordinator
Seen as important role
Person turned to most in several settings for support
If not available = increased insecurity
Volunteers felt secure to go to them
However...
Sometimes became a 'third person' in the relationship between paid staff & volunteers
?unintentional barrier?
Issues due to...
Lack of access = barrier to information sharing
Can lead to...
Increased pressure on volunteers
Shift patterns of paid staff & volunteers "constant change of people"
Lack of communication & volunteer briefings caused confusion and misunderstanding
Emotional or functional
Not all volunteers wished to access emotional support from paid staff – preferring functional support instead
Possibly due to...
Culture of settings and different perspectives between paid staff and volunteers
Desire for social contact and to know each other better
Seen as essential
"permission" given from staff to volunteers
Seen by...
"we are here... come and speak to us"
However...
Even when permission 'given' volunteers still felt awkward about disturbing staff if thought to be busy
Uncertainty if volunteers could initiate a call
?volunteer perception that not important?
Not wanting to bother staff